



IRB GUIDANCE: Quality Assessment Program (Pilot Phase)

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INTRODUCTION

Investigators must follow the standards outlined in [Policy IRB-01](#). This guidance supplies information related to the IRB Quality Assurance Program, set up to help investigators and the IRB supply reasonable assurance of the integrity of human research overseen by the SUNY Downstate Health Sciences University IRB & Privacy Board.

The goal of the Quality Assessment Program (QAP) is to review, inspect and verify the ethical conduct of human research, integrity of data, adherence to the IRB approved protocol, and applicable institutional, state, and federal regulations, policy, and guidance. This program is non-punitive in nature designed to be a productive process for investigators while striving for continuous improvement in every area of the research enterprise. It is important to address newly discovered problems right away and use this as a learning tool to prevent future problems. It is important for investigators and QAP Assessors to be initiative-taking and look for similar issues in other studies. The QAP program is a way to assess readiness for external audits by the Food and Drug Administration (FDA), Office of Human Research Protections (OHRP), You're your State Department of Health (NYSDOH), or a sponsor. With advanced planning and strategic corrective actions, the Downstate QAP improves opportunities for continuous quality improvement and protection of research participants.

Submit any reportable events discovered during the QAP to the IRB within the required reporting timelines as outlined in Policy IRB-01.

This guidance is the IRB's current thinking on this topic; however, the use of the word "must" in this document means the concept is a Downstate policy or regulatory requirement. The use of the word "should" in this document means the concept is guidance, recommended, or suggested, but not needed. An investigator may use an alternative approach if the approach satisfies regulatory requirements. For more information, please contact the Downstate IRB Office at irb@downstate.edu

The IRB is instituting this guidance as a pilot phase. Send feedback on the pilot phase to IRB@downstate.edu

DEFINITIONS

The definitions below are from the Downstate IRB and should serve as general guidance:

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Clinical Trials Office (CTO) Assessment: A quality assessment completed by a member of or a consultant for the Downstate CTO.

Corrective Action and Preventative Action (CAPA) Plan: Corrective actions are those taken to resolve a problem and preventative actions are those actions that keep the problem from recurring.

Corrective Action: Actions take to correct a problem that has already occurred or found.

For-Cause Quality Assessment: Requests for a For-Cause Quality Assessments may come from anyone, including research participants, research staff, investigators, or sponsored research administration, who may contact the IRB to report a concern. For example, requests may come from the IRB, Department Chair, Dean, Institutional Official, Research Integrity Officer, Downstate Leadership, Office of Compliance and Audit Services (OCAS), or CTO. The IRB Chair or Vice-Chair must approve any request to conduct a For-Cause Quality Assessment and may decide the focus of the assessment.

Institutional Review Board Quality Assessment: Assessment which is conducted at the discretion of the IRB or OCAS as a part of ongoing quality assurance.

Immediate Corrective Actions: Immediate corrective actions taken once an investigator becomes aware of a deviation or unexpected event.

OCAS Assessment: A quality assessment completed by a member of or consultant for the Downstate OCAS Office.

Preventative Action: Action taken to keep a problem from recurring.

Root Cause Analysis: A problem solving method used to find the cause or source of a deviation or problem.

Routine (Not-For-Cause) Quality Assessment: Assessment which is conducted at the discretion of the IRB, CTO, or OCAS, for post-IRB approval assessment.

PROCEDURES

The QAP Assessor may review any research project, including exempt studies.

The QAP Assessor notifies the PI in advance to schedule a Routine (Not-For-Cause) Quality Assessment. An example of this notice is available as a separate IRB guidance document.

For-Cause Quality Assessments may occur without prior notification. Follow-up written notice should occur as the assessment takes place. An example of this notice is available as a separate IRB guidance document. The Quality Assessment Team includes Associate IRB Administrators

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and may include members of the Office of Compliance and Audit Services or consultants, as needed.

The Quality Assessment Team and/or OCAS will conduct random assessment of IRB records on a quarterly basis. The Principal Investigator of the project is notified of any applicable findings.

All assessments will be completed using IRB Form 21-1. When applicable or as determined by the IRB, OCAS, or CTO, the study team completes a CAPA Plan on IRB Form 21-2. The IRB, OCAS, or CTO may provide suggested recommendations for the CAPA, when applicable. Form 21-1 and 21-2 are signed by the PI and submitted in IRBNet by the PI to the IRB for review.

The QAP Assessment Team may review the response submitted to the IRB and may supply more information; however, the IRB has the final authority over issuing any IRB determination related to the QAP.

STUDY TEAM PREPARATION

Being prepared for a QAP review is critical to the success of the review. While the PI may receive advance notice for a not-for-cause review a for-cause review or other audits by the FDA, OHRP, NYSDOH, or sponsor, may occur without notice or very minimal notice. Preparing for such reviews involves daily efforts and requires the study team to follow best practices and always maintain a state of readiness.

For best practices related to clinical trials, please contact the Downstate Clinical Trials Office.

All study and IRB files should be complete, current, and correct. All IRB and research staff should be up to date and current with all required education and training.

The QAP program is one way to assess readiness for external audits by the FDA, OHRP, NYSDOH, or sponsor.

SELECTION CRITERIA

For-Cause Quality Assessments occur for any reason approved by the IRB Chair or Vice-Chair, not limited to the following:

- Allegation of non-compliance,
- Data discrepancies,
- Documented accounts of noncompliance or possible non-compliance,
- Failure to obtain continuing review or study closure,
- Follow-up from monitoring visit or an external inspection such as FDA, OHRP, NYSDOH,
- Indication of increased risks to study participants,
- Indication or concerns over the ethical conduct,
- Known or suspected issues with study conduct or data integrity,

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- Lack of unreported reportable events,
- Reason to need verification that research is conducted following the IRB approved protocol,
- Report of concern from a 3rd Party,
- Research Participant or Family Member complaint,
- Response to a substantive written or verbal allegation,
- Response to a sign or indication of non-compliance,
- Request by the Reviewing (External) IRB,
- Suspected research misconduct, serious or continuing non-compliance, or unanticipated problem,
- When FDA issues safety warnings, or
- When there is a change in FDA labeling that increases risks.

Projects are randomly selected for **Routine (Not-For-Cause) Quality Assessment**; however, the Assessors have the discretion to select projects based on stratification and risk level, not limited to the following:

- Experience of investigators,
- Federally funding,
- High degree of uncertainty of risks,
- Investigator-Initiated studies,
- IRB's experience of past investigators,
- Nature or risks posed by the study,
- Phase I or II clinical trials,
- Protocols enrolling vulnerable populations,
- Protocols involving a DSMB,
- Protocols involving international research.
- Protocols which scheduled for audit by FDA, OHRP, or NYSDOH.
- Protocols which do not have external monitoring,
- Protocols with a high number of participants,
- Protocols with more than six reportable events, or
- Protocols with novel therapies.

DOCUMENTATION REVIEW

The items reviewed in a for-cause assessment are similar to those reviewed in a routine assessment. This is an in-depth examination of all components of a research study including, but not limited to all records and documents, observations of processes, and interviews with

investigators, research staff members, and participants for the purpose of deciding if the rights and welfare of participants are upheld according to federal regulatory and IRB requirements.

Most assessments involve the review and inspection of informed consent forms, documentation of the consent process, reported data, regulatory records, source documents to ensure protocol compliance and drug accountability records. The assessors may also request to review the site's internal standard operating procedures (SOPs) for conducting human research and copies of the research team's credentials and documentation of training to ensure proper delegation of specific research tasks.

The Principal Investigator must make all documentation available to the Quality Assessment and/or OCAS, not limited to the following:

- Protocol
- Investigator's Brochure (if applicable)
- Logs (Screening/Enrollment/Delegation/Deviation/Monitoring Visits/Training)
- Records of kept tissue or fluid samples
- Laboratory certifications and lab normal ranges (when applicable)
- Correspondence (e.g., relevant, significant communications with study sponsor, monitor, CRO, or FDA).
- Investigational product labeling, accountability, receipt, storage (if applicable)
- All IRB approved documents and correspondences, including:
 - IRB first applications, renewals, amendments with associated Modifications Required letters, Deferral letters, and Approval letters from the IRB
 - Recruitment material (e.g., flyers, advertisements, newsletters, letters, e-mail) with documented IRB and sponsor approvals
 - All subject materials (i.e., questionnaires, medication diaries, etc.)
 - Safety Report submissions and associated acknowledgments
 - All stamped approved revised versions of the Informed Consent document, assents, and short form for non-English speaking subjects
 - All stamped approved HIPAA Authorization Forms
 - Documentation to prove prompt reporting of adverse events and protocol deviations according to the Immediate Reporting Policy, including Further Information Required and acknowledgment letters from the IRB
 - Exception Requests and associated IRB approvals
- DSMB Report submissions and associated acknowledgments
- Study Team Credentials and training such as:
 - Required Human Research Training, as applicable to the research,
 - Protocol-specific training,
 - Conflicts of interest disclosures and management plans,
 - Curriculum Vitae, and/or
 - Licenses

- Appropriate certification, when needed,
- Research participant source documentation,
- Participant source documentation, including signed Informed Consent Documents (and other related documents). The Assessment Team will decide the number of documents to review. Below is general guidance for their consideration:

TYPE OF REVIEW	TARGET
For-Cause Assessments.	100%
Routine (Not-For-Cause) Quality Assessment, when the study recruited twenty-five (25) or more participants.	Review a random sample of 10%, but no fewer than 25. Always include the first participant enrolled who received study treatment.
Routine (Not-For-Cause) Quality Assessment, when the study recruited fewer than twenty-five (25) or more participants.	100%
Investigator Requested Quality Assessment.	Review a random sample of at least 20% of participants, but no fewer than 3.
Preparation for external inspection.	Review a random sample of at least 20% of participants, but no fewer than 3.

- Evaluation of participants' records will consist of the following:
 - Evaluation of signature, date, and time (where applicable) on informed consent(s), assent(s), and HIPAA Authorization documents, including copy in the electronic medical record (EMR), when needed.
 - Confirmation of participants' eligibility.
 - Study visit assessment.
 - Assessment of participants' adherence to protocol: drug accountability, deviations, etc.
 - Adverse events (AEs and SAEs) assessments and reporting.

SITE REVIEW

When applicable, a tour of the research facility to verify control, storage, and accountability of investigational new test articles, confirm availability of related research equipment, confirm there is adequate space to ensure privacy, confidentiality, and safety of research participants and others.

The Assessor will determine and schedule an unrecorded observation of an investigator conducting the informed consent process for part of the QAP, as required under federal regulations. Prior to observing the informed consent process, the investigator must explain the QAP to them and ask the potential research participant for their verbal permission to be observed during the process. The Assessor will confirm permission to observe the consent process. If they decline to participate, the Assessor will schedule the observation of another participant. The Assessor must document a participant's verbal permission to see the informed consent process.

INTERVIEWS

The Assessor uses their discretion or may consult with the IRB Chair or Vice Chair to decide the need to conduct interviews with Principal Investigator, study team members, and participants.

The Principal Investigator interview takes place on the first day of the assessment to assess the overall research conduct. The interview may last up to 30 minutes and include discussion of the following:

- Assessment of general understanding of research activities.
- Process for delegation of responsibilities.
- Data collection process.
- Practices to support privacy and confidentiality.
- Process for conducting and documenting the informed consent process.
- Process for assessing and documenting adverse events.
- Review of the recruitment practices.

The Assessment Team may interview any investigator or delegated person on the research study. The Assessor bases the interview discussion on individual's role on the protocol and may include:

- Understanding of regulatory obligations.
- Training prior to assuming protocol responsibilities.
- Informed consent process.
- Reporting to the IRB and other regulatory bodies.
- Data security practices and procedures to ensure privacy.
- Practices and procedures to ensure confidentiality.
- Study team communication.
- Protocol management.

The Assessor should tour the research facility to confirm appropriateness for research.

The Assessor may interview study Participants when the preliminary assessment findings warrant further discussion with them to gauge whether the participant understands that he or she is engaging in research rather than receiving clinical care, whether the elements of consent were discussed during the informed consent process, and whether the participant understands the research. The Assessor must document a participant's verbal permission to take part in an interview.

The Assessment Team should conduct an exit interview within 3 days of the completion of the assessment, as soon as possible depending on everyone's availability. The Principal Investigator and Assessor must be present during the exit interview; however, they may invite others to attend.

The Principal Investigator may recommend alternative corrective actions or follow-up.

The Assessor documents recommendations on the Assessment Form which is signed and dated by the Principal Investigator and Assessor.

FINDINGS

Upon completion of the Quality Assessment, the Principal Investigator (PI) will receive a Preliminary written report based on the information gathered during the process. The PI may respond the preliminary report within the stated timeline, prior to the Quality Assessment making the final report.

Of note, the Assessment Team may or may not find any areas of reportable non-compliance.

If the Assessment Team and/or IRB find non-compliance with regulations, policies, and/or the IRB-approved protocol, the Principal Investigator must implement a corrective action plan based on the degree of the noncompliance. The Assessment Team may recommend specific corrective actions. The Principal Investigator may choose whether or not to implement the recommendations or supply his/her own.

When required, the Principal Investigator must send a corrective action plan to the IRB within 21 days of the receipt of the Quality Assessment letter. In extenuating circumstances, the Principal Investigator may request an extension from the Assessor or IRB of no more than 21 additional days to complete the corrective action plan.

The Principal Investigator must submit any required reportable event in IRBNet within the required time deadlines outlined in Policy IRB-01.

CORRECTIVE ACTIONS

The Principal Investigator must implement a Corrective Action and Preventative Action (CAPA) Plan for any findings and report reportable events to the IRB. Later focused assessments may occur to ensure adherence to the CAPA plan and/or ensure corrected non-compliance.

CONFLICTS OF INTEREST

When an investigator is also an IRB member, the investigator must recuse themselves for any IRB review, determination, action, or vote.

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For the purposes of this guidance, if any IRB office staff feel conflicted reporting any issues to their supervisor or the IRB, they may report the issue to OCAS.

APPEALING QUALITY ASSESSMENT FINDINGS

The PI take the follow progressive steps, within 7 days of receiving the finding:

1. The PI should consult with the Assessment Team to try to resolve the situation in an amicable manner.
2. If unresolved, the PI must contact the IRB Vice-Chair. The Vice-Chair may require a written submission or may require more supporting documentation, and/or consult with others about the matter.
3. Unless the Vice Chair refers the situation to the Chair or a Full Board meeting, the PI may escalate an unresolved appeal to the IRB Chair to further consideration.
Finally, for an unresolved appeal not referred to the full board, the PI may ask for a one-time written appeal to the IRB via the electronic IRB submission and reporting system. The IRB makes the final determination as to whether the assessment finding should stand.

QUALITY IMPROVEMENT & TRACKING

The IRB Office will track the status of all assessments on an Excel spreadsheet developed by their office.

The IRB Office will track findings on an Excel spreadsheet developed by their office. This log will be available for OCAS and the CTO, upon request.

The IRB Office will conduct quarterly QAP team meetings to understand issues and trends and review information in preparation for an annual QAP program assessment meeting. OCAS and CTO may take part in these meetings.

The Quality Assessment Team will meet on an annual basis to assess trends or gaps and make recommendations for improvement. The team supplies all findings and recommendations to the IRB for added analysis and feedback. OCAS and CTO may take part in any of these meetings, including the IRB meeting.

REFERENCES

[21 CFR 11, 21, 50, 54, 56, 312, 812](#)

[42 CFR 2 and 93](#)

[45 CFR 46, 160, 162, 164](#)

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[FDA Bioresearch Monitoring \(BIMO\) Checklists](#)

[FDA Compliance Program: Chapter 48: Bioresearch Monitoring](#)

[FDA: IRB Written Procedures](#)

[Food and Drug Administration Guidance for Industry: Electronic Source Data in Clinical Investigations](#)

[ICH E6 R2 \(GCP\)](#)

[OHRP: IRB Written Protocols: Guidance for Institutions and IRBs](#)

[SMART IRB: Post approval; auditing for studies subject to IRB review](#)

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