Procedure Title: Inspections and Audits of Research Records

Associated Policy:	Human Research Protection Policy (OSA Policy 1.0)		
Responsible Unit:	Office of Scholarly Activity		
Created:	09/05/2017	**Executive Lead:**	Chief Research Officer
Effective:	09/05/2017	**Revision History:**	.01 – 10/25/2017; .02 – 10/03/2019; .03 – 3/3/2023
Approved by:	Institutional Review Board		
Procedure Number:	118.03		
Key Words:			
Purpose:	To meet the responsibilities for protecting human subjects as issued by the Office for Human Research Protections (OHRP) requirement for individuals involved in the conduct or review of human subjects research at institutions holding OHRP-approved Federal Wide Assurances (FWAs)		

Process:
This SOP serves to inform all agents, offices, departments, and affiliate sites of PNWU regarding study audits to ensure proper documentation, record keeping, data analysis, and adherence to Federal regulations and PNWU SOPs in order to monitor, measure, and improve the effectiveness of the human research protection program.

This SOP must be used as a guide in parallel with OSA Policy 1.0. SOPs are not intended to supersede existing institutional policies, and local, state, and federal laws and regulations.

General Information:
Audits of ongoing studies are necessary to confirm compliance with approved procedures, study documentation, federal regulations, and to ensure subject safety and/or privacy. Audits may be performed by internal entities such as the Institutional Official (IO), the IRB Chair, or external entities such as the study sponsor, or federal regulatory authorities.

The PI and delegated research team members are required to permit monitoring and auditing by the IRB, the IO, the sponsor, and/or all appropriate regulatory authorities. The PI is responsible for maintaining a list of appropriately qualified persons to whom the PI has delegated significant study related duties.

Responsible Parties

The Institutional Review Board (IRB) is responsible for:

- Reviewing protocols to ensure research records and data management plans are supportive of potential audits/inspections.
- Verifying the validity and integrity of research data submitted in applications for approval.
- Ensuring that the rights and welfare of subjects participating in research have been protected.
- Conducting routine audits.

The Office of Scholarly Activity (OSA) is responsible for:

- Providing the necessary support to investigators and the IRB to help understand and apply federal regulations and FDA guidance.
- Securing a room for the inspection process that can be locked if the inspection is expected to span longer than one day.
- Monitoring compliance with this SOP via random audits, as necessary.
- Posting this SOP for the PNWU community.

The Institutional Official is responsible for:

- Assisting with audits (as needed).
- Consulting with the IRB Chair and IRB Administrator, preparing responses to regulatory agencies including recommendations for corrective actions when discrepancies are identified during an audit.
- Recommending study suspension to the IRB if audit corrective actions are not completed.

The Investigator is responsible for:

- Maintaining well-organized, accurate, and robust research files for all studies.
- Being prepared at all times for audits conducted internally or by the study sponsor or applicable regulatory agencies. Note: Some regulatory agencies will show up unannounced. The study team should always be audit ready.
- Ensuring compliance with the IRB approved protocol, federal regulations, and FDA guidance documents.

Definitions

Please reference the Glossary for complete definitions of the following terms and additional terms not listed.

- Audit
- Federalwide Assurance (FWA)
- Freedom of Information Act
- Institutional Official (IO)
- Internal Revenue Service (IRS)
- Principal Investigator (PI)
- U.S. Food and Drug Administration (FDA)

Procedure:

1. See SOP 113 Data Management and Disposition.

2. Upon request for an inspection or site survey, the PI must have all requested study-related records readily available.

3. Upon receipt of notification of an external audit , the personnel who first received notification, will immediately notify the:
   a. PI of the study
   b. PNWU IO at research@pnwu.edu
      - The IO will notify Sponsors, if applicable.
   c. Chair of the Department where the inspection or survey will occur.
   d. Dean of the college or Director of the program where the inspection or survey will occur.

4. The PI or designee should agree to an audit date to occur within a reasonable period of time. The PI or designee should request the following information:
    a. Starting date and expected duration.
    b. Individual name, identification. and contact information.
    c. Who and what is being inspected.
    d. Reason for the inspection.
    e. Requests for specific personnel.

5. The PI must be available during the inspection or survey. If the proposed date of the audit is inconvenient for the PI, he/she or designee may contact the individual to request rescheduling at a mutually convenient time. Note: regulatory authorities may not be willing to reschedule an audit.

6. The PI or designee must provide only the records requested by the auditor. The auditor may request all research study records including, but not limited to:
    a. Informed Consent and Authorization Forms
    b. Source documents - clinic charts, hospital records, x-rays, lab reports, subject's diaries, referrals, etc.
    c. Case Report Forms
    d. Protocols
    e. Test article accountability records, including any instances in which emergency breaking of the blind occurred
    f. SOPs
    g. Enrollment logs
    h. Screening forms
    i. Brochures
    j. Test article accountability records (storage, receipt, use, return of test article)
    k. Delegation of duties log

7. The PI or designee must be available in person during the audit. and not leave investigators alone. If the audit is external, you are advised to have a second person in the room (e.g., IRB Administrator or IRB Chair). All faculty and staff must cooperate with any inspection or survey. Investigators may request specific copies of records, and a tracking sheet should be used to account for all the requests. All study personnel should be available to answer questions for which they have direct knowledge.

8. The PI will meet with the investigator(s) at the conclusion of the audit to discuss any questions or findings. The PI and research team members should be prepared for the auditor to discuss:
    a. Deviations from the protocol
    b. Applicable regulatory requirements
    c. Signed investigator agreement
    d. SOPs and investigational site processes
    e. Case histories
    f. Recordkeeping or management of regulatory documents
    g. Inaccurate data entry or invalid data
    h. Inadequate accountability and management of investigational product
    i. Inadequate protection of human subjects
    j. Consent discrepancies
    k. Inadequate PI oversight or delegation of responsibilities, and recommendations to secure compliance.

9. The auditor should provide the site with a certificate of audit or a formal audit summary that includes details on what the auditors reviewed, and any significant findings, deviations, and deficiencies noted. Audit findings discussed in detail should also be documented by the site.

10. The PI will address findings, deviations, and deficiencies within a specified timeframe in a formal written response to the audit report. The response may need to be based on requirements set by the auditing body. The formal response should include a cover letter, a statement of acknowledgement of each audit finding, any additional supportive documentation, and a detailed summary of corrective actions that will be implemented to eliminate future deficiencies such as training and education initiatives, protocol revisions, new policies, and SOPs. The PI may request IO assistance with the response. The response must be submitted within 10 business days. All corrective actions will be documented, filed appropriately, and implemented within the timeframe specified in the audit response letter. The PI will notify the IO and the IRB (IRB Chair and/or IRB Administrator) when corrective actions are complete.

11. If the corrective actions are not completed in the specified time period, the IO may recommend to the convened IRB that a suspension be considered for the study that was audited or for the studies that an Investigator is conducting. If participants are subject to immediate harmed, this should be immediate action by the IO.

12. If the audit identifies noncompliance, 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 IO will be notified for further action.

13. Inspection Triggers for external audits (increase the chance of an audit):
    a. Studies with a high enrollment, where test article (i.e., drug or device) approval is pending.
    b. Drug/device studies with few or no adverse events.
    c. PIs who have received an audit in the past.
    d. Studies where other sites have had problematic inspections.
    e. Any study type deemed by the IRB to pose significant risk to participants.

14. For IRB records, the IO or an IO designee may perform routine and for-cause audits using systematic methods to evaluate compliance with federal regulations, state and local laws, and policies and procedures to verify that research is reviewed and conducted in accordance with the IRB approved protocols.

References:

1. Code of Federal Regulations, Title 45, Public Welfare, Department Of Health And Human Services Part 46, Protection of Human Subjects, Revised January 15, 2009, Effective July 14, 2009
2. Title 21 CFR part 11 - Electronic Records; Electronic Signatures
3. Title 21 CFR parts 50 (Protection of Human Subjects), 56 (Institutional Review Boards)
4. Title 21 CFR part 312 (Investigational New Drug Application), part 312.62 Investigator Record Keeping and Record Retention for Clinical Drug or Biological Trials
5. Title 21 CFR part 812 (Investigational Device Exemptions), part 812.140 Investigator Record Keeping and Record Retention for Device Trials
6. ICH GCP Consolidated Guidance Part 4.9 Records and Reports
7. ICH GCP Consolidated Guidance Part 5.15 Record Access

8. FDA Compliance Program Guidance Manuals 7348.811 – Investigators and 7348.810 – Sponsors/CROs/Monitors
9. FDA Investigations Operations Manual
10. PNWU SOP 113 Data Management and Disposition.

Revision History:

Version/ Effective Date	Author	Section Changed & Reason for Revision
0.0/9-5-2017	M. McCarroll	New Standard Operating Procedure
.01/10-25-2017	M. McCarroll	Added section 6.11 regarding immediate harms
.02 / 10-03-2019	C. Case	Moved into new PNWU SOP Format
.03 / 4-13-2023	C. Case	• Added general information section • Added IRB Chair responsibility for conducting routine audits • Added Institutional Official Responsibilities • Revised second bullet under the Investigator Responsibilities to make it more inclusive to include external, internal and regulatory agencies not just FDA. • Item #2 wording order revised and added note about study teams always being audit ready. • Item #5 note added that some regulatory agencies may not be willing to reschedule and audit. • Item #6 updated to include delegation of duties log and further articulate test article accountability (storage, receipt, use, return of test article) • Item #8 regarding audit conclusions updated to indicate information that the investigator should be prepared to discuss with an auditor. • Added #9 regarding audit findings • #10 added regarding written responses to audit findings • #11 added regarding documentation of corrective actions • Added Routing Study Audit Checklist to Appendices.

Appendices:

Routine Study Audit Checklist

Self-audits are encouraged on an annual basis and in preparation for monitoring visits. Not all items included in this checklist will be applicable to all studies. If problems or unreported events are identified, please complete Sections C, the Corrective and Preventative Action (CAPA) Plan at the end of this document. If serious problems are identified a full internal (for cause) audit will be conducted.
If you have questions while completing a self-audit, please contact the IRB at Research@pnwu.edu

Human Subject Research	
Principal Investigator	[Click here to enter text.]
Protocol Date/Version #	[Click here to enter text.]
Study Title	[Click here to enter text.]
Funding Source (if applicable)	[Click here to enter text.]
Person(s) Completing Checklist	[Click here to enter text.]
Date Audit Completed	[Click here to enter a date.]

Section A - Regulatory Documentation

1.	The project is active and has current IRB approval	☐ Yes	☐ No	
2.	Regulatory documents are organized and in an accessible location.	☐ Yes	☐ No	
3.	IRB Approved Protocol: most recently approved version **and** all previous versions (If exempt study, the protocol details section of the application should be present.)	☐ Yes	☐ No	
4.	Consent document(s) [form and/or script]: most recently approved version **and** all previous versions.	☐ Yes	☐ No	☐ N/A
5.	Parental permission/assent document(s): most recently approved version **and** all previous versions	☐ Yes	☐ No	☐ N/A
6.	Study tools, data collection or source documents (e.g., survey/questionnaire, data collection forms: most recently approved version **and** all previous versions)	☐ Yes	☐ No	☐ N/A
7.	Staff training records are on file (Human Research Training certificates for investigators and study staff are at the appropriate level and dated within the past 4 years) and other training provided to study staff (e.g., training on study protocol) is documented.	☐ Yes	☐ No	
8.	CVs or other relevant documents (biosketch/resume) evidencing qualifications of PI, co-investigators, and all study personnel who are engaged in research current (updated within the last 3 years) and previous versions for long term study.	☐ Yes	☐ No	
9.	Valid professional licenses/certifications for study staff (as applicable for protocol related activities)	☐ Yes	☐ No	☐ N/A
10.	Correspondence with the IRB is on file: a. Initial IRB Application b. Initial IRB Approval c. Continuing Review submission(s): Total Number _____ d. Continuing Review Approvals e. Annual Check-in submission(s): Total Number _____ f. Amendment submission(s): Total Number _____ g. Amendment Approvals h. Other such as but not limited to: correspondence notifying the PI of disapproval or deferral of the study; responses to IRB actions; IRB suspensions or terminations; stipulation letters, documentation of telephone conversations with the IRB Office)	☐ Yes	☐ No	☐ N/A
	Recruitment/Enrollment			
11.	Advertising or recruitment materials were approved by the IRB (**all** versions are retained)	☐ Yes	☐ No	☐ N/A
12.	All participants were identified and recruited according to the methods approved by the IRB	☐ Yes	☐ No	☐ N/A
13.	There is documentation of subject eligibility	☐ Yes	☐ No	☐ N/A
14.	Enrolled subjects met the eligibility criteria	☐ Yes	☐ No	☐ N/A
15.	The number of participants recruited/enrolled is in line with the IRB Approval	☐ Yes	☐ No	☐ N/A
16.	Is a modification to add participants needed?	☐ Yes	☐ No	☐ N/A

Informed Consent Documentation Skip if the protocol does not require informed consent or documentation has been waived	
Logs	
17. Participant Screening Log present/complete. **Number screened:**	☐ Yes ☐ No ☐ N/A
18. Participant Enrollment Log present/complete. **Number enrolled** (e.g., signed consent form)**:**	☐ Yes ☐ No ☐ N/A
19. Participant Identification List/Key Code Log (should not be filed in the regulatory binder)	☐ Yes ☐ No ☐ N/A
20. Delegation of Duties/Responsibility Log	☐ Yes ☐ No ☐ N/A
a. Signature log reflects current staff working on the study	☐ Yes ☐ No ☐ N/A
b. Staff working on the study are IRB approved	☐ Yes ☐ No ☐ N/A
c. Signature log captures PI's signature/initials	☐ Yes ☐ No ☐ N/A
21. Sponsor monitoring/auditing logs on file & describes monitoring activities	☐ Yes ☐ No ☐ N/A
22. Data Safety Monitoring Board (DSMB) Reports, meeting minutes or indications of DSMB review/recommendations. DSMB Meeting frequency: _____	☐ Yes ☐ No ☐ N/A
23. Correspondence to and from sponsor (Letters, meeting notes, notes of telephone calls)	☐ Yes ☐ No ☐ N/A
Privacy, Data Storage and Confidentiality	
24. The privacy safeguards approved by the IRB are in place	☐ Yes ☐ No ☐ N/A
25. Anonymous data: For data that was to be collected anonymously, anonymity has been maintained in the physical or electronic records.	☐ Yes ☐ No ☐ N/A
26. Hard copies of data forms are stored in a secure, locked location	☐ Yes ☐ No ☐ N/A
27. Electronic data are kept on a secure and protected computer and are password protected	☐ Yes ☐ No ☐ N/A
28. Access to computer, electronic files, and physical files are limited to appropriate study personnel	☐ Yes ☐ No ☐ N/A
Equipment Safety Monitoring	
29. Equipment safety logs are present and up to date	☐ Yes ☐ No ☐ N/A
30. Equipment cleaning logs are present and	☐ Yes ☐ No ☐ N/A
Lab Tests Non-FDA regulated studies – skip this section if not applicable	
31. Is a copy of normal lab values on file?	

Audit Review Summary & Recommendations <u>Regulatory Documents</u>. Describe each "NO" check above, referring to the point #:

Section B – Participant Files

<u>INSTRUCTIONS</u>:
Please complete the Participant File Assessment.

In most cases it is not necessary to review every participant file for the purposes of this assessment. The IRB recommends randomly sampling approximately 10 percent of participants unless a for cause audit is being conducted.

A. Participant Files	
Total Number Enrolled to Date	

Number Reviewed this Audit					
Participant IDs					
Participant Selection					
1. Eligibility is assessed and documented for each participant (e.g., eligibility checklist)	☐ Yes	☐ No	☐ N/A		
a. The eligibility criteria checklist includes dated signature/initials of the person making the eligibility determination (when applicable for good clinical practice).	☐ Yes	☐ No	☐ N/A		
2. The number of participants enrolled/samples included is no greater than the IRB-approved enrollment/sample size	☐ Yes	☐ No			
Consent/Consent Documentation **SKIP to next section if a waiver of consent or waiver of documentation of consent was granted by the IRB**					
3. An IRB-approved study team member obtained consent	☐ Yes	☐ No	☐ N/A		
4. The current IRB-approved consent forms were used	☐ Yes	☐ No	☐ N/A		
5. The consent process is documented	☐ Yes	☐ No	☐ N/A		
6. All pages of the consent forms are on file for each participant	☐ Yes	☐ No	☐ N/A		
7. Hard copies of the consent forms are stored in a secure, locked location	☐ Yes	☐ No	☐ N/A		
8. All yes/no, checkboxes, or similar options on the consent forms are completed and/or initialed	☐ Yes	☐ No	☐ N/A		
9. Consent forms are free of any handwritten changes or corrections	☐ Yes	☐ No	☐ N/A		
10. Consent forms are signed, dated and timed by the participants and the study staff	☐ Yes	☐ No	☐ N/A		
11. Original copies (not photo copies) of all consent forms signed and dated by participants are on file	☐ Yes	☐ No	☐ N/A		
12. The participant/participant's legally authorized representative signed his/her own consent forms	☐ Yes	☐ No	☐ N/A		
13. An IRB-approved study team member signed/dated the consent	☐ Yes	☐ No	☐ N/A		
14. An IRB-approved study team member entered the same date as the participant/participant's legally authorized representative on the consent form	☐ Yes	☐ No	☐ N/A		
1. Did any of the following occur? 2. Non approved individual signed a participant consent form 3. Consent form dated after study procedures 4. Out of date consent form used	☐ Yes	☐ No	☐ N/A		
5. If Short Form Consent is implemented, a witness signed and dated the consent form	☐ Yes	☐ No	☐ N/A		
6. There is documentation of the participant's/participant's legally authorized representative's receipt of a copy of the consent form (e.g., Enrollment Log or progress notes)	☐ Yes	☐ No	☐ N/A		
7. For protocols that include minors: Parental/guardian permission for the participation for minors was obtained using the current IRB approved parent/guardian permission/consent form	☐ Yes	☐ No	☐ N/A		
a. Parental/guardian permission for the participation for minors was obtained from the IRB approved number of parents/guardians	☐ Yes	☐ No	☐ N/A		
b. Minors were assented using the current IRB approved assent form	☐ Yes	☐ No	☐ N/A		
c. Enrolled minors that reach local age of majority during the study are re-consented as adults	☐ Yes	☐ No	☐ N/A		

Audit Review Summary & Recommendations <u>Participant Files</u>. Describe each "NO" check above, referring to the point #:

Section C – Corrective and Preventative Action (CAPA) Plan

Instructions:
For any questions answered NO, please describe a Corrective and Preventative Action (CAPA) Plan, including the corresponding item identifier, e.g., CITI certification, as a header and implementation/ completion dates.

E. **Corrective and Preventative Action (CAPA) Plan**								
Priority:	**Urgent**	☐	**High**	☐	**Moderate**	☐	**Low**	☐
Problem:								
Root Cause:								
Corrective Action:								
-Preventive Action:								
Due Date for Completion:								
Date of Completion:								

Signature of person completing this form:_____

Date: _____

Signature of Investigator reviewing this form:_____

Date: _____

Supplemental Form – Food & Drug Administration (FDA) Regulated Studies

Skip this section if the study is not FDA Regulated

Investigational New Drugs (IND)	**Mark if this section is Not Applicable ☐**
1. Investigational New Drug Application/approval:	☐ Yes ☐ No ☐ N/A
2. A signed current FDA 1572	☐ Yes ☐ No ☐ N/A
3. Previous signed versions of the FDA 1572	☐ Yes ☐ No ☐ N/A
4. Current signed financial disclosure form submitted to the sponsor from each investigator listed on the 1572 or in the investigator statement.	☐ Yes ☐ No ☐ N/A
5. Previous versions of signed financial disclosure forms submitted to the sponsor from each investigator listed on the 1572 or in the Investigator Statement.	☐ Yes ☐ No ☐ N/A
6. Valid medical license for each investigator/staff member listed on the 1572 or in the Investigator Statement.	☐ Yes ☐ No ☐ N/A
7. The current 1572 lists all sub-investigators.	☐ Yes ☐ No ☐ N/A
8. The current 1572 lists all laboratories	☐ Yes ☐ No ☐ N/A
9. A copy of the normal lab values is on file or is documented with lab results	☐ Yes ☐ No ☐ N/A
10. A copy of the lab certification is on file	☐ Yes ☐ No ☐ N/A
11. There is a shipping log for each drug, which captures the following: a. Date shipment received b. Shipment # from packing slip study drug c. Batch#/lot#/code mark d. Expiration date e. # of boxes, kits, or drugs per lot # f. # bottles, vials, inhalers, or drugs per box or kit g. Condition of study drug shipment (intact/damaged) h. Receiver's name	☐ Yes ☐ No ☐ N/A
12. There is an accountability log for each drug under investigations, which captures the following: a. Participant ID #, initials, or name b. Lot or kit number c. # Bottles, vials, etc d. Amount of study drug per bottle, vial, etc. e. Total # dispensed f. Initials g. Date dispenses h. # of bottles, vials, etc. returned i. Total # returned j. Balance: number dispensed less number returned k. Comments: participant lost, discarded, etc. l. Name of person who dispensed the drug	☐ Yes ☐ No ☐ N/A
13. Package inserts are on file (all versions).	☐ Yes ☐ No ☒ N/A
14. Correspondence (e.g., with another investigator, and IRB, the sponsor, a monitor, or FDA)	☐ Yes ☐ No ☒ N/A
15. Reports to and from sponsor (e.g. IND safety reports).	☐ Yes ☐ No ☐ N/A
16. The PI has promptly reported to the sponsor (and IRB, if applicable) any adverse effect that may reasonably be regarded as caused by, or probably caused by, the drug.	☐ Yes ☐ No ☐ N/A
Investigational Device Exemption (IDE) studies	**Mark if this section is Not Applicable ☐**
17. A signed Investigator Statement	☐ Yes ☐ No ☐ N/A
18. Previous versions of signed Investigator Statements	☐ Yes ☐ No ☐ N/A
19. A current signed financial disclosure form submitted to the sponsor from each investigator listed on the 1572 or in the Investigator Statement.	☐ Yes ☐ No ☐ N/A
20. Previous versions of signed financial disclosure forms submitted to the sponsor from each investigator listed on the 1572 or in the Investigator Statement.	☐ Yes ☐ No ☐ N/A
21. Valid medical license for each investigator/staff member listed on the 1572 or in the Investigator	☐ Yes ☐ No ☐ N/A

Statement	
22. There is shipping log for each device, which captures the following: a. Date shipment received b. Shipment # from packing slip study device c. Expiration date d. # boxes, kits, or devices per lot# e. # bottles or devices per box or kit f. Condition of study device shipment (Intact/damaged) g. Receiver's name	☐ Yes ☐ No ☐ N/A
23. There is an accountability log for each device under investigation, which captures the following: a. Participant ID #, initials, or name b. Model or serial # c. Date used/implemented d. Device disposition e. Comments, such as malfunctions, device failure, disposition of unused devices (returned to sponsor/destroyed,) or any other pertinent information concerning the device f. Person who implemented the device	☐ Yes ☐ No ☐ N/A
24. Device manual is on file (all versions).	☐ Yes ☐ No ☐ N/A
25. Correspondence (e.g., with another investigator, an IRB, the sponsor, a monitor, or FDA)	☐ Yes ☐ No ☐ N/A
26. Reports of unanticipated adverse device effects. The investigator submits to the sponsor a report of any unanticipated adverse device effect occurring during an investigation as soon as possible, but no longer than 5 business days after the investigator first learns of the effect, unless required sooner by sponsor	☐ Yes ☐ No ☐ N/A
27. Normal lab values are on file or is documented with lab results	☐ Yes ☐ No ☐ N/A
28. Copy of the lab certification is on file	☐ Yes ☐ No ☐ N/A

Audit Review Summary & Recommendations <u>FDA Supplement</u>. Describe each "NO" check above, referring to the point #: