Human Subject Research Oversight and Monitoring Procedures

I. Introduction

These procedures supplements the Human Subject Research Oversight and Monitoring Policy ("Policy"). All terms used in these procedures have the same meaning set forth in the Policy, unless otherwise defined in these procedures.

There are two types of Reviews associated with the Policy and these procedures: Routine and Directed. The Office of Research, in consultation with the IRB chair, will conduct Routine Reviews at a frequency consistent with the number of currently active protocols (approximately 2-5% per year). Directed Reviews generally are initiated due to a concern with the conduct of the Human Subjects Research, such as noncompliance, complaints, unanticipated problems, lack of enrollment, or other unusual circumstances, and, therefore, will be conducted only when requested or deemed need by the Office of Research.

The Review team usually will include one representative from the Office of Research, who will lead the Review, and one or two members of the IRB.

II. Review Preparation

A. Protocol Selection for Routine Reviews. Protocols will be selected from any 3 categories of review (exempt, expedited, or full review) on a random basis. Selection does not imply any suspected noncompliance. All open protocols in the IRB SharePoint will be assigned a number, starting with the number 1. On a monthly basis, random numbers will be generated (using programs such as random.org) between 1 and the total number of currently approved protocols. The protocol with an assigned number that corresponds to the randomly generated number will be selected. Reasonable effort will be made to review multiple departments/units, as well as investigators. For example, if a protocol is selected that was recently reviewed and resulted in no compliance concerns, then that protocol will be set aside and another protocol will be randomly selected. A risk-based selection process may also be utilized, randomly selecting from those studies reviewed by either expedited or full board procedures. When this type of selection process is used, the Office of Research considers level of risk of the protocol, the potential enrollment of vulnerable populations, protocol complexity, expertise of the study team, and compliance history.

B. Timing. All Routine and Directed Reviews will be performed at a previously determined scheduled location Monday through Friday during regular business hours. The length of the review will vary depending on protocol specific elements (e.g., the number of case report files to be examined, the overall state of the protocol documentation, and the preparedness of the staff).

C. Notification. The Office of Research contacts the PIs in advance of All Routine and Directed Reviews to: establish a time and place for the review; describe the process; and identify the type of documents that the PI will need to provide for review. The department Chair will also be notified. With the cooperation of the PI, it is expected that the audit visit can be scheduled in a timely manner.

D. Scope of Review. A Review may include evaluation of any or all of the following:

- review of the protocol file
- review of investigator's research records
- meetings with investigator, and/or other research team member(s)

The scope of any Review may be modified as necessary, in the Office of Research's discretion.

E. Documentation. The PI is responsible for making all relevant and/or requested documentation and materials are available for an evaluation, including:

- records of IRB approvals
- informed consent documentation and recruitment materials
- data records (hard-copy and electronic records)
- records of complaints, problems, or unanticipated events involving risk to participants or others

Any other documentation materials the Office of Research deems appropriate or necessary to the Review must be made available by the PI upon request.

III. The Review.

The steps that are involved in a Review usually include: an opening meeting, active protocol review, and closing meeting.

A. Opening Meeting. On the first day of the Review, if possible, an opening meeting will occur. The attendees will include the Review team, the Principal Investigator, the lead study coordinator and any additional key personnel that the PI wishes to invite to the meeting.

B. Active Protocol Review. The protocol evaluation portion of the Review may include any or all of the following: an assessment of the overall conduct of the study, the division of responsibilities for particular portions of the protocol, the documentation of the degree of delegation of authority and the appropriateness of this delegation of authority (certification/training), the "informed consent" process, and assess how the data was recorded and how the research article (such as the drug, device, or biologic) was accounted for and maintained. The Review team will usually conduct a Review based on a prepared checklist.

C. Closing Meeting. The closing meeting will be held after all assessments have been performed. At this meeting, action items assessed during the Review will be discussed with the PI and other appropriate parties, potentially resolving some of the action items.

IV. Post Review

A. Summary and Report. After the closing meeting, the Office of Research will generate a Final Compliance Review Report, which will summarize the Review findings and recommendations. The Office of Research will send a draft version of the report to the PI for review and will provide the PI with five business days to provide comments, if the PI so

desires. A final version will be disseminated to key research personnel, the IRB, department chair, and others, as applicable. The PI will receive a copy of the report, corrective action requests, if any, and applicable subsequent steps.

B. Review Results. Possible Review results include: satisfactory; needs improvement; and significant findings exist.

1. Satisfactory. If the Review findings do not identify any compliance concerns, the Office of Research takes no further action. Receipt of a "satisfactory" result does not imply a guarantee of the absolute integrity of the data that was scrutinized nor the ability of the Research to stand up to an agency, sponsor or other institutional audit or review.

2. Needs Improvement. Needs Improvement is indicated when compliance concerns are found and considered minor. When this occurs, the PI will be provided with correspondence detailing the findings and corrective action plans, if any. Corrective action plans for minor findings may include, for example, completion of additional education or training, correction and proper documentation of the issues identified, or other resolutions as determined by the Office of Research.

3. Significant Findings Exists. When significant findings exist, the IRB Chair, and the Associate Provost for Research will conduct additional review. This review will determine whether serious or continuing noncompliance and/or unanticipated problems involving risks to Human Subjects or others have occurred, and a determination will be made regarding suspension or termination of the Research, when appropriate. In cases of that identify an immediate concern regarding the safety of study subjects, the IRB chair may act accordingly without convening an IRB meeting (e.g. suspend a study in order to avoid harm to human subjects); however, no protocol may be permanently terminated without the concurrence of the IRB at a convened meeting.

    a. Reporting serious or continuing non-compliance to federal regulatory agencies and external organizations**.** As required by applicable law, any serious or continuing non-compliance will be immediately reported by the Office of Research to the Institutional Official, department chair, facility where the research is being conducted, funding agency (if applicable), OHRP, and, if a drug, device, or biologic is involved, the FDA. Other IRBs that are relied upon may also be notified regarding findings regarding investigator compliance as appropriate.

C. Corrective Action Requests.

1. If the Review identifies problems or deficiencies, the Office of Research includes appropriate corrective actions requests in the written report. The Investigator is expected to follow-up with any actions required and to develop a corrective and preventive action plan in a timeframe determined by the Office of Research.

2. The Office of Research follows up with the Investigator to ensure these corrective actions are completed and keeps the TCU IRB updated on the matter.

3. If the corrective actions are not completed within the designated timeframe, the Office of Research will notify the IRB, which may take action, including the suspension of the study that was reviewed or of all the studies that an Investigator is conducting.

4. If the Review identifies non-compliance, such as lack of oversight, deliberate falsification or omission, failure to comply with the requirements and determinations of the IRB, significant protocol violations, or deviations or frequent occurrences of such, the IRB and Office of Research will work in consultation to determine appropriate disciplinary action.

V. Review Closing.

Once the Office of Research is satisfied that all corrective action has been implemented and all action items are resolved, the Office of Research may take steps to close the review. In instances where the Review results were "significant finding exists", the Office of Research must notify the IRB Chair and the Associate Provost for Research of the intent to close the Review and may not close the Review until both parties consent to the closure.

Upon Review closure, the Office of Research will send letter (usually electronically) to the PI confirming the closing of the Review. A copy of the letter will be sent to all parties previously notified in the Review process. If action items are not addressed in the designated timeframe, the Review will remain open until all action items are resolved and a "Failure to Timely Respond" letter will be issued to all appropriate parties.

VI. Related Policies and Procedures

Human Subjects Research Oversight and Monitoring Procedures
Protection of Human Subjects in Research Policy and Procedures
Research Integrity Policy
TCU Code of Conduct