OBJECTIVE

To describe the policies and procedures for IRB audits and monitoring.

POLICY

Charles R. Drew University of Medicine and Science (CDU) Office for the Protection of Human Subjects (OPHS) will conduct audits and monitoring of research protocols and IRB operations to protect human research participants and to ensure adherence to applicable regulations and IRB policies.

PROCEDURES

Auditing Investigators

Routine audits. At the discretion of the OPHS, routine audits are done by notification to the investigator with the reason for the request, who needs to be present, and any information that is required during the on-site visit. The criteria for routine audits, but not limited are listed below.

1. PI’s with several active protocols that are currently open
2. Investigator-sponsored studies
3. Follow-up of previous audit or corrective action plan
4. Studies with large enrollment numbers
5. Requests from PI or staff support
6. Studies with significant risk device
7. PIs doing human participant research for the first time
8. Phase I studies
9. High risk studies that have no adverse events or unanticipated problems

Specific Audits. Specific audits are done at the discretion of OPHS or requests from the IRB chair and/or IRB. OPHS looks for adherence to applicable regulations and IRB requirements in these audits. These audits usually inspect a specific documentation or conduct of the study, such as informed consent documentation, informed consent process, adherence to eligibility criteria, or regulatory documentation. These audits are done with none or minimal notice to the PI. Unsatisfactory results may lead to routine or for-cause audit.

For-cause Audits. These audits are conducted if OPHS or IRB obtains information which raises serious concerns regarding the research participant safety, rights and welfare, investigator non-compliance, or the integrity of the data. These audits may be conducted without any notice to the PI. Unsatisfactory audit may result in suspension or termination. The criteria for for-cause audit are as follows, but not limited to,

1. Unexpected death of the research participant.
2. Complaints from research participant, family, or research support staff.
3. Numerous unanticipated problems, significant serious adverse events, protocol deviations, incidences.
4. Allegations or concerns of non-compliance by research support staff or a third party.
5. Verification from sources other than the PI that unapproved changes have occurred since the previous IRB review.
6. Requested by IRB, research participant, research staff, Data and Safety Monitoring Board (DSMB), third party not associated with research, or other committees having oversight in human research protection.

Investigator Responsibilities

1. Investigator and/or research personnel should cooperate with the auditor with regards to the IRB documentation, observation of consent process, and/or interview. For routine audits, the investigators and staff personnel, whose presence are requested by OPHS, must be available at the time of the audit for questions and answers, as well as showing the research site. Investigator must also respond to any pre-audit letters.

2. An exit interview may be conducted by the auditor to discuss preliminary findings and recommendations with the investigator and/or research staff.

3. OPHS will prepare an audit report and send to the investigator.
4. The investigator will respond, if necessary, in writing to the auditor’s report with corrective action plan as requested within the specified period of time.

5. If there are any outstanding issues that results from the audit, the investigator should work with the auditor to resolve the issue.

6. Investigators will follow the recommendations by the IRB Chair and/or IRB Committee’s decisions. These may include satisfying the corrective action plan, as well as completing education and training within a specified time.

7. The IRB may request that the investigator attend the fully convened IRB meeting to address the audit report.

**IRB Chair/Committee Responsibilities**

**Routine Audits**

1. IRB Chair (or designee) in collaboration with IRB Director (or designee) or IRB will review the routine audit report and investigator’s written response.
   
   a. May request for-cause audit to obtain further information.
   b. Recommend further actions for participant safety.
   c. Recommend education/training for the PI and research team.
   d. May suspend research activity while OPHS conducts for-cause audit or further investigations.

2. Discuss and make decision on the audit report and PI’s written response at the fully convened IRB meeting.

**Specific Audits**

1. IRB Chair (or designee) in collaboration with IRB Director (or designee) or IRB will review the results of the specific audits.
   
   a. May lead to routine audit or for-cause audit to obtain further information.
   b. May suspend research activity while OPHS conducts further audit or investigation.

2. Discuss and make decision on the audit report at the fully convened IRB meeting.

**For-cause Audits**
1. A fully convened IRB will review the for-cause audit report and the PI’s written response.

2. The Chair may request that the investigator attend the IRB meeting.

3. IRB will determine to accept the for-cause audit report without any revisions to the approved study or IRB may request additional provisions to protect the safety of the participant.
   
   a. Request status report after each participant receives intervention.
   b. Continuing review more frequent than once a year.
   c. Require independent safety monitor or DSMB.
   d. Require progress report between the continuing reviews.
   e. Request follow-up audit at specified times.
   f. Limit other research activities.
   g. Increased monitoring of informed consent process for a specified period of time.
   h. Recommend an education plan for the investigator and/or research staff.
   i. Accept the audit report and suspend the research activity in part or whole.
   j. Accept the audit report and terminate the study.
   k. Suspend or restrict research privileges of the investigator.

4. OPHS staff will generate a letter to the PI with the IRB’s determinations and recommendations, including an explanation that any appeal must be made to the IRB in writing within 30 days from the date of notification.

**OPHS Responsibilities**

**Routine Audits**

1. OPHS auditor will schedule an on-site audit visit specifying the individuals that needs to be present for the audit and any document that will be reviewed.

2. The OPHS auditor may review the following items during the audit.
   
   a. Observe consent process and review consent documents
   b. Verify that approved advertisements and other recruitment material are being used
   c. Check storage of investigational drugs and use of investigational devices
   d. Review projects to verify from sources other than the investigator that no unapproved changes have occurred since previous IRB review
   e. Review of regulatory binders, source documents, adverse event reports and safety reports
3. The auditor may conduct exit interview with the investigator and/or the research staff to discuss the preliminary findings.

4. The auditor will make an audit report and send to the investigator, IRB Chair and IRB Director. The auditor will report the results of the audit report to the IRB.

5. The routine audit report will be put in the compliance file, along with any pertinent documentation. The information will be entered into the routine audit database.

6. The audit report will be placed in the investigator's file.

7. Non-compliance will be reported to the IRB Chair and IRB Director promptly for review and determinations.

Specific Audits

1. The auditor will conduct same-day audit on the following items, but not limited to

   a. Informed consent document
   b. Informed consent process
   c. Adherence to eligibility criteria
   d. Regulatory documentation

2. The auditor may summarize the preliminary findings to the investigator and explain procedures to resolve any outstanding issues.

3. An audit report will be provided to the investigator, IRB Chair, IRB Director, with recommendations. The auditor will report the results of the same-day audit at the next IRB meeting.

4. The same-day audit activity will be put in the compliance file, along with any pertinent documentation. The database will be filled in with the results of the audit report.

5. The audit report will be placed in the investigator’s file.

For-cause Audits

1. The auditor will conduct the audit on the following items, but not limited to

   a. Consent documentation or observation of consent process.
   b. Review of all study documentation, regulatory binders, source binders, monitoring reports.
c. Review of selection and recruitment methods and verification that those appropriate participants are enrolled in the study.
d. Review of emergency procedures.
e. General discussion with the PI and research staff about the study protocol, consent process, recruitment process, any challenges, adverse events and unanticipated problems.

2. Exit Interview

   a. The auditor may summarize the preliminary findings to the investigator and explain procedures to resolve any outstanding issues.
   b. The auditor will document the preliminary findings and recommendations.

3. Reporting

   a. An audit report will be provided to the IRB Chair, IRB Director, and IRB.
   b. The audit report may be reviewed and discussed at the next IRB meeting.

4. Documentation

   a. The for-cause audit activity will be put in the compliance file, along with any pertinent documentation.
   b. The database will include the results of the audit report, when to conduct the next audit, status of non-compliance, required education, and progress report.
   c. A reminder system will be set up for all the above actions.
   d. The audit report will be placed in the investigator’s file.

Self-Assessment by OPHS

1. OPHS will conduct a quarterly self-assessment to review adherence to applicable regulations and IRB policies and procedures. OPHS will use the self-assessment checklist as a tool to measure adherence. These will include, but not limited to the following:

   a. Review of IRB minutes and agenda
   b. Accuracy of database
   c. Accuracy and completeness of investigator’s files
   d. Accuracy in determining exempt, expedited, and full review application

2. Information of the self-assessment checklist will be documented in the database.

3. The relevant documents pertaining to the quarterly self-assessment will be electronically filed under OPHS self-assessment.
4. The results of the self-assessment will be reported to the IRB and the FWA institutional official.

**Monitoring Investigator-Initiated Studies**

1. Quality Assurance (QA) Monitor/Research Subject Advocate (RSA) will monitor previously approved project to ensure regulatory and IRB policy compliance and ethical obligations to the participants.

2. The QA Monitor/RSA is responsible for monitoring the conduct and progress of the human participant research in order to ensure that the rights and well-being of human participants are protected, the reported data are accurate, complete, and verifiable with source documents, and study is conducted in compliance with currently approved IRB protocol, Good Clinical Practice Guidelines, applicable regulatory requirements and institutional policies.

3. QA Monitor/RSA conducts an on-site monitoring visit. The criteria for being selected for monitoring are as follows but not limited to,
   a. Random selection
   b. Complex projects involving unusual levels or types of risks to participants
   c. Projects conducted by a PI who previously failed to comply with IRB determinations
   d. Projects where continuing review or reports from other sources have indicated that changes without IRB approval may have occurred
   e. As requested by the IRB or OPHS

4. The on-site review may include, but not limited to,
   a. Contacting research participants about the informed consent process
   b. Observation of the consent process
   c. Review of informed consent documents
   d. Review of regulatory binders and source documents

5. QA Monitor/RSA can verify information presented or provided by the PI or research staff. These verifications include, but not limited to;
   a. Inconsistencies in the submitted protocol
   b. Information as requested by the IRB
   c. Verification of information provided by PI who has history of non-compliance or difficulty interacting with IRB
   d. Past history of continuing review problems
e. Ensuring that significant new findings that might affect the willingness to continue participation are adequately provided to the participants

6. QA Monitor/RSA can also work with IRB Analyst to facilitate submission and review of research protocols. They can also work with PIs to submit protocols that require modifications after pre-review by the analysts.

Regulations

45CFR46
21CFR50
21CFR56