



# **Pennington Biomedical Research Center**

## **Human Research Protections Program Policies and Procedures**

Combined version 9.8.14



## 302.00 Human Research Protections Program Policy

### 1.1 Scope

This Institution's Human Research Protection Program (HRPP) is a comprehensive system to ensure the protection of the rights and welfare of subjects in human research. The Human Research Protection Program is based on all individuals in this Institution along with key individuals and committees fulfilling their roles and responsibilities described in this plan. Throughout this document "Institution" refers to Pennington Biomedical Research Center.

### 1.2 Purpose

This Institution is committed to protecting the rights and welfare of subjects in human research. The purpose of this plan is to describe this Institution's plan to comply with ethical and legal requirements for the conduct and oversight of human research.

### 1.3 Definitions

#### 1.3.1 Agent

An individual who is an employee is considered an agent of this Institution for purposes of engagement in human research when that individual is in any official capacity as an employee of this Institution.

An individual who is not an employee is considered an agent of this Institution for purposes of engagement in human research when that individual has been **specifically authorized** to conduct human research on behalf of this Institution.

#### 1.3.2 Clinical Trial

A biomedical or behavioral research study of human subjects designed to answer specific questions about therapeutic interventions (drugs, treatments, devices, or new ways of using known drugs, treatments, or devices). Clinical trials are used to determine whether new therapeutic interventions are safe and effective. NIH PHS 398

#### 1.3.3 Principal Investigator, Co-Investigator or Investigator

Principal Investigator ("PI"), Co-Investigator or "Investigator" is an individual who conducts research or under whose immediate direction research is conducted; or, in the event of an investigation conducted by a team of individuals, is the responsible leader of that team. NIH PHS 398



Investigator means an individual who actually conducts a clinical investigation, i.e., under whose immediate direction the test article is administered or dispensed to, or used involving, a subject, or, in the event of an investigation conducted by a team of individuals, is the responsible leader of that team. FDA 21 CFR 50.3.25(d)

For the purposes of this Institution Principal Investigators must be a member of the regular faculty, adjunct faculty, or a member of the faculty of one of the institutions affiliated with the Pennington Biomedical Research Center. Professionals in training (graduate students, post-doctoral researchers, interns, and residents) are permitted to be Principal Investigators as long as permitted by their home institution policies. In order to serve as a Principal Investigator, any person who is not a member of the regular faculty must have at least one regular faculty member as a Co-Investigator on the project.

### **1.3.4 Engaged in Human Research**

This Institution is engaged in human research when its employees or agents are interacting or intervening with human subjects for the purpose of conducting research. This Institution follows OHRP guidance on “Engagement of Institutions in Research” to apply this definition.

The Institution defines all research according the DHHS definition, unless the clinical trial is subject to FDA oversight.

### **1.3.5 Human Research**

Any activity that either:

- Is “research” as defined by DHHS and involves “human subjects” as defined by DHHS (“DHHS Human Research”); or DHHS 45 CFR 46.102
- Is “research” as defined by FDA and involves “human subjects” as defined by FDA (“FDA Human Research”). FDA 21 CFR 56.102.22(c); 21 CFR 50.3.25 (c)

### **1.3.6 Human Subject as Defined by DHHS**

A living individual about whom an investigator (whether professional or student) conducting research obtains (1) data through intervention or interaction with the individual, or (2) information that is both private information and identifiable information. For the purpose of this definition:



### *1.3.6.1 Definitions of Human Subject as Defined by DHHS*

- **Intervention** means physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes.
- **Interaction** means communication or interpersonal contact between investigator and subject.
- **Private Information** means information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record).
- **Identifiable Information** means information that is individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information).

DHHS 45 CFR §46.102(f) (1&2)

### **1.3.7 Human Subject as Defined by FDA**

An individual who is or becomes a subject in research, either as a recipient of the test article or as a control. A subject may be either a healthy human or a patient. A human subject includes an individual on whose specimen (identified or unidentified) a medical device is used. When medical device research involves in vitro diagnostics and unidentified tissue specimens, the FDA defines the unidentified tissue specimens as human subjects. FDA 21 CFR 56.23(e)

### **1.3.8 Research as Defined by DHHS**

A systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. The institution defines all research according the DHHS definition, unless the clinical trial is subject to FDA oversight. 45 CFR 46.102(d)

Generalizable Knowledge means information from which one may infer a general conclusion: knowledge brought into general use or that can be applied to a wider or different range of circumstances. For example, publication and presentation are typical methods used to disseminate research findings, thereby contributing to generalizable knowledge. However, not all information that is published or presented represents



generalizable knowledge. Generalizable knowledge is also interpreted to include data intended for general use, regardless of its eventual distribution or acceptance.

For additional guidance on when activities meet the definition of human research see Table 1 at the end of this document.

### **1.3.9 Research as Defined by FDA**

Research means any experiment that involves a test article and one or more human subjects, and that either must meet the requirements for prior submission to the Food and Drug Administration under section 505 (i) or 520 (g) of the Federal Food, Drug, and Cosmetic Act, or need not meet the requirements for prior submission to the Food and Drug Administration under these sections of the Federal Food, Drug and Cosmetic Act, but the results of which are intended to be later submitted to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit. (21 CFR 50.3(c), 21 CFR 56.102(c))

Any experiment that involves a test article and one or more human subjects, and that meets any one of the following:

- Must meet the requirements for prior submission to the Food and Drug Administration under section 505(i) of the Federal Food, Drug, and Cosmetic Act meaning any use of a drug other than the use of an approved drug in the course of medical practice;
- Must meet the requirements for prior submission to the Food and Drug Administration under section 520(g) of the Federal Food, Drug, and Cosmetic Act meaning any activity that evaluates the safety or effectiveness of a device; OR

Any activity the results of which are intended to be later submitted to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit. FDA 21 CFR 50.3

## **1.4 Mission**

The mission of this Institution's human research protection program plan is to protect the rights and welfare of subjects involved in human research that is overseen by this Institution. All human subject research is subject to the human research protection program plans policies and procedures.

The HRPP includes mechanisms to:

- Establish a formal process to monitor, evaluate and continually improve the protection of human research participants;



- Dedicate resources sufficient to do so;
- Exercise oversight of research protection;
- Educate IRB members, IRB support staff, investigators and research staff about their ethical responsibility to protect research participants;
- When appropriate, intervene in research and respond directly to concerns of research participants;
- Educate research participants and the community.

#### 1.4.1 Ethical Requirements

In the oversight of all human research, this Institution (including its investigators, research staff, students involved with the conduct of human research, the Institution's Institutional Review Boards (IRBs), IRB members and chair, IRB staff, the Institutional official, and employees) follows the ethical principles outlined in the April 18, 1979 report of The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research titled "Ethical Principles and Guidelines for the Protection of Human Subjects of Research," also known as "The Belmont Report", which includes:

- Respect for Persons
- Beneficence
- Justice

#### 1.4.2 Legal Requirements

All human research must undergo review by the Institution's IRB. Activities that do not meet the definition of human research (e.g., most classroom activities, quality improvement activities, program evaluation, and surveillance activities that do not meet the definition of human research) do not require review and approval by the Institution IRB and do not need to be submitted to the Institution IRB unless there is a question regarding whether the activity is human research.

When this Institution is engaged in DHHS human research that is conducted, funded, or otherwise subject to regulations by a federal department or agency who is a signatory of the Common Rule, the Institution commits to apply the regulations of that agency relevant to the protection of human subjects.

When this Institution is engaged in FDA human research, this Institution commits to apply the FDA regulations relevant to the protection of human subjects.

Any questions about whether an activity meets the regulatory definitions of human research should be referred to the IRB Office who will provide a determination.



When there is a perceived conflict between state, local, federal or institution law, such situations will be referred to the Director of Legal and Regulatory Compliance.

### 1.4.3 Other Requirements

- This Institution commits to apply its ethical standards to all human research regardless of funding.
- For clinical trials, this Institution commits to apply the “International Council on Harmonization – Good Clinical Practice E6.” International Research studies must adhere to recognized ethics codes such as: the Common Rule and the Declaration of Helsinki. (World Medical Association Declaration of Helsinki, A1,2)
- This Institution prohibits payments to professionals in exchange for referrals of potential subjects (“finder’s fees”) and payments designed to accelerate recruitment that were tied to the rate or timing of enrollment (“bonus payments.”) FDA Guidance “Payment to Research Subjects”
- When Human Research is conducted or funded by the Department of Defense (DOD), this Institution commits to apply the Department of Defense (DOD) Directive 3216.02, which includes the requirement to apply 45 CFR §46 Subparts B, C, and D<sup>1</sup>. This Institution will comply with the terms of the DFARS clause or comparable language used in the agreement with the Department of Defense (DOD) component supporting the research involving human subjects. See HRPP Policy 15.0 for Research Funded by the Department of Defense.
- When Human Research is conducted or funded by the Department of Education (ED), this Institution commits to applying 34 CFR §97 Subpart D (equivalent to 45 CFR §46 Subpart D), 34 CFR §98.3, 34 CFR §98.4, 34 CFR §356.3, and 34 CFR §99. See HRPP Policy 16.0 for Research Funded by the Department of Education

#### 1.4.3.1 Research in Other Countries

- All policies and procedures that are applied to Human Research conducted domestically are applied to Human Research conducted in other countries.
  - For research conducted in other countries the PI must provide the IRB the following:
    - Necessary information on local law and cultural context.

<sup>1</sup> Quick applicability table for DHHS Subparts:

	DHHS	DOD	ED
Subpart B	X	X	
Subpart C	X	X	
Subpart D	X	X	X



- qualifications of the researchers and research staff for conducting research in that country
- The PI must ensure the following:
  - initial review, continuing review, and review of modification
  - post-approval monitoring
  - handling of complaints, non-compliance and unanticipated problems involving risk to subjects or others.
  - consent process and document and other language issues
  - coordination and communication with local IRBs when appropriate.
- The IRB will ensure appropriate expertise and knowledge of the country(ies) either through IRB members or consultants.

#### **1.4.4 Sponsored Human Research**

For both sponsored and non-sponsored human research this Institution abides by its ethical principles, regulatory requirements and its policies and procedures.

#### **1.4.5 Scope of Human Research Protection Program**

The categories of human research overseen by the IRB include:

- Research conducted or funded by the Department of Defense (DOD). For additional requirements of research conducted by the Department of Defense, see Guidance G-003: Additional Requirements Conducted by the Department of Defense
- Federally funded research
- Research involving fetuses.
- FDA-regulated research.
- Research involving drugs that require an IND.
- Research involving devices that require an IDE issued by FDA.
- Research involving pregnant women as subjects.
- Research involving non-viable neonates.
- Research involving neonates of uncertain viability.
- Research involving children as subjects.
- International research
- Research conducted or funded by the Department of Education (ED)
- Research involving children, pregnant women, fetuses, or neonates that is not otherwise approvable without approval of an agency secretary or director.
- Investigator held IND or IDE.
- Research involving devices that require an abbreviated IDE.
- Investigator held abbreviated IDE.



The categories of human research not overseen include:

- Research conducted or funded by the Veteran Administration (VA)
- Research conducted or funded by the Department of Justice (DOJ)
- Research conducted or funded by the Department of Energy (DOE)
- Research conducted, funded, or subject to oversight by the Environmental Protection Agency (EPA)
- Research involving *in vitro* fertilization.
- Research that plans to or is likely to involve prisoners as subjects.
- Research involving a waiver of consent for planned emergency research.
- Emergency use of a test article in a life threatening situation.
- Activities involving humanitarian use devices.
- Research using the short form of consent documentation.

#### **1.4.6 Human Research Protection Program Policies and Procedures**

Pennington Biomedical Research Center Policies and procedures are made available for all Pennington Biomedical investigators and research staff at the following web site: <http://pbrc.edu/HRPP>. Pennington Biomedical uses the HRPP website to communicate policies and procedures, guidance to investigators and staff, required forms and contact information for the HRPP office.

### **1.5 Human Research Protection Program Components**

The components comprising the HRPP and their responsibilities, ethical obligations, and authorities for carrying out the mission of the program are described below.

#### **1.5.1 Institutional Official**

The Executive Director of Pennington Biomedical Research Center is designated as the Institutional Official.

The Institutional Official has the authority to take the following actions or to delegate these authorities to a designee:

- Create the Human Research Protection Program budget.
- Allocate resources within the Human Research Protection Program budget.
- Appoint and remove IRB members and IRB chairs.
- Employ and remove research review staff.
- Determine what IRBs the Institution will rely upon.
- Approve and rescind authorization agreements for IRBs.
- Place limitations or conditions on an investigator's or research staff's privilege to conduct human research.



- Create policies and procedures related to the Human Research Protection Program that are binding on the Institution.
- Suspend or terminate research approved by one of the Institution's IRBs.
- Disapprove research approved by one of the Institution's IRBs.

Research that has been reviewed and approved by the IRB may be subject to further review and suspension and disapproval by the Institutional Officials consistent with Pennington Biomedical Research Center policy (see section 3.11.1 – Suspension or Termination). However, such Institutional Officials may not approve research that has not been approved by the IRB. Pennington Biomedical Research Center Institutional Officials may strengthen requirements and/or conditions or add other modifications to secure approval or approval by another committee.

The Institutional Official has the responsibility to:

- Oversee the review and conduct of human research under the jurisdiction of the Human Research Protection Program.
- Periodically review this plan to assess whether it is providing the desired results and recommend amendments as needed.
- Establish policies and procedures designed to increase the likelihood that human research will be conducted in accordance with ethical and legal requirement.
- Institute regular, effective, educational and training programs for all individuals involved with the Human Research Protection Program.
- Ensure that the research review process is independent and free of coercion or undue influence, and ensure that officials of the Institution cannot approve research that has not been approved by the IRB.
- Implement a process to receive and act on complaints and allegations regarding the Human Research Protection Program.
- Implement an auditing program to monitor compliance and improve compliance in identified problem areas.
- Investigate and remediate identified systemic problem areas, and where necessary removal of individuals from involvement in the Human Research Protection Program.
- Ensure that the Human Research Protection Program has sufficient resources, including that the IRB has appropriate resources to address the volume and types of human research to be reviewed, so that reviews are accomplished in a thorough and timely manner.
- Review and sign federal assurances (FWA) and addenda.
- Fulfill educational requirements mandated by OHRP.



- Grant the IRB the authority to act independently to bind the entire organization, including but not limited to the Institutional Official with regards to human subjects protections.

### **1.5.2 All members of the Institution**

All individuals within the Institution have the responsibility to:

- Be aware of the definition of human research.
- Consult the IRB when there is uncertainty about whether an activity is human research.
- Not conduct human research or allow human research to be conducted without review and approval by the IRB.
- Report allegations of undue influence regarding the oversight of the Human Research Protection Program or concerns about the Human Research Protection Program to the Institutional Official.
- Report allegations or finding of non-compliance with the requirements of the Human Research Protection Program to the IRB.
- Research involving human participants must not commence until the research has received all approvals required by the organization.
- Complete required training and education as mandated by Institutional Policy 106.00.

### **1.5.3 IRBs**

The IRB designated by the Institutional Official to be the IRB relied upon by the Human Research Protection Program and the scope of review of this IRB is listed in the IRB roster available from the IRB Office.

Competing business interests can influence the review process when individuals responsible for business development serve on the IRB are involved in the day to day operations of the IRB. Therefore, no individual responsible for raising funds or garnering support for research should serve as an IRB member or be involved in the day to day operations of the IRB.

The IRB functions independently of, but in coordination with, other institutional regulatory entities. The IRB, however, makes its independent determination whether to approve or disapprove a protocol based upon whether or not human subjects are adequately protected. The IRB has review jurisdiction over all research involving human subjects, conducted, supported or otherwise subject to regulation by any federal department or agency that has adopted the human subject regulations.



The IRB verifies the research involving human participants does not commence until the research has received all approvals required by the organization.

This Institution may rely upon IRBs of another Institution provided one of the following is true:

- The IRBs are part of an AAHRPP accredited Institution.
- This Institution's investigator is a collaborator on Human Research that is primarily conducted at another Institution and the investigator's role does not include interaction or intervention with subjects.
- The Institution is engaged in the Human Research solely because it is receiving federal funds. (Employees and agents of the institution do not interact or intervene with subjects, gather or possess private identifiable information about subjects, nor obtain the consent of subjects.)

Reliance on an external IRB requires an Institutional Agreement for IRB review (IAIR) and a local review for compliance with local policies of the Institution.

The IRBs relied upon by this Institution have the authority to:

- Approve, require modifications to secure approval, and disapprove all human research overseen and conducted by the Institution. All human research must be approved by the IRB designated by the Institutional Official. Officials of this Institution may not approve human research that has not been approved by one of the Institution's IRBs.
- Suspend or terminate approval of human research not being conducted in accordance with an IRBs' requirements or that has been associated with unexpected serious harm to subjects.
- Observe, or have a third party observe, the consent process and the conduct of the human research.
- Determine whether an activity is human research as described in HRPP Policy 3.0. 45 CFR 46.102(d)
- Evaluate financial interests of investigators and research staff and have the final authority to decide whether the financial interest and management plan, if any, allow the human research to be approved. PBRC Policy 401.00

IRB member and IRB staff have the responsibility to follow Human Research Protection Program policies and procedures that apply to IRB members and staff.

#### **1.5.4 Investigators and Research Staff**

Investigators and research staff have the responsibility to:

- Follow the Human Research Protection Program policies and procedures that apply to IRB members and staff.



- Comply with all determinations and additional requirements of the IRB, the IRB chair, and the Institutional Official.
- Oversee the review and conduct of Human Research in their department or laboratory.
- Forward complaints and allegations regarding the Human Research Protection Program to the Institutional Official.
- Ensure that each Human Research study conducted in their department or laboratory has adequate resources.

### **1.5.5 Director of Legal and Regulatory Compliance**

The Director of Legal and Regulatory Compliance has the responsibility to:

- Provide advice upon request to the Institutional Official, IRB, and other individuals involved with the Human Research Protection Program.
- Determine who meets the definition of “legally authorized representative” and “children” when human research is conducted in jurisdictions not covered by policies and procedures in accordance with applicable law.
- Resolve conflicts among applicable laws.

### **1.5.6 Sponsored Projects Office**

The Sponsored Projects Office has the responsibility to review contracts and funding agreements for compliance with Human Research Protection Program policies and procedures.

## **1.6 Education and Training**

All new employees are made aware of this plan as part of initial orientation. The IRB is to conduct refresher training on current employees as needed to maintain awareness of this policy.

IRB members, IRB staff, and others involved in the review of human research must complete CITI GCP- IRB training. This training is valid for a one-year period, after which time a refresher CITI course or additional training must be completed. IRB staff also train IRB members on the SOPs and forms applicable to IRB members including regulatory and guidance requirements noted in the section “Other Requirements.”

IRB Members, Investigators and research staff must complete CITI training in accordance with PBRC policy 106. The IRB is notified electronically when CITI training is completed and notified by the Director of Legal and Regulatory Compliance of any investigator and research staff out of compliance with the policy.

## **1.7 Resources for the HRPP**



Resources for the HRPP components are provided through the annual budget review processes in the administrative units in which the components reside.

The need for study-specific resources is evaluated at the local level. Investigators and sponsoring units are responsible to ensure that sufficient resources are allocated to all projects, whether sponsored or investigator-initiated. These include staffing and personnel (in terms of availability, number, expertise and experience); psychological, social and medical services (including counseling or social support services that may be required because of participation in a study); psychological, social, or medical monitoring, ancillary care, equipment needed to protect participants, and resources for participant communication. Study-specific resources are verified electronically as defined by Policy 301.00 Clinical Study Budget, Resource Facilitation and Initiation.

The need for incremental or off-cycle resources may emerge as a result of special or unusual demands on the offices, either as reported by the offices or by quality assurance/review activities, or by Executive Director deliberations.

### ***1.8 Questions and Additional Information for the IRB***

The IRB Office wants your questions, information, and feedback.

Contact and location information for the IRB Office is:

Michelle Brignac  
Human Research Protections Program Manager  
Pennington Biomedical Research Center  
6400 Perkins Road  
Baton Rouge, LA 70808  
Email: michelle.brignac@pbrc.edu  
(225) 763-2693

### ***1.9 Reporting and Management of Concerns***

Questions, concerns, complaints, allegations of undue influence, allegations or findings of non-compliance, or input regarding the Human Research Protection Program may be reported orally or in writing. Employees are permitted to report concerns on an anonymous basis. Concerns may be reported to the IRB Chair, IRB Office, Institutional Official or Director of Legal and Regulatory Compliance.

The IRB has the responsibility to investigate allegations and findings of non-compliance and take corrective actions as needed. The Institutional Official has the responsibility to investigate all other reports and take corrective actions as needed.



Employees who report in good faith possible compliance issues should not be subjected to retaliation or harassment as a result of the reporting. Concerns about possible retaliation should be immediately reported to the Institutional Official or designee.

To make such reports, contact:

Steven Heymsfield, M.D.

Executive Director

Pennington Biomedical Research Center

6400 Perkins Road

Baton Rouge, LA 70808

Email: [steven.heymsfield@pbrc.edu](mailto:steven.heymsfield@pbrc.edu)

(225) 763-2513

### ***1.9 Monitoring and Auditing***

In order to monitor and ensure compliance, internal or external auditors who have expertise in federal and state statutes, regulations and Institutional requirements will conduct periodic audits. Audits will focus on areas of concern that have been identified by any entity, i.e., federal, state or Institutional. Random audits may also be conducted. See HRPP policy 13.0 – Quality Improvement in the HRPP Program

### ***1.10 Disciplinary Actions***

The Institutional Official may place limitations or conditions on an investigator's or research staff's privilege to conduct human research whenever in the opinion of the Institutional Official such actions are required to maintain the Human Research Protection Program.

### ***1.11 Approval and Revisions to the Plan***

This Human Research Protection Program Policy is to be approved by the Policy Committee of Pennington Biomedical Research Center. This policy is intended to be flexible and readily adaptable to changes in regulatory requirements. The Institutional Official has the responsibility to review this plan to assess whether it is providing the desired results. At the request of the Institutional Official the Executive Policy Committee has the authority to amend this plan as deemed necessary.



**Table 1. – Activities that May or May Not Constitute Research Involving Human Subjects**

Below is a list of activities that may or may not constitute research involving human subjects. The table is intended to provide examples and is not a definitive determination of whether a specific activity requires IRB review or exemption. For study-specific determinations, contact the IRB office at [irb@pbrc.edu](mailto:irb@pbrc.edu)

Activity	Research that may Involve Human Subjects?
<b>Scholarly or Scientific</b>	
Intent to Publish – Activities that obtain data about individuals, systematically performed with the intent to generalize findings and to publish or present the results (regardless of eventual publication or presentation)	Yes
Pilot Studies – Development of research, including activities involving individuals that are performed to refine a data collection or study methodology	Yes
Viewing Identifiable Private Information - Identification of potential participants for a study or use of living individuals' data for research purposes, whether or not the data will be recorded in an identifiable manner	Yes
Coded Data – Study or use of data that cannot be readily associated with the living individual about whom the information relates	No; however, there are some instances where you will need IRB approval. Contact the IRB office.
Deceased Individuals – Study of or use of data relating to individuals no longer living, when data do not also apply to living relatives	No, but there may be HIPAA requirements. Contact the IRB office.
Quality Improvement – Activities involving individuals intended solely for internal use, performed to improve services or develop new services or programs, (e.g., satisfaction surveys) without plans for presentation or publication; audits (internal or external) performed as a part of organizational operations	Yes
Data Banking – Collection and storage of private information, if the data may be used in the future for research purposes, whether or not the data will be recorded in an identifiable manner	



<b>Social Science, Behavioral, Educational</b>	
Survey, Interview, Observation – Collection of individuals' data using surveys, interviews, or observation with the intent to generalize findings	Yes
Audio- or Videotaping – Taping individuals for study in situations not normally expected to be recorded or when individuals can be identified from recordings	Yes
Internet Survey Research – Online collection of individuals' data with the intent to generalize findings	Yes
<b>Medical or Biomedical</b>	
Practice of Medicine – Standard diagnostic or therapeutic procedures performed for treatment purposes to benefit an individual, with or without associated research activities	No
Additional Procedures – Standard diagnostic or therapeutic procedures that would not otherwise be performed if not for the research (e.g., additional x-rays or blood draws)	Yes
Changes in Procedures – Alterations in patient care (including randomization between standard acceptable treatments) with the intent to generalize the results	Yes
Clinical Investigation – Use of drugs or devices, except approved products used in the practice of medicine, including use of a human specimen with FDA-regulated devices	Yes
Retrospective Record Review – Review of existing personally identifiable records, including collection of historical controls for FDA-regulated studies, whether or not the data will be recorded in an identifiable manner	Yes
Remnant Specimens – Collection or study of specimens generated from routine clinical procedures that would otherwise have been discarded	Yes
Specimen Banking – Collection and storage of human fluids or tissue regardless of whether individual identifiers are retained	Yes

\*\* This table was copied from Ohio State University HRPP policy with permission from their Office of Responsible Research Practices



## 2.0 Institutional Review Board

### 2.1 Policy

Pennington Biomedical Research Center has one IRB to ensure the protection of human subjects in research.

- IRB – Biomedical (IRB 00000708) (IORG00006218)  
The IRB is delegated to review human subject research for the following areas:
  - clinical trials such as drug studies;
  - research involving the social sciences
  - prevention, treatment, or understanding of diseases
  - research involving medical interventions

Pennington Biomedical Research Center also utilizes the services of three off-site IRBs (Baton Rouge General Medical Center – FWA00001821, Louisiana State University and Agriculture and Mechanical College Baton Rouge – FWA00003892, Louisiana State University Health Care Services Division Baton Rouge – FWA00010253) on a protocol-by-protocol basis. All non-exempt human research subjects must be reviewed and approved by Pennington Biomedical Research Center IRB prior to initiation of research activities.

Regulations & Guidance: DHHS 45 CFR §46.103

### 2.2 IRB Authority

Pennington Biomedical Research Center policy authorizes the IRB to:

- a) Approve, conditionally approve (minor modifications required), withhold approval (major modifications required or major clarifications) or disapprove all research activities overseen and conducted at this Institution;
- b) Suspend or terminate approval of research not being conducted in accordance with the IRB requirements or has been associated with unexpected serious harm to subjects; and
- c) Observe, or have a third party observe, the consent process and the conduct of the research.

Research that has been reviewed and approved by the IRB may be subject to further review and suspension and disapproval by the Institutional officials consistent with Pennington Biomedical Research Center policy (see section 3.11.1 – IRB Review Process). However, such officials may not approve research that has not been approved by the IRB. Pennington Biomedical Research Center officials may strengthen



requirements and/or conditions, or add other modifications to secure approval or approval by another committee. Previously approved research proposals and/or consent forms must be re-approved by the IRB before initiating the changes or modifications. The IRB Chair (or designee) makes the determination whether the changes require convened IRB re-review or expedited review.

Regulations & Guidance: DHHS 45 CFR §46.112; FDA 21 CFR §56.103; 21 CFR §56.109; 21 CFR §56.112; and 21 CFR §56.113.

## **2.3 Roles and Responsibilities**

### **2.3.1 IRB Chair**

The Executive Director of Pennington Biomedical Research Center appoints an IRB Chair to serve for unlimited terms on the IRB. Any change in appointment, including re-appointment or removal, requires written notification from the Executive Director.

The IRB Chair should be a highly respected individual, employed by Pennington Biomedical Research Center, fully capable of managing the IRB, and the matters brought before it with fairness and impartiality. The task of making the IRB a respected part of the Institution will fall primarily on the shoulders of the IRB Chair. The IRB must be perceived to be fair, impartial and immune to pressure by the Institution's administration, the Investigator whose protocols are brought before it, and other professional and nonprofessional sources.

The criteria used to select an IRB Chair include experience with, and knowledge of, applicable federal and state laws and regulations, and Institutional policies. This individual must be willing to commit to the IRB; must have past experience as an IRB member; and must demonstrate excellent communication skills, along with an understanding of clinical research. The IRB Chair must also be flexible and demonstrate a thorough understanding of ethical issues involved in clinical research.

The IRB Chair convenes and chairs the meetings of the IRB and is required to attend a majority of the convened meetings of the IRB. The IRB Chair may conduct or delegate expedited review of research that qualifies for such review; review the responses of Investigators to contingencies of the IRB (to secure IRB approval); and to review and approve minor changes in previously approved research during the period covered by the original approval. The IRB Chair may delegate such authority to another experienced IRB member.

The IRB Chair is a voting member and is the signatory for correspondence generated by the IRB and may delegate signatory authority to another experienced IRB member.



The performance of the IRB Chair will be reviewed on an annual basis by the Executive Director or designee. The IRB Chair self-assessment will be used to assist in this evaluation. If the IRB Chair is not functioning in accordance with the IRB's mission, policies and procedures; has an undue number of absences; or is not fulfilling the responsibilities of IRB Chair, then he/she will be removed by the Executive Director and replaced by a suitable alternative.

### **2.3.2 HRPP/IRB Staff**

#### ***2.3.2.1 HRPP Director***

The HRPP Manager supervises the Human Research Protections Program. The HRPP Manager is the primary contact and liaison at the Institution for communications with Federal, State and local regulatory agencies with respect to Human Subjects (e.g., OHRP or the FDA). The HRPP Manager responds to faculty and staff questions about Human Subjects Research as well as organizing and documenting the IRB review process. The HRPP Manager works closely with the IRB Chair in the development of policy and procedures and is not a voting member of the IRB.

#### ***2.3.2.2 IRB Manager***

The IRB Manager manages all day to day operations of the IRB office. Assesses minutes for quality, completeness, and regulatory compliance and IRB member reviews for quality, completeness, and regulatory compliance. The IRB Manager analyzes overall findings for trends and key process failures, providing input for team training regarding identified quality trends. Participates in and provide support during preparation for and conduct of internal and external quality audits of PBRC. Contributes in making not human subject or exempt determinations and approving minor expedited submissions as allowed by HRPP policy and authorized by the IRB Chair. The IRB Manager provides guidance to researchers on IRB policies and assist investigators and research staff with protocol and consent requirements for IRB submission. Works in partnership with the HRPP Manager, the IRB Chair and others to develop written guidelines to improve communication and understanding of human research requirements. Assist in the maintenance of the HRPP website as needed. The IRB Manager is a voting member of the IRB.

#### ***2.3.2.3 IRB Coordinator***

The IRB Coordinator organizes IRB meetings and review activities: prepares relevant materials and necessary correspondence, including agendas and reports. Reviews project submissions for completeness; communicates with



investigators and coordinators for any additional information or materials. Prepares and enters information into database for new submissions. Prepares appropriate paperwork and approval correspondence in conjunction with submissions to the IRB; communicates with investigators and coordinators for additional information or materials. Updates and maintains records related to IRB membership, maintains various tracking logs and files related to IRB activities. The IRB Coordinator maintains records of IRB approvals and oversees the archiving of terminated IRB files and responds to general information queries from investigators and study coordinators regarding IRB procedures. Assists HRPP Manager and IRB Manager with administrative tasks as needed and maintains a good working relationship with IRB members, Principal Investigators, Project Managers, and Study Coordinators

## **2.4 IRB Membership<sup>1</sup>**

IRB members are selected based on appropriate diversity, including consideration of race, gender, and cultural backgrounds; varied community involvement and affiliations; knowledge and experience with vulnerable populations; and with multiple, diverse professions or specialties, including both scientific members and non-scientific members. The structure and composition of the IRB must be appropriate to the nature of the research that is reviewed. Every effort is made to have member representation that has an understanding of the areas of specialty that encompasses the types of research performed at the Institution. Pennington Biomedical Research Center has procedures (see section 2.6, Use of Consultants, 3.7.1.1, Scientific Merit) that specifically outline the requirements for protocol review by individuals with appropriate scientific or scholarly expertise beyond or in addition to that available through the IRB members.

In addition, the IRB will include members who are knowledgeable about and experienced in working with vulnerable populations (e.g., children, pregnant women, or handicapped or cognitively-disabled persons) that typically participate in research.

The IRB must promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects and possess the professional competence necessary to review specific research activities. Ideally, a single member of the IRB could exhibit a profile that fulfills multiple specific requirements for IRB composition.

Regulations & Guidance: DHHS 45 CFR §46.107; FDA 21 CFR §56.107

### **A. Definitions**

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<sup>1</sup> The membership of the IRB is based upon Federal policy requirements as described in 45 CFR 46.107 and 21 CFR 56.107.



**Affiliated IRB member:** is an employee or agent of Pennington Biomedical Research Center or affiliated with Pennington Biomedical Research Center (faculty or medical staff). If a member of that person's immediate family is affiliated with Pennington Biomedical Research Center then the IRB member must disclose this information. Affiliated members include, but are not limited to individuals who are: full or part-time employees; members of any governing panel or board of the Institution; paid or unpaid consultants; and volunteers working at the Institution on business unrelated to the IRB.

**Experienced Member:** An IRB member determined by the IRB Chair to be qualified to perform reviews using expedited procedures. The following criteria are considered when determining whether an IRB member is experienced: length of IRB service, training regarding expedited review procedures, research experience/expertise, and/or work with the research participants being studied.

**Non-Affiliated Members:** is an IRB member with no affiliation to the Institution, nor can any immediate family member be affiliated with the Institution. The non-affiliated member is drawn from the community and must be willing to discuss issues and research from that perspective.

**Alternate member:** is an individual who has the experience, expertise, background, professional competence, and knowledge comparable to that of the primary IRB member(s) whom the alternate would replace.

**Non-scientific Member:** is any IRB member who has formal education and training in a discipline generally considered to be non-scientific (e.g. humanities, law, business) and/or is engaged in an occupation or role that is generally considered to be non-scientific (e.g. law enforcement, minister).

**Scientific member:** is an individual who has formal education and training as a physician or other medical professional, and M.S. and/or Ph.D. level physical, biological, or social behavioral scientists.

#### B. Composition of the IRB

- a. The IRB will have at least five members with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the Institution.
- b. The IRB will be sufficiently qualified through the experience, expertise, and diversity of its members, including consideration of race, gender, cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects.



- c. In addition to possessing the professional competence necessary to review specific research activities, the IRB will be able to ascertain the acceptability of proposed research in terms of Institutional policies and regulations, applicable law, and standards of professional conduct and practice. The IRB will therefore include persons knowledgeable in these areas.
- d. If the IRB regularly reviews research that involves a vulnerable category of subjects, consideration will be given to the inclusion of one or more individuals on the IRB, who are knowledgeable about and experienced in working with these subjects. When protocols involve vulnerable populations, the review process will include one or more individuals who are knowledgeable about or experienced in working with these subjects, either as members of the IRB or as consultants (see section 3.6.7 Consultant Advice on Vulnerable Populations and Section 6, Vulnerable Subjects in Research).
- e. Every nondiscriminatory effort will be made to ensure that the IRB does not consist entirely of men or entirely of women, including the Institution's consideration of qualified persons of both sexes. The IRB shall not consist entirely of members of one profession.
- f. The IRB includes at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in non-scientific areas.
- g. At least one member who is not otherwise affiliated with Pennington Biomedical Research Center and who is not part of the immediate family of a person who is affiliated with Pennington Biomedical Research Center.
- h. One member may satisfy more than one membership category.

Regulations & Guidance: DHHS 45 CFR §46.107; FDA 21 CFR §56.107

#### C. Nomination & Appointment of IRB Members

The IRB Chair identifies a need for a new and/or replacement IRB member who may be either a regular or alternate member of the IRB.

#### D. Appointment of New IRB Members

The IRB Chair is responsible for selecting individuals to serve as a new IRB member (and indicate whether regular or alternate).

Initial appointments are made for a year service term and IRB members are evaluated annually for extension of appointment. Any change in appointment or removal by the IRB Chair, requires written notification. Members may resign by written notification to the IRB Chair.

#### E. Documentation and Information for New IRB Members



The following items are required from each member of the IRB at initial appointment and as directed and will be made available as appropriate, upon request [DHHS 45 CFR §46.107]:

- Current curriculum vitae (“CV”) annually;
- Participation in the required initial training and new IRB member orientation must occur prior to review of any research; and
- Documentation of current Institutional certification in compliance education in the conduct of human subjects research (e.g., CITI Training). The IRB office documents and files compliance training for IRB members not affiliated with Pennington Biomedical Institution. Compliance training for all affiliated members (employees of Pennington Biomedical) is documented and filed in the Director of Legal and Regulatory Compliance Office.
- Attend at minimum of 75% of IRB meetings. (see 2.7, Duties of IRB Members)
- All members must sign a Confidentiality Agreement upon assignment as a member which is effective for the duration of the term served regardless of the length of the term. A Conflict of Interest Disclosure must be completed and signed annually.
- Documents supporting final appointments along with records of continuing education will become part of the permanent membership records maintained by IRB office. The IRB membership is indefinite pending annual IRB evaluation. Required changes will be reported to the OHRP.

#### F. Periodic Review of IRB Composition and Membership

On an annual basis, the IRB Chair shall review the membership and composition of the IRB to determine if they continue to meet regulatory and Institutional requirements. Required changes in IRB members will be reported to the OHRP.

### **2.5 *Alternate IRB Members***

The appointment and function of alternate members is the same as that of regular IRB members; and the alternate’s expertise and perspective are comparable to those of the regular member. The area of expertise of the alternates should match that of the regular member such that the federal policy requirements are met if a regular member cannot attend an IRB meeting. The role of the alternate member is to serve as a voting member of the IRB when the regular member is unavailable to attend a convened meeting. When an alternate member substitutes for a primary member, the alternate member will receive and review the same materials prior to the IRB meeting that the regular member received or would have received.



The IRB roster identifies the regular member(s) for whom each alternate member may substitute. The alternate member will not be counted as a voting member unless the regular member is absent. The IRB minutes will document when an alternate member has replaced a regular member.

## **2.6 IRB Member Conflict of Interest**

No IRB member may participate in the review (initial, continuing review, modification, unanticipated problem or non-compliance) of any research project in which the member has a conflict of interest (“COI”), except to provide information as requested. Matters involving financial COI involving IRB members are governed by the Institution’s policy detailed in Pennington Biomedical Research Center Policy 401.00 Individual Financial Conflicts of Interest Policy, IRB members may find themselves in any of the following COI when reviewing research:

1. Where the member or consultant is involved in the design, conduct, and reporting of the research;
2. Where an immediate family member of the member or consultant is involved in the design, conduct, and reporting of the research;
3. Where the member holds significant financial interests related to the research being reviewed; and
4. Any other situation where an IRB member believes that another interest conflicts with his or her ability to deliberate objectively on a protocol. For expedited reviews all reviewers must attest on the expedited reviewer form whether a COI exists. If a COI exists, a member is asked to notify the IRB immediately, so the review can be re-assigned.

It is the responsibility of each IRB member to disclose any COI with a study submitted for review, and recuse him/herself from the deliberations and vote by leaving the room, which departure is noted in the minutes.

The IRB Chair, will poll IRB members at each convened meeting to determine if a COI exists regarding any protocols to be considered during the meeting and reminds the committee that members with conflicts should recuse themselves by leaving the room during the discussion and vote of a specific protocol. IRB members with a conflicting interest are excluded from being counted towards quorum. All recusals by members with COI are recorded in the minutes.

If the conflict of interest status of an IRB member changes during the course of a study, the IRB member is required to declare this to the IRB Chair.

Regulations & Guidance: DHHS 45 CFR §46.107(e); FDA 21 CFR §54; 21 CFR §56.107(e);



## 2.7 Use of Consultants

A consultant is an individual with competence in a special area that the IRB has invited to assist in the review of issues which require expertise beyond or in addition to the availability on the IRB. These individuals do not count for IRB quorum purposes and cannot vote on any issue before the IRB [45 CFR §46.107(f)].

When necessary, the IRB Chair may solicit advice or otherwise engage individuals to assist the IRB in its review of issues or IRB proposals, which require appropriate scientific or scholarly expertise beyond or in addition to that available on the IRB.

The need for an outside reviewer is determined in advance of the IRB meeting by the IRB Chair by reviewing the IRB proposals scheduled to be reviewed at the convened meeting. The IRB staff will ensure that all relevant materials are provided to the outside reviewer prior to the convened IRB meeting.

Outside reviewers or consultants can be obtained either within or outside the Pennington Biomedical Research Center. In the event that additional scientific or scholarly expertise cannot be obtained for a research proposal the IRB Chair will defer the proposal to the next IRB meeting in order that appropriate review may be obtained.

IRB Chair will review the COI policy for IRB members (see section IRB Member Conflict of Interest) with consultants. Consultants must verbally confirm to the IRB Chair that they do not have a COI prior to review. Individuals who have a COI or whose spouse or family members have a COI in the research will not be invited to provide consultation. The consultant's findings will be presented to the convened IRB for consideration either in person or in writing. If in attendance, these individuals will provide consultation but may not participate in or observe the vote.

Ad hoc or informal consultations requested by individual IRB members (rather than for convened IRB review) will be requested in a manner that protects the researcher's confidentiality and is in compliance with the IRB COI policy.

To the extent that written statements or recommendations are provided by a consultant, a copy will be kept in IRB records. Key information provided by consultants at meetings will be documented in the minutes. Written reviews provided by the outside reviewer will be filed with the protocol. If a consultant is obtained, the consultant will be required to complete the same review documentation required by IRB members for appropriate review of a submission.

Regulations & Guidance: DHHS 45 CFR §46.107(f); FDA 21 CFR §56.107(f)



## **2.8 Duties of IRB Members**

Except for emergency IRB meetings, the agenda, submission materials, proposals, proposed informed consent forms and other appropriate documents are distributed to IRB members at least one week prior to the convened meetings at which the research is scheduled to be discussed. For emergency IRB meetings, these written materials will be submitted as timely as possible in advance of the scheduled IRB meeting date and time. IRB members will treat the IRB proposals, protocols, and supporting data confidentially. All copies of the protocols and supporting data are returned to the IRB staff at the conclusion of review for document destruction.

Attendance at 50% (at minimum) of the regularly scheduled IRB meetings during the course of a year is required. The member is to contact the IRB office of any potential absence as far in advance as possible; a member who repeatedly misses meetings (>50% unless excused) will either be asked to step down or have an alternate assigned who can act in his/her stead.

## **2.9 Attendance Requirements**

IRB members should attend all meetings for which they are scheduled. If a member is unable to attend a scheduled meeting, they should timely inform the IRB Chair or IRB staff member at least one week prior to the scheduled meeting. In the case of an emergency, members should provide notification as soon as possible. If an IRB member is unable to attend IRB meetings for a prolonged period, then such notice should be given so that the IRB Chair can determine whether an alternate member is needed and, if so, such alternate member should be temporary or permanent. If an IRB member is to be absent for an extended period of time, such as for a sabbatical, he or she must notify the IRB at least 30 days in advance so that an appropriate replacement can be obtained. The replacement can be temporary, for the period of absence, or permanent if the member is not returning to the IRB. If the member has a designated alternate (see Section 2.3.A and 2.4), the alternate can serve during the regular member's absence, provided the IRB has been notified in advance.

## **2.10 Training & Education**

Pennington Biomedical Research Center is committed to providing initial and on-going training and education for the IRB Chair, IRB members, and IRB staff related to research ethics concerns. [The](#) IRB Chair, IRB members and IRB staff are subject to the institutional policy 106.00 for training and education requirements.

### **A. New IRB Members--Orientation**



New IRB members, including alternate members, will meet with the IRB Chair for an informal orientation session. At the session, the new member will be given a handbook that includes copies of the following:

- Pennington Biomedical Research Center FWA
- Pennington Biomedical Research Center IRB policies and procedures
- IRB member Reviewer forms
- IRB member handbook
- The Belmont Report
- Applicable federal and state regulations including
  - 45 CFR Part 46 – The Common Rule
  - 21 CFR Part 50 – Protection of Human Subjects
  - 21 CFR Part 56 – Institutional Review Boards

#### **B. New IRB Members—Initial Education**

Before serving as a primary reviewer, a new IRB member must receive and successfully complete the Institutional education requirement, which consists of the training for the protection of Human Subjects involved in Research for both biomedical and social behavioral research.

#### **C. IRB Members—Continuing Education**

- To ensure that oversight of research involving human subjects is ethically grounded and the decisions made by the IRB is consistent with current regulatory and policy requirements, training is continuous for IRB members throughout their service on the IRB. Educational activities include, but are not limited to:
  - In-service training at IRB meetings
  - Distribution of appropriate publications; and
  - Identification and dissemination by the IRB Chair of new information that might affect the IRB, including laws, regulations, policies, procedures, and emerging ethical and scientific issues to IRB members via e-mail, mail, or during IRB meetings.

### ***2.11 Insurance Coverage for Research Oversight Activity***

Non-Pennington employees are appointed adjunct gratis faculty members of the Pennington Biomedical Research Center, for the sole purpose of their activities as members of the IRB. In this way, they, along with Pennington Biomedical Research Center employees, are protected by the Louisiana State University System Office of Risk Management.



## ***2.12 Review of IRB Member Performance***

IRB members performance will be reviewed on an annual basis by the IRB Chair, which feedback from such review shall be provided to the IRB member under review. Annually IRB members will be asked to fill out self-assessment and the IRB Chair will use the assessment to evaluate IRB members. IRB members who are not acting in accordance with the IRB mission or IRB policies and procedures, or who have an undue number of absences will be removed.



## 3.0 IRB Review Process

### 3.1 Policy

All human subjects' research in the Institution must meet the criteria for one of the following methods for review:

- Exempt review
- Expedited review
- Full review by a convened IRB

The IRB will ensure that the researchFu meets all required ethical and regulatory criteria for initial, continuing review and any modifications of approved research.

The following describe the procedures required for the review of research by the IRB.

### 3.2 Human Subjects Research Determination

The responsibility for an initial determination as to whether an activity constitutes human subjects research rests with the IRB. The IRB will make this determination based on the definitions of human subject and research contained in Section 1.0. Since the Institutional Official and the IRB will hold the Investigator responsible if the determination is not correct, Investigators are urged to request a confirmation from the IRB office that an activity does not constitute human subjects. The request may be made, by e-mail or through a formal written communication. All research requests must include sufficient documentation of the activity to support a determination by the IRB.

Determinations as to whether an activity constitutes human subjects research will be made according to the definitions in section 1.0 and using Decision Tree(s) at [www.hhs.gov/ohrp/policy/checklists/decisioncharts.html](http://www.hhs.gov/ohrp/policy/checklists/decisioncharts.html). Determinations regarding activities that are either clearly or clearly not human subject's research based on this guidance document will be made in writing and may be made by the IRB Chair (or designee). Determinations regarding less clear-cut activities will be referred to the IRB Chair, who may make the determination or refer the matter for convened IRB review. If a clear determination cannot be made, then, out of an abundance of caution, the activity should be deemed to constitute human subjects research for further review (e.g., exempt, expedited or convened IRB review).

Documentation of all determinations made of whether activity constitutes human subjects research are recorded and maintained by IRB office. Formal submissions will be responded to in writing and a copy of the submitted materials and determination letter will be kept on file. Regulations & Guidance: DHHS 45 CFR §46.101(a); FDA 21 CFR §56.101



### **3.3 Exempt Studies**

While all research using human subjects must be approved by the IRB, certain categories of research (i.e., “exempt research”) do not require convened IRB review and approval. Exempt research is subject to Institutional review and must be determined and approved by the IRB Chair (or designee). The following sections will describe activity that is exempt and the procedures for conducting exempt review. Investigators will submit an Application for Initial Review and protocol to the IRB for an exempt determination. After a determination that research is exempt by qualified IRB members, the Investigator is notified in writing of the exemption status. The study is not subject to continuing review on an annual basis; however, the Investigator is asked to let the IRB know when the study is closed.

Documentation of all exemption determinations made are recorded and maintained by the IRB office.

#### **3.3.1 Limitations on Exemptions**

- Exemption for research involving survey, interview procedures or observations of public behavior does NOT apply to research in children, except for research involving observations of public behavior when the Investigator does not participate in the activities being observed.
- Research involving prisoners as human subjects is not eligible for exemption. “Prisoners” are defined as “any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures which provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing.
- Exempt research categories do not apply to research that involves FDA-regulated products (studies using investigational drugs, biologics, or devices for which the FDA has granted an investigational new drug [IND] or investigational device exemption [IDE], or non-significant-risk devices).

#### **3.3.2 Categories of Exempt Research**

Unless an exception exists, the following categories of research below are considered exempt research and not regulated by the Common Rule or FDA regulations.



1. Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as:
  - a. Research on regular and special education instructional strategies, or
  - b. Research on the effectiveness of, or the comparison among instructional techniques, curricula, or classroom management methods.[45 CFR §46.101(b) (1)]
2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
  - a. Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and
  - b. Any disclosure of the human subjects responses outside the research could reasonably place the subjects at risk of criminal or civil liability, loss of insurability or be damaging to the subject's financial standing, employability, or reputation [see 45 CFR §46.101(b)(2) or (b)(3)]
3. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (2), if:
  - a. The human subjects are elected or appointed public officials or candidates for public office; of
  - b. Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter. Any disclosure of the human subjects responses outside the research could reasonably place the subjects at risk of criminal or civil liability, loss of insurability or be damaging to the subject's financial standing, employability, or reputation. [see 45 CFR §46.101(b)(2) or (b)(3)]
4. Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the Investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. [45 CFR §46.101(b)(4)]

NOTE: In order to be eligible for this exemption, all of the materials have to exist at the time the research is proposed.
5. Research and demonstration projects which are conducted by or subject to the approval of federal department or agency heads, and which are designed to study, evaluate, or otherwise examine:
  - a. Public benefit or service programs;



- b. Procedures for obtaining benefits or services under those programs;
  - c. Possible changes in or alternatives to those programs or procedures; or
  - d. Possible changes in methods or levels of payment for benefits or services under those programs.
  - e. The program under study must deliver a public benefit (e.g., financial or medical benefits as provided under the Social Security Act) or service (e.g., social, supportive, or nutrition services as provided under the Older American Act).
  - f. The research demonstration project must be conducted pursuant to specific federal statutory authority, there must be no statutory requirements of IRB review, the research must not involve significant physical invasions or intrusions upon the privacy of subjects', and the exemption must be invoked only with authorization or concurrence by the funding agency.
6. Taste and food quality evaluation and consumer acceptance studies,
- a. If wholesome foods without additives are consumed; or
  - b. If a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the US. Department of Agriculture.

Regulations & Guidance: DHHS 45 CFR §46.101(b); 45 CFR §46.401(b); FDA 21 CFR §56.104(c)-(d); OHRP Guidance at 45 CFR §46.101(b)(5): Exemptions for research and Demonstration Projects on Public Benefit and Service Programs

In addition to the federal criteria for exemptions this Institution evaluates whether the proposed research meets the Institution's ethical standards. The following ethical standards are reviewed on proposed research considered for an exemption:

- The research holds out no more than a minimal risk to participants
- The selection of subjects is equitable
- If there is a recording of identifiable information, there are adequate provisions to maintain the confidentiality of data.
- If there are interactions with participants, the IRB should determine whether there should be a consent process that will disclose such information as:
  - The activity involves research
  - A description of procedures
  - The participation is voluntary
  - The name and contact information of the researcher
- There are adequate provisions to maintain the privacy interests of participants.



### 3.3.3 FDA Exemptions

The following category of clinical investigation is exempt from the FDA requirements of IRB review:

- Taste and Food Quality Evaluations and Consumer Acceptance Studies, if wholesome foods without additives are consumed or if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural, chemical, or environmental contaminant at or below the level found to be safe, by the FDA or approved by the EPA or the Food Safety and Inspection Service of the U.S. DOA. [FDA 21 CFR §56.104(d)]

## 3.4 Expedited Review

The IRB Chair or one or more experienced IRB members designated by the Chair may use expedited review procedures to approve a limited class of research activities involving human subjects. Expedited IRB review procedures may be used for the following:

- Initial or continuing review of specific categories of research not greater than minimal risk
- Continuing review of research previously approved by the convened IRB, under specified circumstances
- Review of minor changes to previously approved research.

This policy describes the situations in which research may qualify for expedited review, as well as the process by which the IRB reviews research by expedited procedures.

### 3.4.1 Definitions

**Expedited Review:** Process by which designated IRB members, on behalf of the full IRB, approve a limited class of research activities through reviews conducted outside of the convened IRB meeting.

Expedited Review is used by the IRB for either or both of the following:

- Some or all of the research appearing on the list of categories of research eligible for expedited review and found by the reviewer(s) to involve no more than minimal risk; and/or
- Minor changes in previously approved research during the period (of one year or less) for which approval is authorized. (See section 3.4.2)



Minor changes: Research that in the judgment of the IRB does not affect the assessment of the risks and benefits of the study by substantially altering any of the following:

- The level of risk to subjects;
- The research design or methodology;
- The subject population;
- The qualifications of the research team;
- The facilities available to support the safe conduct of the research;
- A minor change does not increase risk more than minimally or add procedures;
- Any other factor which would warrant review of the proposed changes by the convened IRB.

Examples of changes to previously approved research that may be considered minor (and may be reviewed using expedited procedures) when they do not alter the risk/benefit ratio include:

1. Changes in study documents, such as recruitment materials, consent forms, questionnaires, etc. that do not materially affect participation of the subject in the study or alter the meaning of the text (e.g., formatting, phone or room numbers, etc.).
2. Clarifications of the study protocol, procedures, or consent language that do not introduce new procedures or information.
3. Changes in wording or deletions of a question(s) on a survey or in the material properties of a stimulus, where the change or deletion does not alter the fundamental meaning of the item for the research or change the nature of the subject's participation in the study.
4. Addition of a standardized survey instrument that does not substantially increase risk to participants or the duration of their study participation.
5. Addition of advertisements or recruitment materials that are not considered coercive and are easily compared to the approved informed consent script or document.
6. Increases in numbers of participants, who are identified and recruited by approved methods from currently approved populations, or increases in local site enrollment in multi-site studies where the increase does not exceed the approved total number of participants across all sites.
7. Decreases in number or frequency of data collection points that do not compromise study integrity or decrease safeguards for participants.
8. Decreasing the amount of blood draw or the frequency of blood draw
9. Reducing the time period of the study
10. Adjusting incentives (as long as they are not coercive or pose undue influence)
11. Response to a conditional approval determination by the convened IRB.



[DHHS 45 CFR §46.110; FDA 21 CFR §56.110(b)]

### 3.4.2 Categories of Research Eligible for Expedited Review<sup>1</sup>

Inclusion on this list merely means that the activity is eligible for review through the expedited review procedure when the specific circumstances of the proposed research involve no more than minimal risk to human subjects. The activities listed below should not be deemed to be of minimal risk simply because they are included on this list.

The expedited review procedure may not be used for the following:

- Where identification of the subjects and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the subjects financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal risk.

The availability of expedited review contained in paragraphs one (1) through nine (9) of this section below apply regardless of the age of subjects, unless specifically excepted as noted.

The standard requirements for informed consent (or its waiver, alteration, or exception) apply regardless of the type of review (i.e., expedited review or convened IRB review) used by the IRB. However, it should be noted that, while research that involves paragraphs one (1) through seven (7) below pertains to both initial review and continuing review, paragraphs eight (8) and nine (9) below only pertain to continuing reviews.

1. Clinical studies of drugs and medical devices only when condition (a) or (b) is met.
  - a. Research on drugs for which an IND [21 CFR Part 312] is not required.  
(NOTE: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the produce is not eligible for expedited review.)
  - b. Research on medical devices for which (i) an IDE [21 CFR Part 812] is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.
2. Collections of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:

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<sup>1</sup> 63 FR 60364-60367, November 9, 1998.



- a. From healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or
  - b. From other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.
3. Prospective collection of biological specimens for research purposes by noninvasive means. Examples:
- a. Hair and nail clippings in a non-disfiguring manner;
  - b. Deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction;
  - c. Permanent teeth if routine patient care indicates a need for extraction;
  - d. Excreta and external secretions (including sweat);
  - e. Uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gum base or wax or by applying a dilute citric solution to the tongue.
  - f. Placenta removed at delivery;
  - g. Amniotic fluid obtained at the time of rupture of the membrane prior to or during labor;
  - h. Supra-and sub-gingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques;
  - i. Mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings;
  - j. Sputum collected after saline mist nebulization.
4. Collection of data through non-invasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where Medical Devices are employed, they must be cleared/approved for marketing.

(Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.) Examples:

- a. Physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject's privacy;



- b. Weighing or testing sensory acuity;
  - c. Magnetic resonance imaging;
  - d. Electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, Doppler blood flow, and echocardiography;
  - e. Moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.
5. Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis).

[NOTE: Some research in this category may be exempt from the DHHS regulations for the protection of human subjects. See exempt categories and 454 CFR §46.101(b)(4). This listing refers only to research that is not exempt.]

6. Collection of data from voice, video, digital, or image recordings made for research purposes.
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

[NOTE: Some Research in this category may be exempt from the DHHS regulations for the protection of human subjects. See exempt categories and 45 CFR §46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.]

8. Continuing review of research previously approved by the convened IRB as follows:
- a. Where
    - i. The research is permanently closed to the enrollment of new subjects;
    - ii. All subjects have completed all research-related interventions; and
    - iii. The research remains active only for long-term follow-up of subjects; or
  - b. Where no subjects have been enrolled and no additional risks have been identified; or
  - c. Where the remaining research activities are limited to data analysis.



Of note, category (8) identifies three situations in which research that is greater than minimal risk and has been initially reviewed by a convened IRB may undergo subsequent continuing review by the expedited review procedures.

For a multi-center protocols, an expedited review procedure may be used by the IRB at a particular site whenever the conditions of category (9)(a), (b), or (c) are satisfied for that site. However, with respect to category 9(b), while the criterion that “no subjects have been enrolled” is interpreted to mean that no subjects have ever been enrolled at a particular site, the criterion that “no additional risks have been identified” is interpreted to mean that neither the Investigator nor the IRB at a particular site has identified any additional risks from any site or other relevant source.

9. Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories two (2) through eight (8) do not apply by the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

Under category (9), an expedited review procedure may be used for continuing review of research not conducted under an investigational new drug application or investigational device exemption where categories (2) through (8) do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified. The determination that “no additional risks have been identified” does not need to be made by the convened IRB.

### **3.4.3 Submission Requirements**

- A. When submitting applications for initial or continuing review using the expedited procedure, investigators must submit all applicable materials: protocol, consent, assent, tracked copy of any protocol/consent/assent being modified , any other protocol related documents and applicable IRB applications.
- B. When submitting amendment requests for expedited review, investigators must submit all applicable materials (originals and revised tracked copies of modified documents) listed in HRPP policy [IRB Submission and Pre-Review].
- C. Upon receipt of an application for expedited review, an IRB staff member pre-reviews the submission (e.g., to verify whether the materials are complete, required



education has been completed, etc.) and makes an initial determination as to whether the submission is eligible for expedited review.

### **3.4.4 Expedited Review Procedures**

Under an expedited review procedure, the review may be carried out by the IRB Chair or by one or more reviewers designated by the IRB Chair from among IRB members. IRB members who serve as designees to the IRB Chair for expedited review will be matched as closely as possible with their field of expertise to the study under review. Only experienced IRB members may conduct reviews using the expedited procedure.

IRB members with a COI in the research (see section 2.5 – Conflict of Interest for IRB members) will not be selected to serve as expedited reviewers.

When reviewing research under an expedited review procedure, the IRB Chair, or designated IRB member(s), should receive and review all documentation that would normally be submitted for convened IRB review including the complete protocol. This includes review of the following:

1. The complete protocol or any protocol related documents
2. For continuing review, an application for continuing review that summarizes research activities since the previous annual review (including modifications and adverse events);
3. Notes from pre-screening conducted by the IRB staff;
4. Any applicable IRB applications; and
5. The current consent documentation.
6. The investigator's current curriculum vitae, biosketch or other documentation evidencing qualifications.
7. Any newly proposed consent document;
8. Recruitment materials;
9. A status report on the progress of the research including the following:
  - a. number of participants accrued
  - b. a summary since the last IRB review of the following:
    - i. unanticipated problems involving risks to participants or others;
    - ii. participant withdrawals and the reasons for withdrawals;
    - iii. complaints about the research;
    - iv. any relevant recent literature;
    - v. any interim findings;
    - vi. any relevant multi-center trial reports;
    - vii. the researcher's current risk-potential benefit assessment based on study results.



Protocols submitted for expedited review will be pre-screened by IRB staff to ensure that the package is complete. The reviewer(s) conducting initial continuing reviews or modifications to previously approved research will determine whether the research meets the criteria allowing review using the expedited procedure, and if so, whether the research meets the regulatory criteria for approval. If the research does not meet the criteria for expedited review, then the reviewer will indicate that the research requires convened IRB review and the protocol will be placed on the agenda for the next IRB meeting.

In reviewing the research, the reviewers will follow the review procedures described in sections 3.7 and 3.8 and may exercise all of the authorities of the IRB except that the reviewers may not disapprove the research. A research activity may be disapproved only after review in accordance with the non-expedited procedure set forth below.

The IRB Chair (or designee) will indicate approval, required modifications or referral to the convened IRB. If modifications are required, the IRB staff will inform the Investigator. If the modifications are minor, the IRB Chair may determine if the Investigator has sufficiently addressed the modifications. If the modifications are major or if the IRB Chair (or designee) requests, the modified protocol will be sent back to the IRB member(s) for further review at a convened IRB meeting.

If research involving an FDA-regulated article is involved, a licensed physician must be involved in the review, unless the expedited submission is an administrative change and does not alter the risk/benefit ratio. See policy 3.4.1 for examples of expedited review that do not alter the risk/benefit ratio. The physician may be a voting IRB member or a consultant.

Regulations & Guidance: DHHS 45 CFR §46.100; FDA 21 CFR §46.110; Categories of Research that May Be Reviewed by the IRB through an Expedited Review Procedure - FDA & DHHS; OHRP Guidance on Written IRB Procedures; OHRP Guidance on Use of Expedited Review Procedures; OHRP Guidance on Continuing Review; FDA Information Sheets: Continuing Review after Study Approval

### **3.4.5 Informing the IRB**

All members of the IRB will be apprised of all expedited review approvals that were reviewed by the IRB Chair (or designee). This notification is accomplished by means of a list in the agenda and a list in the monthly IRB meeting minutes. Any IRB member can request to review the full expedited review and all supporting documentation by contacting the IRB office.

## **3.5 Convened IRB Review**



Convened IRB review means review by a fully convened IRB. Except when an expedited review procedure is used, the IRB will conduct initial, continuing reviews and modifications of previously approved research at convened meetings at which a quorum (see section 3.5.5 below) of the members is present. Regulations and Guidance: FDA 21 CFR §56.108(c)

### **3.5.1 IRB Meeting Schedule**

The IRB meets on a regular basis throughout the year. The schedule for the IRB may vary due to holidays or lack of quorum. The schedule for IRB meetings is given to all IRB members in December before the next calendar year. Additionally, this information is posted on the Pennington Biomedical Research Center HRPP website for the benefit of all Investigators, research coordinators and other research staff when submitting protocol materials. Special meetings may be called at any time by the IRB Chair.

### **3.5.2 Preliminary Review**

All submissions by Investigators to the IRB are stamped to confirm the date of submission.

The IRB staff will perform a preliminary review of all submission materials submitted for determination of completeness and accuracy. Only complete submissions will be referred for further consideration (i.e., exempt, expedited or convened IRB review).

The Investigator will be informed either by e-mail or phone of missing materials and the deadline to resubmit corrections before further review can take place. The Investigator is responsible to provide the IRB with an active e-mail address and current contact information.

Specific questions regarding the IRB policies and procedures, determining whether a particular protocol is human subjects research or not, and which forms are required for a particular study, can be submitted by email, writing and/or via the telephone to the IRB office for further information and/or clarification.

### **3.5.3 Primary Reviewers**

After it has been determined that the protocol submission is complete, the IRB Chair, with the assistance of the IRB Staff, assigns protocols for review based on the scientific content of the protocol, reviewer's area of expertise, and requirements for representation of vulnerable populations involved in the research. A primary reviewer is assigned to each agenda item and a scientific/scholarly reviewer to each agenda item who has expertise in the area of research (one person could do both).



When the IRB is presented with a protocol which, in the opinion of the IRB Chair, may be outside of the knowledge base or representative capacity of all of the IRB members, an outside consultant will be sought (see section 3.6.6, Consultant - Children and section 3.6.7, Consultant - Vulnerable Populations). Proposals for which appropriate expertise cannot be obtained for a given meeting will be deferred to another meeting when appropriate expertise can be achieved.

Primary reviewers are responsible for:

- Having a thorough knowledge of all details of the proposed research;
- Performing an in-depth review of the proposed research and supporting documents;
- Leading the discussion of the proposed research at the convened meeting and presenting both positive and negative aspects of the research. (section 3.6.4 – Initial, Continuing Review and Requests for Modification);
- Making suggestions for changes to the proposed research.
- Completing all applicable IRB Member Reviewer Forms.

If the primary reviewer will be absent from the meeting, a new reviewer with appropriate expertise will be assigned if time allows. If the reviewer is unable to attend the meeting and an alternate is not able to be assigned, the submission will be tabled until the appropriate expertise can be obtained.

It should be noted that all IRB members have access to and are expected to review all IRB proposals, not just the ones they are responsible for reviewing.

During the convened IRB meeting, primary reviewers must give the IRB staff the completed an appropriate reviewer forms. All reviewer forms will be filed with the appropriate meeting minutes.

### **3.5.4 Pre-Meeting Distribution of Documents to Reviewers**

Documents reviewed by expedited review are not submitted to members.

The following materials will be distributed to primary reviewers:

- Initial submissions – Application for Initial Review (submitted by investigator), any relevant appendices, any relevant grant applications; the protocol; sponsor or DHHS approved protocol (if one exists), the DHHS approved sample consent (if one exists), the Investigator's Brochure (when one exists); the sample informed consent document (when one exists); the complete consent document , any supporting documents and any other protocol related documents
- Continuing review submissions - the primary reviewer will receive the following:
  - the continuing review report,



- the last approved consent,
- the complete protocol, protocol summary or application containing the relevant information necessary to determine whether the proposed research continues to fulfill the criteria for approval. Investigator brochure (if one exists), all protocol modifications reviewed during the current continuing review timeframe, all adverse events reviewed during the current continuing review timeframe, all protocol deviations reviewed during the current continuing review time frame.
- Modifications – the primary reviewer will receive a copy all items being modified, and an application for a modification of approved human research.

The following materials will be distributed to all attending members not involved in the primary review:

- Initial submissions – all members will receive the Initial Submission Application, protocol summary or protocol, the complete consent document, recruitment materials (if available) and any supporting documentation.
- Continuing review submissions – all members will receive the full protocol, the continuing review report, or a protocol summary containing the relevant information necessary to determine whether the proposed research continues to fulfill the criteria for approval; any newly proposed consent document; and a status report on the progress of the research.
- Modifications – all members will receive a copy of all items being modified and the application for modification of approved human research.

Documents are distributed to IRB members at least one week before the IRB meeting to allow adequate review time.

All expedited submissions and other supporting documents are available to all members before, during and after the IRB meeting.

### **3.5.5 IRB Agenda**

While the IRB will make every effort to review all submissions, the IRB has the right to limit the agenda based on IRB member attendance of appropriate expertise.

### **3.5.6 Quorum**

A quorum consists of a simple majority (more than fifty percent (50%) of the voting IRB membership, including at least one member whose primary concern is in a non-scientific area, one unaffiliated member and one member that represents the general perspective of participants. For research to be approved it has to receive the approval of a majority of members present at the meeting. If a regular IRB member and his/her



alternate are present at a convened IRB meeting, only one counts towards the quorum and the IRB member (not the alternate) is the only one entitled to vote.

Additional quorum requirements include the following:

- If research involving an FDA-regulated article is involved, a licensed physician must be involved in the review. The physician may be a voting IRB member or a consultant. The review can be provided via email, fax, mail or he reviewer may be present for the discussion and for the review of any studies (including initial review, continuing review, modification, Investigator brochure or report of anticipated problems involving risks to subjects and others) that involve the FDA-regulated article; and
- For research that involves cognitively-disabled persons or persons with impaired decision-making capacity, IRB membership must include at least one member who is an expert in the area of the research.

At meetings of the IRB, a quorum must be established and maintained for the deliberation and vote on all matters requiring a vote. The IRB Chair, with the assistance of the IRB staff, will confirm that an appropriate quorum is present before calling the meeting to order. If an IRB member leaves the meeting due to a conflict of interest or any other reason the IRB Chair and/or IRB staff are responsible for assuring a quorum is maintained. The IRB staff will document in the meeting minutes the quorum determination. If a quorum is not maintained, the proposal or pending action item must be tabled or the meeting terminated. The IRB staff will document the time of arrival and departure for all IRB members and notify the IRB Chair if a quorum is not present. A sign-in sheet is completed by IRB members, guests and ex-officio (non-voting members) guests to document their attendance at a convened IRB meeting.

IRB members are considered present and participating at a duly convened IRB meeting when either physically present or participating through electronic means (e.g., teleconferencing or video conferencing) that permits them to listen to and speak during IRB deliberations and voting.

When not physically present, the IRB member must have received all pertinent materials prior to the meeting and must be able to participate actively and equally in all discussions.

Opinions of absent IRB members that are transmitted by mail, voicemail, facsimile or e-mail may be considered by the attending IRB members, but may not be counted as votes or to satisfy the quorum for convened meetings.



IRB members commit to contact the IRB office by e-mail or phone approximately two weeks before a scheduled IRB meeting date if unable to make the IRB meeting, so IRB staff can ensure appropriate notification of IRB alternate members.

## **3.6 IRB Meeting Procedures**

### **3.6.1 Call to Order and Quorum**

The IRB Chair (or designee in the event that the IRB Chair is absent) will call the IRB meeting to order, once it has been determined that a quorum exists.

### **3.6.2 Conflict of Interest of IRB Members**

Where there is a COI involving an IRB member, the IRB Chair (or designee) will remind the IRB member to recuse him/herself from the discussion and vote by leaving the room when there is a conflict for the particular action item under review. Known conflicts of interest of an IRB member is also noted on the agenda, which is made available to all members prior to the IRB meeting.

### **3.6.3 Review and Approval of Prior Meeting Minutes**

The IRB will review and discuss the IRB meeting minutes from the previous meeting and determine if there are any revisions/corrections to be made. If there are no changes to be made, the minutes will be accepted as presented and considered final. If it is determined that revisions/corrections are necessary, the Chair will conditionally approve the minutes and approve the final version with the requested changes. A majority of the members present at a duly constituted IRB meeting are required to accept the minutes.

### **3.6.4 Initial, Continuing Review and Requests for Modification**

The IRB reviews all submissions for initial review and continuing review, as well as requests for modifications. The primary reviewer presents an overview of the research and lead the IRB through a discussion of the criteria approval for research documented on the IRB Member Reviewer Forms. If a primary reviewer is unable to attend the meeting and an alternate with the appropriate expertise is not available, the item will be tabled until the next meeting. All IRB members present at a duly convened IRB meeting have full voting rights, except in the case of a COI (see section 2.5 – Conflict of Interest for an IRB member) and ex-officio members. In order for the research to be approved, it must receive the approval of a majority of those voting members present at a duly constituted IRB meeting.



Regulations & Guidance: DHHS 45 CFR §46.103(b)(4); 45 CFR §46.108(b); 45 CFR §46.109; 45 CFR §46.116(b)(5); FDA 21 CFR §50.25(b)(5); 21 CFR §56.108; OHRP Guidance on Written IRB Procedures; OHRP Guidance on Continuing Review; FDA Information Sheets: Continuing Review After Study Approval

### **3.6.5 Recording of Proceedings**

It is the responsibility of the IRB staff to record the proceedings of the IRB meeting with digital equipment to ensure accuracy of discussion. All recording of proceedings are destroyed upon approval of the minutes. In addition, the IRB staff is responsible for taking minutes at each IRB meeting.

In order for research activity to be approved, it must receive the approval of a majority of those members present at a convened IRB meeting. The vote is recorded by means of signifying for, against, and abstained by show of hands. The vote is recorded by the staff and reflected on the IRB meeting minutes.

### **3.6.6 Consultant - Children**

When reviewing a protocol involving children, the IRB will ensure that appropriate pediatric expertise is available to review the specific research activities. Non-voting consultants may be invited to assist with the review if additional expertise is needed.

### **3.6.7 Consultant - Vulnerable Populations**

When reviewing studies with other vulnerable populations, including pregnant women, fetuses, neonates, handicapped persons, and cognitively impaired, the IRB will request review by expert consultant, as needed. If the IRB regularly reviews research involving a vulnerable category of subjects, one or more individuals who are knowledgeable about and experienced in working with these subjects should be included as IRB members (refer to policy on vulnerable subjects for more detail section 3.7.6 – Vulnerable Subjects).

### **3.6.8 Guests and Non-Voting Members**

At the discretion of the IRB, the Investigator (or designee such as a Co-Investigator) may be invited to the IRB meeting to answer questions about their proposed or ongoing research. The Investigator may not be present for the discussion or vote on the study or action under review by the IRB.

Other invited guests may be permitted to attend IRB meetings at the discretion of the IRB Chair. Invited guests may not speak unless requested by the IRB and must sign a confidentiality agreement prior to the convened meeting.



Certain ex officio individuals (non-voting members, IRB staff) regularly attend IRB meetings as ex-officio guests. While they are not voting members of the IRB, they may participate in the IRB discussion and may provide additional information to the IRB. The IRB Chair may ask the ex-officio individual to formally review an IRB submission if they feel the ex-officio's expertise is warranted. However, the non-voting member will not be asked to be the primary reviewer; as the non-voting member has no voting rights.

### ***3.7 Criteria for IRB Approval of Research***

At the time of initial, continuing review and review of a modification to previously approved research (if the modification affects the criteria for approval), the IRB must determine that the following requirements are satisfied in order to approve research involving human subjects.

Risks to subjects are minimized:

- By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk; and
- Whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.
- Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result.
- In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research).
- The IRB should not consider possible long-range effects of applying knowledge gained in the research (e.g., the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.
- Selection of subjects is equitable. In making this assessment, the IRB should take into account the purpose of the research and the setting in which the research will be conducted and should be particularly cognizant of the special problems of research involving vulnerable populations, such as children, pregnant women, cognitively disabled persons, or economically or educationally disadvantaged persons.
- Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by 45 CFR §46.116.
- Informed consent will be appropriately documented, in accordance with, and to the extent required by 45 CFR §46.117.



- When appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of subjects.
- When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.
- When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, pregnant women, cognitively disabled persons, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects.
- Research studies have the resources necessary to protect participants:
  - Adequate time for the researchers to conduct and complete the research.
  - Adequate number of qualified staff.
  - Adequate facilities.
  - Access to a population that will allow recruitment of the necessary number of participants.
  - Availability of medical or psychosocial resources that participants may need as a consequence of the research.

Regulations & Guidance: DHHS 45 CFR §46.111; FDA 21 CFR §56.111

### **3.7.1 Risk-Benefit Assessment**

The goal of a risk-benefit assessment is to ensure that the risks to research subjects posed by participation in a research study are justified relative to the anticipated benefits for the subjects or society. The IRB must:

- Judge whether the anticipated benefit, either of new knowledge or of improved health for the research subjects, justifies asking any person to undertake the risks;
- Disapprove research in which the risks are judged unreasonable in relation to the anticipated benefits.

The assessment of the risks and benefits of the proposed research involves a series of steps:

- Identify the risks associated with the research, as distinguished from the risks of therapies the subjects would receive even if not participating in research;
- Determine whether the risks to subjects will be minimized to the extent possible. This can be done, for example by using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk. This also can be accomplished, as appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes; identify the probable benefits to be derived from the research; determine whether the risks to subjects are reasonable in relation to the benefits to subjects, if any, and assess the importance of the knowledge to be gained.



- In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research.
- The IRB should not consider possible long-range effects of applying knowledge gained in the research (e.g., the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility
- Ensure that potential subjects will be provided with an accurate and fair description of the risks or discomforts and the anticipated benefits.

Based on this assessment, risk associated with the research will be classified as either minimal risk or greater than minimal risk, which will be based on the interpretation of minimal risk.

Regulations & Guidance: DHHS 45 CFR §46.111(a); FDA 21 CFR §56.111(a)

### **3.7.1.1 Scientific Merit**

In order to assess the risks and benefits of the proposed research, the IRB must determine that the research uses procedures consistent with sound research design, the research design is sound enough to reasonably expect the research to answer its proposed question and the knowledge expected to result from this research is sufficiently important to justify the risk.

The IRB considers the following during the initial protocol review:

- Does the protocol accurately describe the following in a clear, detailed method?
  - Objectives of research
  - Background of research
  - Setting of research
  - Procedures of research
  - Data and safety monitoring plan
  - Risks of research
  - Potential benefits of research
  - Alternatives to participation in research
  - The Investigator has demonstrated a potential for recruiting the required number of suitable subjects within the agreed recruitment period
- Is the available non-clinical and clinical information on an investigational product adequate to support the proposed clinical trial?



- All research under the purview of Pennington Biomedical Research Center must have a qualified physician, credentialed by Pennington Biomedical that will be responsible for all trial related medical decisions.

Regulations & Guidance: DHHS 45 CFR §46.111(a)(1); FDA 21 CFR §56.111(a)(1)

### **3.7.2 Equitable Selection of Subjects**

The IRB determines by viewing the protocol that the selection of subjects is equitable with respect to gender, age, class, etc. The IRB will not approve a study that does not provide adequately for the equitable selection of subjects or has not provided an appropriate scientific and ethical justification for excluding classes of persons who might benefit from the research. In making this determination, the IRB evaluates:

- the purpose of the research;
- the setting in which the research occurs;
- scientific and ethical justification for including vulnerable populations such as children, pregnant women, cognitively disabled persons, or economically or educationally disadvantaged persons;
- the scientific and ethical justification for excluding classes of persons who might benefit from the research,
- inclusion/exclusion criteria,
- payment amount and timing of payments to participants (see 3.8.9 – Payments to Research Subjects) and
- participant recruitment and enrollment procedures.

At the time of the continuing review, the IRB will determine the Investigator has followed the subject selection criteria that he/she originally set forth at the time of initial IRB review and approval.

Regulations & Guidance: DHHS 45 CFR §46.111(a)(3); FDA 21 CFR §56.111(a)(3)

#### **3.7.2.1 Recruitment of Subjects**

The Investigator will provide the IRB with all recruiting materials to be used in identifying subjects including recruitment methods, advertisements, and payment arrangements. See Section 3.8.8-Advertisements for a discussion of IRB review of advertisements, and section 3.8.9 - Payments to Research Subjects for a discussion of IRB review of payments/compensation to subjects.



Regulations & Guidance: DHHS 45 CFR §46.111(a)(3); 45 CFR §46.116; FDA 21 CFR §50.20; 21 CFR §56.111(a)(3)

### **3.7.3 Informed Consent**

The IRB will determine the following:

- Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by 45 CFR §46.116 and 21 CFR §50.20.

In addition, the IRB will ensure that the consent will be appropriately documented according to legal requirements in accordance with, and to the extent required by 45 CFR §46.117 and 21 CFR §50.27 (see section 5.0 - Obtaining Consent from Research Subjects for further information on Informed Consent elements). Regulations & Guidance: DHHS 45 CFR §46.111(a)(4) & (a)(5); FDA 21 CFR 56.111(a)(4) & (a)(5).

### **3.7.4 Safety Monitoring**

Pennington Biomedical Research Center requires that all research must have a data safety monitoring plan. Any reports generated from the data safety monitoring plan will be submitted to IRB and forwarded to the Medical Staff for review.

The data safety monitoring plan must describe the procedures for safety monitoring, reporting of unanticipated problems involving risks to subjects or others, descriptions of interim safety reviews and the procedures planned for transmitting the results to the IRB. This description should include information regarding an independent Data and Safety Monitoring Board (DSMB), if one exists, or an explanation why an independent data safety monitor is not necessary.

The IRB determines that the data safety monitoring plan makes adequate provision for monitoring the reactions of subjects and the collection of data to ensure the safety of subjects. The overall elements of the monitoring plan may vary depending on the potential risks, complexity, and nature of the research study. The method and degree of monitoring needed is related to the degree of risk involved. Monitoring may be conducted in various ways or by various individuals or groups, depending on the size and scope of the research effort. These exist on a continuum from monitoring by the Investigator in a small, low risk study to the establishment of an independent DSMB for a large phase III clinical trial.

The factors the IRB will consider in determining whether the safety monitoring plan is adequate for the research are as follows:



1. Monitoring is commensurate with the nature, complexity, size and risk involved.
2. Monitoring is timely. Frequency should commensurate with risk. Conclusions are reported to the IRB.
3. For low risk studies, continuous, close monitoring by the study Investigator or an independent individual may be an adequate and appropriate format for monitoring, with prompt reporting of problems to the IRB, sponsor and regulatory bodies as appropriate.
4. For an individual Safety Monitor, the plan must include:
  - parameters to be assessed,
  - mechanism to assess the critical efficacy endpoints at intervals in order to determine when to continue, modify, or stop a study.
  - frequency of monitoring procedures for reporting to the IRB
5. For a DSMB, the plan must include:
  - name of the Data Safety Monitoring Board, if applicable
  - is independent from the sponsor,
  - availability of written reports,
  - composition of the monitoring group (if a group is to be used):
  - experts in all scientific disciplines needed to interpret the data and ensure patient safety. Clinical trial experts, biostatisticians, bioethicists, and clinicians knowledgeable about the disease and treatment under study should be part of the monitoring group or be available if warranted.
  - frequency and content of meeting reports
  - frequency and character of monitoring meetings (e.g., open or closed, public or private).

In general, it is desirable for a DSMB to be established by the study sponsor for research that is blinded, involves multiple sites, involves vulnerable subjects, or employs high-risk interventions. The IRB has the authority to require a DSMB as a condition for approval of research where it determines that such monitoring is needed. When DSMBs are utilized, IRBs conducting continuing review of research may rely on a current statement from the DSMB indicating that it has and will continue to review study-wide adverse events, interim findings, and any recent literature that may be relevant to the research, in lieu of requiring that this information be submitted directly to the IRB.

Regulations & Guidance: DHHS 45 CFR §46.111(a)(6); FDA 21 CFR §56.111(a)(6)



### 3.7.5 Privacy and Confidentiality

Under the research regulations, the IRB is required to determine whether adequate procedures are in place to protect the privacy of subjects and to maintain the confidentiality of the data.

#### 3.7.5.1 Definitions

**Confidentiality:** methods used to ensure that information obtained by researchers about their research subjects is not improperly divulged.

**Identifiable Information:** for research privacy purposes, this means information where the identity of the subject is or may readily be ascertained by the Investigator or associated with the information.

**Individually Identifiable Private Information:** is information where, for research purposes, the identity of the subject is or may readily be ascertained by the Investigator or associated with the information.

**Obtain:** means to receive or access Individually Identifiable private Information (or identifiable specimens) for research purposes. This includes an Investigator's use, study, or analysis for research purposes of Individually Identifiable private Information (or identifiable specimens) already in the possession of the Investigator.

**Private information:** for research privacy purposes, this means information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (e.g., a medical record). [45 CFR §46.102(f)]

#### 3.7.5.2 Privacy

The IRB must determine whether the activities in the research constitute an invasion of privacy. In order to make that determination, the IRB must obtain information regarding how the Investigators are getting access to subjects or subjects' private, identifiable information. Investigators must have an appropriate authorization to access subjects or the subjects' information.

In developing strategies for the protection of subjects' privacy, consideration should be given to:

- Methods used to identify and contact potential subjects;



- Settings in which an individual will be interacting with an Investigator;
- Appropriateness of all personnel present for research activities;
- Methods used to obtain information about subjects and the nature of the requested information;
- Information that is obtained about individuals other than the target subjects, and whether such individuals meet the regulatory definition of human subject (e.g., a subject provides information about a family member for a survey); and
- How to access the minimum amount of information necessary to complete the study.

### **3.7.5.3 Confidentiality**

The level of confidentiality protections should be commensurate with the potential of harm from inappropriate disclosure.

At the time of initial review, the IRB ensures that the privacy and confidentiality of research subjects are protected. The IRB assesses whether there are adequate provisions to protect subject privacy and maintain confidentiality. The IRB does this through the evaluation of the methods used to obtain information:

- About subjects;
- About individuals who may be recruited to participate in studies;
- The use of personally identifiable records; and
- The methods to protect the confidentiality of research data.

The Investigator will provide information regarding the privacy and confidentiality of research subjects at the time of initial review through the completion of the study; Pennington Biomedical Research Center approved HIPAA Authorization Form, and/or other submitted, applicable materials. The IRB will review all information received from the Investigator and determine whether or not the privacy and confidentiality of research subjects is sufficiently protected. In some cases, the IRB may also require that a certificate of confidentiality be obtained to additionally protect research data from compulsory disclosure.

In reviewing confidentiality protections, the IRB shall consider the nature, probability, and magnitude of harm that would be likely to result from a disclosure of collected information outside the research. It shall evaluate the effectiveness of proposed de-identification techniques, coding systems, encryption methods, storage facilities, access limitations, and other relevant factors in determining the adequacy of confidentiality protections.



Regulations & Guidance: DHHS 45 CFR §46.111(a)(7); FDA 21 CFR §56.111(a)(7)

### **3.7.6 Vulnerable Populations**

At the time of initial review, the IRB will consider the scientific and ethical reasons for including vulnerable subjects in research. The IRB may determine and require that, when appropriate, additional safeguards are put into place for vulnerable subjects, such as those without decision-making capacity.

For an extensive discussion about the IRB's review and approval process for individual populations of vulnerable subjects, please refer to Section 6.0-Vulnerable Subjects in Research.

Regulations & Guidance: DHHS 45 CFR §46.111(b); 45 CFR 46 Subpart B, Subpart C & Subpart D; 45 CFR §46.205; FDA 21 CFR §50.3; 21 CFR §56.111(b)-(c); 21 CFR Subpart D

## ***3.8 Additional Considerations During IRB Review and Approval of Research***

### **3.8.1 Determination of Risk**

At the time of initial review and continuing review, the IRB will make a determination regarding the risks associated with the research proposals. Risks associated with the research will be classified as either minimal risk or greater than minimum risk based on the absolute interpretation of minimal risk. The meeting minutes will reflect the IRB's determination regarding risk levels.

### **3.8.2 Frequency of Review**

At the time of initial review and at continuing review, the IRB will make a determination regarding the frequency of review of the research protocols. All protocols will be reviewed by the IRB at intervals appropriate to the degree of risk but no less than once per year. In some circumstances, a shorter review interval (e.g. semi-annually, quarterly, or after accrual of a specific number of subjects) may be required (see 3.8.3 Review More Often Than Annually). The meeting minutes will reflect the IRB's determination regarding review frequency. Regulations & Guidance: DHHS 45 CFR §46.109(e); FDA 21 CFR §56.109(f).

### **3.8.3 Review More Often Than Annually**



Unless specifically waived by the IRB, research that meets any of the following criteria will require review more often than annually:

- Significant risk, as determined by the IRB, to research subjects (e.g., death, permanent or long lasting disability or morbidity, severe toxicity) without the possibility of direct benefit to the subjects;
- The involvement of especially vulnerable populations likely to be subject to coercion (e.g., terminally ill); or
- A history of serious or continuing non-compliance on the part of the Investigator.

The following factors also will be considered when determining which studies require review more frequently than on an annual basis:

- The probability and magnitude of anticipated risks to subjects;
- The likely medical condition of the proposed subjects;
- The overall qualifications of the Investigator and other members of the research team;
- The specific experience of the Investigator and other members of the research team in conducting similar research;
- The nature and frequency of adverse events observed in similar research at this and other Institutions;
- The novelty of the research making unanticipated adverse events more likely; or
- Any other factors that the IRB deems relevant.

In specifying an IRB approval period of less than one year, the IRB may define the period with either a time interval or a maximum number of subjects either studied or enrolled. If a maximum number of subjects studied or enrolled is used to define the approval period, it is understood that the approval period in no case can exceed one year and that the number of subjects studied or enrolled determines the approval period only when that number of subjects is studied or enrolled in less than one year.

If an approval period of less than one year is specified by the IRB the reason for more frequent review must be documented in the minutes.

#### **3.8.4 Independent Verification That No Material Changes Have Occurred**

The IRB recognizes that protecting the rights and welfare of subjects sometimes requires that the IRB independently verify utilizing sources other than the Investigator that no material changes occurred during the IRB designated approval period. Independent verification from sources other than the Investigator may be necessary at times (e.g., in cooperative studies, or other multi-center research).



The IRB will determine the need for verification from outside sources on a case-by-case basis and according to the following criteria:

- Protocols where concern about possible material changes occurred without IRB approval have been raised based on information provided in continuing review reports or from other sources;
- Protocols conducted by Investigators who have previously failed to comply with federal regulations and/or the requirements or determinations of the IRB;
- Protocols randomly selected or for cause audits conducted internally; or
- Whenever else the IRB deems verification from outside sources is relevant.

The following factors also will be considered when determining which studies require independent verification:

- The probability and magnitude of anticipated risks to subjects;
- The likely medical condition of the proposed subjects; or
- The probable nature and frequency of changes that may ordinarily be expected in the type of research proposed.

In making determinations about independent verification, the IRB may prospectively require that such verification take place at predetermined intervals during the approval period, or may retrospectively require such verification at the time of continuing review, review of amendments and/or unanticipated problems.

If any material changes have occurred without IRB review and approval, the IRB will decide the corrective action to be taken. (see section 10.0-Non-Compliance)

### **3.8.5 Consent Monitoring**

In reviewing the adequacy of subject informed consent procedures for proposed research, the IRB may on occasion determine that special monitoring of the consent process by an impartial observer (i.e., a consent monitor) is required to reduce the possibility of coercion and undue influence.

Such monitoring may be particularly warranted when the research presents significant risks to subjects, or if subjects are likely to have difficulty understanding the information that will be provided. Monitoring may also be appropriate as a corrective action where the IRB has identified problems associated with a particular Investigator or a research project.

Regulations & Guidance: DHHS 45 CFR §46.109(e); FDA 21 CFR §56.109(f)



### **3.8.6 Investigator Conflicts of Interest**

The research application asks protocol-specific questions regarding conflict of interests for Investigators and key research personnel. As part of its review process, the IRB notifies the Director of Legal and Regulatory Compliance of the potential conflict. (see Policy 401.00 – Individual Financial Conflict of Interest).

Regulations & Guidance: 42 CFR §50.603; 42 CFR §50.606(a); FDA 21 CFR §50.606(a); 21 CFR §54.1; 21 CFR §54.2; 21 CFR §54.4; 21 CFR §312.64(d); 21 CFR §812.110(d); 45 CFR §690

### **3.8.7 Significant New Findings**

During the course of research, significant new knowledge or findings about the medication and/or the condition under study may develop. The Investigator must report any significant new findings to the IRB and the IRB will review such findings with regard to potential impact on the subjects' rights and welfare. Since the new knowledge or findings may affect the risks or benefits to subjects or subjects' willingness to continue in the research, the IRB may require, during the ongoing review process that the Investigator contact the currently enrolled subjects to inform them of the new information. The IRB will communicate this to the Investigator. The informed consent should be updated and the IRB may require that the currently enrolled subjects be re-consented, acknowledging receipt of this new information and for affirming their continued participation.

Regulations & Guidance: OHRP Guidance on Written IRB Procedures; OHRP Guidance on Continuing Review; FDA Information Sheets: Continuing Review After Study Approval

### **3.8.8 Advertisements**

The IRB must approve any and all recruitment materials and/or advertisements prior to posting and/or distribution for studies that are conducted under the purview of the Institutional IRB. The IRB will review:

- The information contained in the advertisement;
- The mode of its communication;
- The final copy of printed advertisements, prior to posting; and
- The final audio/video taped advertisements

The IRB reviews the material to assure the material is accurate, and not coercive or unduly optimistic, creating undue influence to the subject to participate which includes, but is not limited to:



- Does not make claims, either explicitly or implicitly, about the drug, biologic, or device under investigation that are inconsistent with FDA labeling.
- Does NOT state or imply a certainty of favorable outcome or other benefits beyond what is outlined in the consent document and the protocol
- Does NOT promise “free treatment,” when the intent is only to say subjects will not be charged for taking part in the research
- Does NOT include exculpatory language
- Does NOT emphasize the payment or the amount to be paid, by such means as larger or bold type

The advertisement is limited to the information prospective subjects need to determine their eligibility and interest, such as:

- The name and address of the Investigator or research facility
- The condition under study or the purpose of the research
- In summary form, the criteria that will be used to determine eligibility for the study
- A brief list of participation benefits, if any
- The time or other commitment required of the subjects
- The location of the research and the person or office to contact for further information

For FDA-Regulated research, the advertisement:

- Does NOT make claims, either explicitly or implicitly, that the drug, biologic or device is safe or effective for the purposes under investigation
- Does NOT make claims, either explicitly or implicitly, that the test article is known to be equivalent or superior to any other drug, biologic or device
- Does NOT use terms, such as “new treatment,” “new medication” or “new drug” without explaining that the test article is investigational.
- Does NOT include a coupon good for a discount on the purchase price of the product once it has been approved for marketing.

Once approved by the IRB, an advertisement cannot be altered or manipulated in any way without prior IRB approval.

Regulations & Guidance: DHHS 45 CFR §46.111(a)(3); 45 CFR §46.116; FDA 21 CFR §50.20; 21 CFR §56.111(a)(3)



### 3.8.9 Payment to Research Subjects

Payment to research subjects may be an incentive for participation or a way to reimburse a subject for time, travel, parking, and other expenses incurred due to participation. However, payment for participation is not considered a research benefit. Regardless of the form of remuneration, Investigators must take care to avoid coercion of subjects. Payments should reflect the degree of risk, inconvenience, or discomfort associated with participation. The amount of compensation must be proportional to the risks and inconveniences posed by participation in the study.

The following regarding payments are described in the protocol and/or initial application:

- Amount
- Method
- Timing of disbursement
- Schedule of all payments
- Credit for payment accrues as the study progresses.

The following must be addressed in the consent or protocol:

- The consent and/or protocol cannot have a statement stating payment is contingent upon completing the entire study.
- The amount of payment and the proposed method and timing of disbursement is neither coercive nor presented undue influence.
- Any amount paid as a bonus for completion is reasonable and not so large as to unduly induce subjects to stay in the study when they would otherwise have withdrawn.
- All information concerning payment, including the amount and schedule of payments, is in the informed consent document.
- Compensation does not include a coupon good for a discount on the purchase price of the product once it has been approved.
- The subject will be informed through the consent process that all payments will come from the LSU payroll department. Subjects may be paid with gift cards; as long as the value of the gift card is not coercive.

Pennington Biomedical Research Center has a standard payment schedule for compensation to subjects based on number of visits, type of procedure and time to complete visit procedures. Most studies consider this uniform compensation schedule when assigning a compensation amount for subjects. While the IRB does not approve the Pennington Biomedical compensation schedules; the IRB has the final authority to



determine whether compensation is considered coercive. The IRB will review payments to determine that credit for payment accrues as the study progresses.

### **3.8.10 Recruitment Incentives**

Payment arrangements among sponsors, Institutions, Investigators, and those referring research subjects may place subjects at risk of coercion or undue influence or cause inequitable selection. Payment in exchange for referrals of prospective subjects from researchers (physicians) (finder's fees) is not permitted and may be considered illegal under federal or state law. Similarly, payments designed to accelerate recruitment that is tied to the rate or timing of enrollment (bonus payments) also is not permitted. Investigators are strongly encouraged to consult with the IRB office if they have any questions or concerns about recruitment incentives.

### **3.8.11 Multi-Site Trials Where the Researcher is the Lead Research**

When the Researcher is the lead Researcher of a multi-site study, policies and procedures have applications include information about the management of information that is relevant to the protection of participants, such as:

- Unanticipated problems involving risks to participants or others.
- Interim results
- Protocol modifications

When the Researcher is the lead Researcher of a multi-site study, policies and procedures have the IRB or EC evaluate whether the management of information that is relevant to the protection of participants is adequate.

## **3.9 Compliance with all Applicable Laws and Regulations**

The IRB follows and adheres to all applicable federal, state and local laws in the jurisdictions where the research is being carried out. The IRB relies on the Pennington Biomedical Research Center Director of Regulatory and Compliance for interpretation and application of federal and state law and the laws of any other jurisdiction where research is conducted as they apply to human subject research.

## **3.10 Possible IRB Actions**

The IRB or reviewer(s) may arrive at the following decisions:

- Approval - see Section 3.10.1;
- Conditional Approval (requiring minor modifications) - see Section 3.10.2;
- Withheld (the IRB has requested major modifications in order to secure approval) - see Section 3.10.3;
- Disapprove - see Section 3.10.4;



- Suspension or Termination - see 3.11

The following Sections provide clarification with respect to each of these decision options.

### 3.10.1 Approval

**Approved:** means the determination by the IRB that the investigation and protocol, as submitted, has been reviewed and may be conducted at an institution within the constraints set forth by the IRB and other Institutional and federal regulations. The research may begin as of the IRB approval date.

[DHHS 45 CFR §46.102(h); FDA 21 CFR §56.103(m)].

### 3.10.2 Conditional Approval

#### 3.10.2.1 Definitions

**Conditional Approval:** is a situation where the IRB cannot approve the research as submitted or the proposal and/or consent require minor revisions (e.g., wording changes, with replacement language provided). For proposals submitted for convened IRB review, the needed revisions are agreed upon at the IRB meeting. For proposals submitted expedited review, the needed revisions are designated by the IRB Chair (or designee). None of the required modifications can be related to the regulatory criteria for approval. These revisions are presented to the Investigator for incorporation by simple concurrence. Revisions must be made exactly as designated by the IRB or IRB reviewer(s).

#### 3.10.2.2 Policy

In order to receive an approval following a conditional approval determination the Investigator's response, the revised protocol and the previously submitted protocol is given to the IRB Chair, and/or a designee of the IRB for review. The reviewer(s) may approve the study upon receipt and approval of the revisions without further action by the IRB. For protocols initially submitted for expedited review, the Investigator's response, the revised proposal and the previously submitted proposal is given to the same reviewer(s) for re-review. The date of the final approval of the submission is the date the conditions were determined to be met.

Approval of the protocol application will not be granted and certification will not be issued until all deficiencies, if any, are corrected to the satisfaction of the IRB or the reviewer(s).



The outcome of the IRB's deliberations or reviewer(s) findings is communicated to the Investigator in writing. The Investigator may not proceed with the research until receipt of notice of IRB approval of the research.

The IRB's determination concerning the revision will be documented in the minutes of the next regularly scheduled IRB meeting.

An Investigator asking the IRB for review of a "Just-In-Time" grant for funding purposes, should submit an abstract of the project and a statement stating the review is required for funding purposes. If the IRB Chair or designated reviewer determines the study is one the IRB would support in concept, the IRB Chair will issue a letter of support. The Investigator is required to prospectively submit the developed study for IRB review and approval prior to identifying, recruiting or enrolling any subjects in accordance with Department of Health and Human Services (DHHS) 45 CFR 46 (Common Rule), DHHS Standards for Privacy of Individually Identifiable Health Information 45 CFR 160 and 164 (Privacy Rule), and the U.S. Food and Drug Administration (FDA) 21 CFR, parts 50, 56, and 312.

If the IRB approves research with conditions and the research expires before the conditions are reviewed and approved, all research activities must stop until approval is obtained.

### **3.10.3 Withheld Approval**

#### **3.10.3.1 Definitions**

**Withheld Approval:** Made when the research does not qualify for approval or conditional approval. When making this motion, the assigned primary reviewer describes the IRB members' reasons for the decision and describes recommendations to make the research approvable.

Descriptions include:

1. the protocol and/or consent require major modification or clarification; or
2. insufficient information is provided to adequately judge the protocol application (e.g., the risks and benefits cannot be assessed with the information provided).

IRB approval of the proposed research must not occur until subsequent review of the material is reviewed by the convened IRB.



### ***3.10.3.2 Policy***

This IRB action is taken if major modification or clarification is required, or insufficient information is provided to adequately judge the protocol application (e.g., the risks and benefits cannot be assessed with the information provided). IRB approval of the proposed research must not occur until subsequent review of the material the Investigator submitted by the convened IRB or the expedited reviewer(s).

For protocols initially submitted for convened IRB review, in order to receive approval for a Withheld Approval (Major Modifications), the Investigator's response must be submitted for review at a subsequent, convened meeting of the IRB. The IRB staff provides the IRB with the Investigator's response, the revised protocol and the previously submitted protocol. The item is placed on the agenda for re-review at the next meeting.

IRB approval of the protocol will not be granted and an approval letter will not be issued until all deficiencies, if any, are corrected to the satisfaction of the IRB.

The IRB's determination concerning the subsequent amended protocol will be documented in the minutes of the IRB meeting. The outcome of the IRB action is communicated to the Investigator in writing.

### ***3.10.3.3 Time Limit for Submitting Requested Changes for New Research Protocol Application with Conditional Approval or a Withheld Determination***

Failure to submit a response to IRB stipulated changes or inquiries related to new research protocols with a conditional approval or withheld approval within 90 days will result in deactivation of the new research protocol application. The Investigator will receive written notification of the closure of the IRB file including an explanation for this action. Investigator's wishing to re-open their file must re-apply to the IRB following procedures outlined in this document. After the 90-day deadline, the IRB staff will send e-mail notification of the time lapse to the Investigators requesting a withdrawal of the study application. An extension beyond 90 days may be granted by the IRB if sufficient cause is provided by the Investigators. If changes or e-mail notification of the circumstances surrounding the delay are not received by the IRB staff within one week of issuance of this notice, the study may be withdrawn by the IRB staff.



#### ***3.10.3.4 Time Limit for Submitting Requested Changes for Continuing Review or Modifications with Conditional Approval or a Withheld Determination***

If the IRB approves research with conditions and the research expires before the conditions are reviewed and approved, all research activities must stop until approval is obtained.

#### **3.10.4 Disapproved**

The IRB action of Disapproved means that it cannot approve the protocol as written. The IRB has determined that the research cannot:

1. be conducted on Institutional or Pennington Biomedical Research Center premises, or other facilities;
2. cannot involve Pennington employees;
3. be conducted on or by Pennington Biomedical employees.

Notice of the Disapproval will be issued by the IRB in writing.

##### ***3.10.4.1 Policy***

The IRB will not review research given a Disapproval determination more than twice in a calendar year.

### ***3.11 Study Suspension, Termination and Investigator Hold***

#### **3.11.1 Suspension or Termination**

IRB approval may be suspended or terminated if research is not being conducted in accordance with IRB or regulatory requirements or has been associated with unexpected problems or serious harm to subjects. (see section 8.0 for a discussion of unanticipated problems and section 10.0 for a discussion of non-compliance)

Suspension of IRB approval is a directive of a convened IRB or the IRB Chair to temporarily stop either some or all previously approved research activities to ensure protection of the rights and welfare of study subjects or for non-compliance. Suspension directives made on an urgent basis by the IRB Chair must be reported to a meeting of the convened IRB. Suspended protocols remain open and require continuing review.

Termination of IRB approval is a directive of the convened IRB to permanently stop some or all activities in a previously approved research protocol. If all research activities are terminated, the research no longer requires continuing review.



The IRB shall notify the Investigator in writing of such suspensions or terminations and shall include an explanation of the reasons for the decision. The Investigator shall be provided with an opportunity to respond in person or in writing.

When a study is suspended or terminated, the convened IRB or authorized individual will:

- Consider actions to protect the rights and welfare of subjects;
- Consider whether procedures for withdrawal of enrolled subjects take into account their rights and welfare; and
- Consider informing current subjects of the suspension or termination.
- Have the Investigator report any adverse events or outcomes to the IRB.

Investigators have to report to the IRB when a study is suspended or terminated:

- New information that might affect adversely the safety of the participants or the conduct of the clinical trial.
- Any changes significantly affecting the conduct of the clinical trial or increasing the risk to participants.

All suspensions or terminations must be reported to the Institutional Official and reporting agency (if applicable).

Suspension or termination of research that involves an IRB approved protocol also can be issued by Institutional Officials on matters unrelated to the IRB (i.e., not necessarily related to protecting the rights and welfare of study subjects). Such actions can be made by the Executive Director and will be reported to the IRB.

The corrective action(s) and stipulations necessary for the IRB to consider reinstatement of the research must be decided by the convened IRB. The approval will be described in written correspondence to the Principal Investigator.

Regulations & Guidance: DHHS 45 CFR §46.113; FDA 21 CFR §56.113; ICH-GCP (E6)

### **3.11.2 Investigator Hold**

An Investigator or sponsor may request an Investigator hold on a protocol when the Investigator/sponsor wishes to temporarily or permanently stop some or all approved research activities. Investigator holds are not suspensions or terminations.

#### **3.11.2.1 Procedures**

Investigators must notify the IRB in writing: providing a description of the research activities that will be stopped; describing proposed actions to be taken



to protect current subjects; and describing actions that will be taken prior to IRB approval of proposed changes in order to eliminate apparent immediate harm.

Upon receipt of written notification from the Investigator, the IRB staff places the research study on the agenda for review. The IRB Chair, in consultation with the Investigator, determines whether any additional procedures need to be followed to protect the rights and welfare of current subjects as described in Protection of Currently Enrolled Subjects below in section 3.11.2.2.

The IRB Chair, in consultation with the Investigator, determines how and when currently enrolled subjects will be notified of the administrative hold.

Investigators may request a modification of the administrative hold by submitting a request for a modification to previously approved research.

### **3.11.2.2 *Protection of Currently Enrolled Subjects***

Before an Investigator hold, termination or suspension is put into effect, the convened IRB, IRB Chair (or designee) considers whether any additional procedures need to be followed to protect the rights and welfare of current subjects. Such procedures might include:

- Transferring subjects to another Investigator;
- Making arrangements for clinical care outside the research;
- Allowing continuation of some research activities under the supervision of an independent monitor;
- Requiring or permitting follow-up of subjects for safety reasons;
- Requiring adverse events or outcomes to be reported to the IRB and the sponsor;
- Notification of current subjects; and/or
- Notification of former subjects.

### **3.12 *Continuing Review***

The IRB will conduct a continuing review of ongoing research at intervals that are appropriate to the level of risk for each research protocol, but not less than once per year. Continuing review must occur as long as the research remains active for long-term follow-up of subjects, even when the research is permanently closed to the enrollment of new subjects and all subjects have completed all research-related interventions. Continuing review of research must occur even when the remaining research activities are limited to the analysis of private identifiable information. For continuing review of research the IRB determines that the current consent document is still accurate and complete.



Regulations & Guidance: DHHS 45 CFR §46.109(e); FDA 21 CFR §56.109(f).

### **3.12.1 Approval Period**

Determination of the approval period and the need for additional supervision and/or participation is made by the IRB on a protocol-by-protocol basis.

For each initial or continuing approval the IRB will indicate an approval period with an approval expiration date specified. IRB approval is considered to have lapsed at close of business on the expiration date of the approval. For a study approved by the convened IRB, the approval period starts on the date that the IRB conducts its final review of the study; that is, the date that the convened IRB approved the research. For a study approved under expedited review, the approval period begins on the date the IRB Chair (or designee) gives final approval to the protocol.

The approval date and approval expiration date are noted on initial approvals and subsequent continuing review approvals sent to the Investigator and must be strictly adhered to. Investigators should allow sufficient time for development and review of renewal submissions.

Review of a change in research ordinarily does not alter the date by which continuing review must occur. This is because continuing review is review of the full protocol, not simply a change to it.

The regulations make no provision for any grace period extending the conduct of research beyond the expiration date of IRB approval. Therefore, continuing review and re-approval of research must occur by close of business of the date when IRB approval expires.

### **3.12.2 Continuing Review Process**

To assist Investigators, the IRB staff generates courtesy reminders to Investigators approximately 45 days in advance of the study expiration date so that they timely submit continuing reviews. It is the Investigator's responsibility to ensure that the continuing review of ongoing research is approved prior to the expiration date. By federal regulation, no extension to that date can be granted.

Information and documentation to be sent to the IRB office by Investigators includes the following:

- Continuing review report
- The current consent
- Newly proposed consent with redline edits (i.e., changes are to be highlighted, deletions are to be lined through) to reflect any changes from the prior submission



- The full protocol or a protocol summary containing the relevant information necessary to determine whether the proposed research continues to fulfill the criteria for approval
- A status report on the progress of the research that includes:
  - A summary since the last IRB review of:
    - Number of Participants accrued
    - Unanticipated Problems Involving risks to subjects or others;
    - Adverse Events, untoward events, and adverse outcomes experienced by subjects.
    - Subject withdrawals;
    - The reason for withdrawals;
    - Complaints about the research;
    - Amendments or modifications;
    - Any relevant recent literature; and
    - Any interim findings;
    - Any relevant multi-center trial reports;
    - The Investigator's current risk-potential benefit assessment based on study results;
    - The gender and minority status of those entered into the protocol, including:
      - Number of subjects considered as members of specific vulnerable populations; and
      - An assurance that all serious and unexpected adverse events had been reported as required.

In conducting continuing review of research not eligible for expedited review, all IRB members will have the last approved consent and the continuing review report. The primary reviewer receives all the previous listed materials (see section 3.5.4). At the meeting, the primary reviewer leads the IRB through the completion of the regulatory criteria for approval. See section 3.5.3 - Primary Reviewers

The IRB staff attends the convened meetings and ensures that the proposed study documents (consent, protocol, IB, application, supporting documents) for each protocol on the agenda have been distributed to the IRB members appropriately. The IRB staff will retrieve any additional materials should the IRB members or reviewer(s) request.

In the case of expedited reviews, the IRB members may request the IRB staff to provide them with additional materials required for the review.



Review of currently approved or newly proposed consent documents must occur during the scheduled continuing review of research by the IRB. However, informed consent documents should be reviewed whenever new information becomes available that would require modification of information in the IRB approved informed consent document. Changes to consent documents are modifications and will be reviewed according to the procedures in section 3.13 – Modification of an Approved Protocol.

Continuing review of a study must continue until:

- The research is permanently closed to the enrollment of new subjects
- All subjects have completed all research related interventions
- Collection and analysis of private identifiable information has completed.

### **3.12.3 Expedited Review of Continuing Review**

In conducting continuing review under expedited review, at least one IRB member is provided and reviews the complete protocol, including any protocol modifications previously approved by the IRB. At least one reviewer receives and reviews the same materials that the convened IRB receives for protocols reviewed by the convened IRB:

- Any newly proposed consent document.
- Recruitment materials.
- A status report on the progress of the research (broader than modifications and adverse events).

The status report on the progress of the research must include:

- Number of participants accrued.
- A summary since the last IRB review of:
  - Unanticipated problems involving risks to participants or others.
  - Participant withdrawals.
  - The reasons for withdrawals.
  - Complaints about the research.
  - Any relevant recent literature.
  - Any interim findings.
  - Any relevant multi-center trial reports.
  - The researcher's current risk-potential benefit assessment based on study results.

Generally, if research did not qualify for expedited review at the time of initial review, it does not qualify for expedited review at the time of continuing review, except in limited circumstances described by expedited review paragraphs (8) and (9) found in section 3.4.2 -Expedited Review Categories. It is also possible that research activities that previously qualified for expedited review in accordance with 45 CFR §46.110, have



changed or will change, such that expedited review would no longer be permitted for continuing review.

#### **3.12.4 Lapse in Continuing Review Approval**

The regulations permit no grace period or approval extension after approval expiration. Research that continues after the approval period has expired and is considered to be research conducted without IRB approval. If the continuing review approval does not occur within the timeframe set by the IRB, this is a lapse in continued review approval. All research activities must stop. This includes cessation of subject recruitment (e.g., media advertisements must be pulled), enrollment, consent, interventions, interactions, and data collection, unless the IRB finds that it is in the best interests of individual subjects to continue participating in the research interventions or interactions. This will occur even if the Investigator has provided the required information for continued review before the expiration date. Therefore, Investigators must allow sufficient time for IRB review and approval.

It is the responsibility of the Investigator to ensure that a lapse in approval does not occur. The IRB staff will notify the Investigator of the expiration of approval and that all research activities must cease.

If research subjects are currently enrolled in the research project and their participation is ongoing, once notified of the expiration of approval, the Investigator must immediately submit to the IRB Chair a list of research subjects for whom suspension of the research would cause harm. Enrollment of new subjects cannot occur and continuation of research interventions or interactions for already enrolled subjects will only continue when either the IRB or IRB Chair upon consultation with the Institutional Official finds that it is in the best interest of the individual subjects to do so.

Failure to timely submit continuing review information is considered non-compliance by the Investigator and will be handled according to the non-compliance policy (See Section 10.0-Non-Compliance).

Once approval has expired (i.e., lapse in continuing review approval), IRB review and re-approval must occur prior to re-initiation of the research. If the study approval has lapsed more than 30 days and the Investigator has not submitted an application for continuing review, the study will be closed by the IRB.

If the IRB requires revisions to obtain continuing review approval and no response has been received from the Investigator within 60 days following IRB correspondence, the study will be closed unless the IRB determines that study closure will harm subjects.



### **3.13 Modification of an Approved Protocol**

Investigators who wish to modify or amend their approved applications must seek IRB approval before making any changes in approved research. This requirement exists even though the changes are planned for the period for which IRB approval has already been given. One noteworthy exception are for changes necessary to eliminate an immediate hazard to the subject, in which case the IRB must then be notified at once.

Modifications may be approved if they are within the scope of what the IRB originally authorized. For example, if a researcher wishes to add a population to an existing study, but not alter the study procedures or purpose, a modification request is appropriate. Likewise, modifying a procedure without changing the study's purpose or study population may also be appropriate. If, however, the researcher wishes to add a population and revise study procedures, he or she will need to submit a new application for research in human subjects.

Investigators must submit documentation to inform the IRB about the changes in the status of the study. To this end, Investigators are required to submit the changes to the IRB office. The following completed forms must be turned in:

- Application for a modification; revised sponsor's protocol (if applicable)
- Revised approved consent /assent documents (if applicable) or other documentation that would be provided to subjects when such information might relate to their willingness to continue to participate in the study
- Revised or additional recruitment materials; or any other relevant documents provided by the Investigator.

The IRB Chair will determine whether the proposed changes may be approved through an expedited review process, if the changes are minor, or whether the modification warrants convened IRB review. The reviewer(s) using the expedited procedure has the ultimate responsibility to determine that the proposed changes may be approved through the expedited review procedure and, if not, must refer the protocol for convened IRB review. (see 3.13.1 Expedited Review of Protocol Amendments/Modifications)

Regulations & Guidance: OHRP Guidance on Written IRB Procedures.

#### **3.13.1 Expedited Review of Protocol Amendments/Modifications**

An IRB may use expedited review procedures to review minor changes in ongoing previously approved research during the period for which approval is authorized. An



expedited review may be carried out by the IRB Chair and/or designee(s) among the IRB members.

The reviewer(s) determine whether the modifications meet the criteria allowing review using the expedited procedure, and if so, whether the research with the proposed modifications continues to meet the regulatory criteria for approval.

The reviewer will also consider whether information about those modifications might relate to subjects' willingness to continue to take part in the research and if so, whether to provide that information to subjects.

### **3.13.2 Convened IRB Review of Protocol Modifications**

When a proposed change in a research study is not minor (e.g., procedures involving increased risk or discomfort are to be added), then the IRB must review and approve the proposed change at a convened meeting before the change can be implemented. The only exception is a change necessary to eliminate apparent immediate hazards to the research subjects. In such a case, the IRB should be promptly informed of the change following its implementation and should review the change to determine that it is consistent with ensuring the subjects' continued welfare.

All documents provided by the Investigator are given to the primary reviewer (see section 3.5.3 - Primary Reviewer)

At the meeting, the primary reviewer presents an overview of the modifications and leads the IRB through the completion of the regulatory criteria required for approval. The IRB will determine whether the research with the proposed modifications continues to meet the regulatory criteria for approval.

When the IRB reviews modifications to previously approved research, the IRB consider whether information about those modifications might relate to subjects' willingness to continue to take part in the research and if so, whether to provide that information to subjects.

### **3.13.3 Changes in the Informed Consent Document**

When a modification makes it necessary to change the informed consent document, regardless of whether any subjects are enrolled, two copies of the revised consent document are to be submitted to the IRB. One tracked copy should show all changes from the previous version (i.e., highlighting all additions and striking through all deletions). The one clean copy will contain the IRB approval stamp without any outdated text.



### **3.14 Closure of Protocols**

The completion or termination of a study is a change in activity that must be reported by the Investigator to the IRB on the closure report. Although subjects will no longer be at risk under the study, a final report to the IRB allows it to close the study files as well as provide information that may be used by the IRB in the evaluation and approval of related studies involving the Investigator.

The Investigators should submit the closure report to the IRB office. IRB staff will review the closure application for completeness and will notify the IRB. Closure applications in which the protocol will expire prior to the next scheduled IRB meeting will be closed and the final report will be included on the next agenda as a closure item. Closure applications in which the expiration date of the protocol is after the next scheduled meeting will be placed on the agenda as a closures item and closed effective the date of the meeting. If the study is closed prematurely it must be reported to the IRB.

### **3.15 Notice to Investigators of IRB Actions**

Barring extraordinary circumstances, all IRB action letters are prepared by IRB staff in writing and sent to the Investigator and research team within ten (10) working days. For an approval, along with written notification of approval, a copy of the approved consent document(s) containing the stamped approval with the dates of the approval and expiration on each sheet will be attached. For required modifications, the notification will include the information that is required, the basis for requiring those modifications, and a deadline for response submission. For a disapproval, termination or suspension, the notification will include the basis for making that decision.

All correspondence between IRB and Investigators are retained in the study file.

When the IRB requires modifications to research, investigators' responses will be reviewed to verify that the conditions for approval have been satisfied. Depending on the nature of the modifications, this subsequent review/verification may be performed by the IRB Chair and/or one or more IRB members or a consultant with specific expertise. Questions about whether the conditions for approval have been satisfied will be forwarded to the IRB Chair. When the conditions for approval are not met, investigators will be notified; and the submission will be referred to the convened IRB for review (i.e., research cannot be disapproved except by convened review).

The IRB reports its findings and actions to the Institution in the form of IRB minutes, a copy of which is distributed by IRB staff to Institutional Officials with a copy stored in the IRB files.



### **3.16 Appeal of IRB Decisions**

When an IRB protocol presented at a convened meeting is Disapproved, given a Conditional Approval, or Withheld Approval, the IRB will notify the Investigator in writing about the specific deficiencies and the modifications that are necessary for appropriate IRB approval. The IRB shall include in its written notification a statement of the reasons for its decision and give the Investigator an opportunity to respond in writing. The Investigator also is given the opportunity to schedule a meeting with the IRB to discuss this matter. All appeal letters sent by researchers for IRB consideration will be confirmed in writing. If the matter will be presented to the convened board, the IRB staff will notify the researcher of the convened board meeting date.

In cases where there is disagreement between the IRB and the Investigator regarding the nature and extent of the requested changes and these disagreements cannot be resolved amicably in an informal manner, the Investigator and/or the IRB may make an appeal to the Institutional Official for a resolution of the matter. The Institutional Official may organize a meeting to help facilitate discussion between the IRB and the Investigator. While the Institutional Official may provide input and make recommendations to the IRB for expeditious resolution of the matter, final recommendations for approval remain under the purview of the IRB.

Regulations & Guidance: DHHS 45 CFR §46.109(d); FDA 21 CFR §56.109(e)



## 4.0 Documentation and Records

### 4.1 Policy

Pennington Biomedical Research Center shall prepare and maintain adequate documentation of IRB activities. All records must be accessible for inspection and copying by authorized representatives of the FDA, OHRP, sponsors, and other authorized entities at reasonable times and in a reasonable manner.

### 4.2 Definitions

Research records: consists of records prepared, created, gathered, or maintained by an investigator or research staff for research at the institution.

### 4.3 IRB Records

IRB records include, but are not limited to:

- Written operating procedures
- IRB membership rosters (See Section 4.5).
- IRB member training records. The IRB maintains accurate records listing IRB members and IRB staff that have fulfilled the institution's human subject training requirements. All Pennington Biomedical employees' (investigators, administration and support staff) human research protections training are coordinated by the Director of Legal and Regulatory Compliance. Outside investigators involved in research are required to show proof of human subjects training to the IRB before study approval
- IRB correspondence (other than protocol related)
- IRB study files (See Section 4.4 for information included in study files)
- Documentation of exemptions (See Section 4.7)
- Documentation of convened IRB meetings minutes (see Section 4.6 for information included in the minutes)
- Documentation of review by another institution's IRB when appropriate
- Documentation of cooperative review agreements
- Federal wide assurances
- Quality assurance reviews
- Workflow/SOPs

Regulations & Guidance: DHHS 45 CFR §46.115(a)-(b); FDA 21 CFR §56.115(a)-(b)



#### **4.4 IRB Study Files**

The IRB office will maintain a study file for each IRB study submission that is submitted for review. Once a study submission is confirmed to include appropriate submission materials and signature of investigator(s), it is assigned a unique IRB number by the IRB staff.

All communications to and from the IRB are maintained. Depending on the type of communication, maintenance may be via e-mail or paper. IRB study files include, but are not limited to:

1. Protocol and all other documents submitted as part of an initial IRB application
2. Protocol and all other documents submitted as part of a request for continuing review/closure report. This also includes progress reports, statements of significant new findings provided to subjects, reports of injuries to patients
3. Documents submitted and reviewed after the study has been approved, including reports of modifications to research and unanticipated problem reports
4. Copy of the IRB-approved consents/assents
5. Sponsor-approved sample consent form document and protocol, when they exist
6. IRB member reviewer forms
7. Documentation of type of IRB review
8. For expedited review, documentation of any determinations required by the regulations and protocol-specific findings supporting those determinations, including: waiver or alteration of the consent process, research involving pregnant women, neonates, and research involving children
9. Documentation of all IRB review actions
10. Notification of suspension of research, if applicable
11. Correspondence pertaining to appeals/grievances, if applicable
12. Copies of approval letters and forms that describe what investigators must have before beginning the study
13. IRB correspondence to and from investigators
14. All other IRB correspondence related to the research
15. Reports of unanticipated problems
16. Documentation of audits, investigations, reports of external site visits
17. Scientific evaluations



18. DHHS-approved sample consent document and protocol, when they exist
19. Protocol Deviations/Violations/Exceptions
20. Documentation of non-compliance
21. Investigator Brochure, if any
22. Recruitment materials
23. Data and safety monitoring reports, if any

Regulations & Guidance: FDA 21 CFR §56.115(a)

#### ***4.5 IRB Membership Roster***

A membership list of IRB members must be maintained for each IRB committee. It must identify members sufficiently to describe each member's chief anticipated contributions to IRB deliberations. The list must contain the following information about IRB members:

1. Name
2. Earned degrees
3. Affiliated or non-affiliated status (neither the member nor an immediate family member of the member may be affiliated with the institution)
4. Employment or other relationship between each IRB member and Pennington Biomedical Research Center
5. Status as scientist (physician-scientist, other scientist, non-scientist or social behavioral scientist). For purposes of this roster, IRB members with research experience are designated as scientists. Research experience includes training in research (e.g., doctoral degrees with a research-based thesis) and previous or current conduct of research.
6. Indications of experience, such as board certifications or licenses sufficient to describe each member's principal anticipated contributions to IRB deliberations
7. Representative capacities of each IRB member; which IRB members are knowledgeable about or experienced in working with children, pregnant women, cognitively-impaired individuals, and other vulnerable populations locally involved in research
8. Role on the IRB (e.g., IRB Chair, etc.)
9. Voting status. Note that all IRB members are, by definition, entitled to vote. Guests and non-voting member's guests do not have a right to vote or be counted toward a quorum



10. Alternate member status, including the IRB member for whom they alternate with

The IRB office must keep the IRB membership list current. IRB records including a curriculum vitae and human subjects' protection training of each IRB member. The IRB staff must promptly report changes in IRB membership to OHRP.

Regulations & Guidance: FDA 21 CFR §56.115(a).

#### **4.6 IRB Minutes**

Actions by duly convened IRB proceedings must be reduced to writing and available for review within 3 weeks of the recorded meeting date. Once approved by the IRB at a subsequent IRB meeting, the minutes must not be altered by anyone including a higher institutional authority. It should be noted that errors or corrections to approved IRB minutes, as approved by a majority of the convened IRB, will be included in the next meeting minutes.

A copy of IRB approved minutes for each IRB meeting is distributed to the designated institutional official.

Minutes of IRB meetings must contain sufficient detail to show:

1. Names of IRB members present
2. Names of IRB members or IRB alternate members who are participating through videoconference, teleconference or other electronic means, and documentation that those not physically present have received all pertinent material prior to the meeting and were able to actively and equally participate in all discussions
3. Names of absent IRB members
4. Names of alternates attending in lieu of specified (named) absent IRB members. Alternates may substitute for specific absent members only as designated on the official IRB membership roster
5. Names of consultants present, if applicable
6. Name of investigators or research staff present
7. Names of guests present
8. The attendance list shall include those members present at the meeting. The minutes will indicate, by name, those members who enter or leave the meeting. The vote on each action will reflect those members present for the vote on that item;
9. The presence of a quorum initially and throughout the IRB meeting, including the presence of one member whose primary concern is in a non-scientific area;



10. Business items discussed;
11. Continuing education conducted;
12. Actions taken, including separate deliberations, actions, and votes for each protocol undergoing initial review, continuing review, or review of modifications by the convened IRB;
13. Votes on these actions (total number voting; number voting for; number voting against; number abstaining; number of those excused, number of those recused);
14. Basis or justification for all IRB actions and/or decisions including required changes in research or disapproval;
15. Summary of controverted issues and their resolution;
16. Approval period for initial and continuing review protocols, including identification of research that warrants review more often than annually and the basis for that determination;
17. Risk level of initial and continuing review approved protocols;
18. Review of interim reports (e.g. adverse events or safety reports; amendments; report of violations or deviations, etc.);
19. Review of DSMB summaries;
20. Review of DSMB plans;
21. Applications that have met or not met the stipulations;
22. Justification of deletion or modifications of information concerning risks or alternative procedures contained in the DHHS-approved sample consent document;
23. Protocol-specific documentation that the research meets the required criteria [45 CFR §46.116(d)] when approving a consent procedure that does not include or that alters some or all of the required elements of informed consent, or when waiving the requirement to obtain an informed consent;
24. Protocol-specific documentation that the research meets the required criteria [45 CFR §46.117(c)] when the requirements for documentation of consent are waived;
25. When approving research that involves populations covered by subparts B or D of 45 CFR §46, the minutes will document the IRB justifications and findings regarding IRB determinations stated in the Subparts or the IRB agreement with the findings and justifications as presented by the investigator on IRB forms;
26. The rationale for significant risk device/non-significant device determinations;
27. COI determinations;



28. Identification of any research for which there is need for verification from sources other than the investigator that no material changes are made in the research (e.g., cooperative studies, or other collaborative research);
29. Special protections warranted in specific research projects for groups of subjects who are likely to be vulnerable to coercion or undue influence, such as children, pregnant women, cognitively-disabled persons, or economically or educationally disadvantaged persons, regardless of source of support for the research;
30. A list of research approved since the last meeting utilizing expedited review procedures and the specific citation for the category of expedited review of the individual protocol;
31. Documentation of approval by the IRB Chair (or designee) of research contingent on specific minor conditions in the minutes of the first IRB meeting that takes place after the date of the approval;
32. An indication that, when an IRB member has a COI (see section 2.5 – IRB Member Conflict of Interest) with the research under review, the IRB member was not present during the deliberations or voting on the proposal, and that the quorum was maintained. The name of the IRB member will be captured in the minutes as well as the reason for their departure; and
33. Key information provided by consultants will be documented in the minutes or in a report provided by the consultant.

IRB minutes are audited every quarter to ensure all items are included. Regulations & Guidance: 45 CFR §46.116(c)-(d); 45 CFR §46.117(c); 45 CFR §46.204; 45 CFR §46.205; 45 CFR §46.206; 45 CFR §46.207; 45 CFR §46.305; 45 CFR §46.306; 45 CFR §46.404; 45 CFR §46.405; 45 CFR §46.406; 45 CFR §46.407; 45 CFR §46.408; 42 USC 498 A(b)(1); 42 USC 498 A(b)(2); 42 USC 498 A(c); FDA 21 CFR §50.51; 21 CFR §50.52; 21 CFR §50.53; 21 CFR §50.54; 21 CFR §50.55; 21 CFR §50.56; 21 CFR §56.109(c); 21 CFR §56.115(a)

#### ***4.7 Documentation of Exempt Review Findings***

Documentation of exempt review consists of the reviewer's citation of a specific exemption category and written concurrence by the IRB of the activity.

#### ***4.8 Documentation of Expedited Reviews***

IRB records for initial and continuing review by the expedited procedure must include:

1. The specific permissible category;



2. A description of action taken by the reviewer;
3. The approval period; and
4. Any determinations required by the regulations including protocol-specific findings supporting those determinations.

#### **4.9 Access to IRB Records**

The IRB has policies and procedures to protect the confidentiality of research information:

1. All paper IRB records are kept secure in filing cabinets or locked storage rooms. The IRB office is closed and locked when unattended.
2. Access to IRB records, whether paper or electronic, is limited to the IRB Chair, IRB members, IRB staff, authorized institutional officials, and officials of federal and state regulatory agencies (OHRP, FDA). Research investigators are provided reasonable access to files related to their research. Appropriate accreditation bodies are provided access and may recommend additional procedures for maintaining security of IRB records. All other access to IRB records is limited to those who have legitimate need for them, as determined by the institutional official.
3. Records are accessible for inspection and copied by authorized representatives of federal regulatory agencies during regular business hours.
4. Paper records may not be removed from the IRB office; however, the IRB staff will provide copies of records for authorized personnel if requested.
5. All other access to IRB study files, paper or electronic, is prohibited.

#### **4.10 Record Retention**

IRB records (as described in Section 4.3) pertaining to research, which is conducted, must be stored securely. Paper records are stored in the IRB office.

IRB records must be retained for at least three (3) years after completion of the research. IRB records not associated with research or for protocols cancelled without subject enrollment will be retained at the facility for at least 3 years after closure of the IRB file.

IRB records retained beyond their retention date will be shredded or otherwise destroyed unless prohibited by institutional policy.



See Section 4.12 for record retention requirements for studies involving investigational drugs and investigational devices.

Regulations & Guidance: DHHS 45 CFR §46.115(b); FDA 21 CFR §56.115(b); 21 CFR §56.312.62(c)

#### **4.11 Investigator Records**

Investigators are required to maintain accurate, current and complete records of their human subject research activities. In general, investigators should establish and maintain a file for each study that has been reviewed by the IRB. These files should closely resemble the IRB's file structure on the study.

Within each study, investigators also should maintain a file for each subject who signs a consent document agreeing to participate in the study. These subject-specific files should include the original signed consent document and copies of case report forms, and any other correspondence between the investigator and the subject.

Research records should be maintained as appropriate to the type of study. For example, when a study is sponsored externally, these records should be kept for at least 3 years after the study has been completed and the sponsor has indicated that the records are no longer required.

#### **4.12 Records for FDA-Regulated Studies**

##### **4.12.1 Investigational Drugs**

Investigators are expected to maintain accurate, complete and current records with respect to studies involving investigational drugs consistent with FDA requirements found at 21 CFR §312.62(a)(b)(c). This includes the following:

1. Disposition of drug: an investigator is required to maintain adequate records of the disposition of the drug, including dates, quantity, and use by subjects.
2. Case histories: an investigator is required to prepare and maintain adequate and accurate case histories that record all observations and other data pertinent to the investigation on each individual that administered the investigational drug or employed as a control in the investigation. Case histories include the case report forms and supporting data including (e.g., signed and dated consent forms), and medical records (e.g., physician progress notes, the individual's hospital chart(s), and the nurses' notes). The case history for each individual shall document that informed consent was obtained prior to participation in the study.



3. Record retention: A investigator shall retain records involving investigational drugs involved in an FDA-regulated study for a period of 2 years following the date a marketing application is approved for the drug for the indication for which it is being investigated; or, if no application is to be filed or if the application is not approved for such indication, until 2 years after the investigation is discontinued and FDA is notified.

Regulations & Guidance: FDA 21 CFR §312.62.

#### **4.12.2 Investigational Devices**

Investigators must maintain accurate, complete and current records involving investigational devices involved in an FDA-regulated study consistent with FDA requirements found at 21 CFR §812.140(a)(d). This includes the following:

1. All correspondence with another investigator, an IRB, the sponsor, a monitor, or FDA, including required reports;
2. Records of receipt, use or disposition of a device that relate to:
  - a. The type and quantity of the device, the dates of its receipt, and the batch number or code mark.
  - b. The names of all persons who received, used, or disposed of each device.
  - c. Why and how many units of the device have been returned to the sponsor, repaired, or otherwise disposed of.
3. Records of each subject's case history and exposure to the device. Case histories include the case report forms and supporting data (e.g., signed and dated consent forms) and medical records (e.g., physician progress notes, copies of individual's hospital chart(s), and the nurses' notes). Such records shall include:
  - a. Documents, evidencing informed consent and, for any use of a device by the investigator without informed consent, any written concurrence of a licensed physician and a brief description of the circumstances justifying the failure to obtain informed consent. The case history for each individual shall document that informed consent was obtained prior to participation in the study.
  - b. All relevant observations, including records concerning adverse device effects (whether anticipated or unanticipated), information and data on the condition of each subject upon entering, and during the course of, the



investigation, including information about relevant previous medical history and the results of all diagnostic tests.

- c. A record of the exposure of each subject to the investigational device, including, the date and time of each use, and any other therapy.
- 4. The protocol with documents showing the dates of and reasons for each deviation from the protocol.
- 5. Any other records that FDA requires to be maintained by regulation or by specific requirement for a category of investigations or a particular investigation.



## 5.0 Obtaining Informed Consent from Research Subjects

### 5.1 Policy

No investigator conducting research at Pennington Biomedical Research Center may involve a human subject in research without obtaining the legally effective informed consent of the subject or the subject's legally authorized representative unless a waiver of consent has been approved by the IRB in accordance with section 5.10 of these procedures. Except as provided in section 5.12, informed consent must be documented by the use of a written consent form approved by the IRB (see section 5.7).

The IRB will evaluate both the consent process and the procedures for documenting informed consent to ensure that adequate informed consent is obtained from subjects.

The following procedures describe the requirements for obtaining consent from subjects in research at Pennington Biomedical Research Center.

Regulations & Guidance: DHHS 45 CFR §46.116; FDA 21 CFR §50.20

### 5.2 Basic Requirements

Informed consent must be obtained by the investigator (or properly trained designee) prior to entering or enrolling a subject into an IRB approved study and/or conducting any study related procedures required by the protocol, unless consent is waived by the IRB.

If someone other than the investigator conducts the interview and obtains consent from the subject, the investigator needs to formally delegate this responsibility, and the person so delegated must have received appropriate training to perform this activity. The person so delegated must be knowledgeable about the research to be conducted and the consenting process, and must be able to answer questions about the study.

These informed consent requirements are not intended to preempt any applicable federal, state or local laws that require additional information to be disclosed for informed consent to be legally effective.

All consents under the purview of Pennington Biomedical Research Center IRB must be on the Pennington Biomedical Research Center consent template format located on the HRPP website. Sample or draft consent documents may be developed by a sponsor or cooperative study group; however, they must be in the Pennington Biomedical Research Center consent template.



Regulations & Guidance: FDA 21 CFR §50.20.

### ***5.3 Securing and Documenting Informed Consent***

An investigator (or properly trained designee) is required to obtain legally effective informed consent from a subject or the subject's legally authorized representative. DHHS 45 CFR §46.177; FDA 21 CFR §50.20

When informed consent is required, it must be sought prospectively, and properly documented according to legal and regulatory requirements. DHHS 45 CFR §46.117; FDA 21 CFR §50.20

The requirement to obtain the legally effective informed consent of individuals before involving them in research is one of the central protections provided for by the federal regulations and the IRB Office.

The informed consent process involves three key features:

- Disclosing to the prospective human subject information needed to make an informed decision
- Facilitating the understanding of what has been disclosed
- Promoting the voluntariness of the decision about whether or not to participate in the research.

Informed consent is more than just a signature on a form. It is a process of information exchange to include reading and signing the informed consent document. The informed consent process is the critical communication link between the prospective human subject and an investigator, beginning with the initial approach of an investigator and continuing through the completion of the research study. Investigators must have received the appropriate training and be knowledgeable about the study protocol in order that they may answer questions to help provide understanding to the study subject or potential study subject. The exchange of information between the investigator and study subject can occur via one or more of the following modes of communication, among others; face to face contact, mail; telephone; or fax however obtaining informed consent must be obtained face to face between the investigator or trained staff eligible to consent subjects and the potential study subject.

### ***5.4 Informed Consent Process***

Informed consent must be obtained under the following circumstances:



- Informed consent may only be obtained from subjects who have the legal and mental capacity to give consent. For subjects without that capacity, consent must be obtained from a legally authorized representative.
- The informed consent process shall be sought under circumstances that provide the subject (or legally authorized representative) with sufficient opportunity to consider whether or not to participate. The researcher must give either the participant or the representative adequate opportunity to read the consent document before it is signed.
- The informed consent process shall be sought under circumstances that minimize the possibility of coercion or undue influence. Coercion occurs when an overt or implicit threat of harm is intentionally presented by one person to another in order to obtain compliance. Undue influence, by contrast often occurs through an offer of an excessive or inappropriate reward or overture in order to obtain compliance.
- The informed consent information must be presented in language that is understandable to the subject (or legally authorized representative). To the extent possible, the language should be understandable by a person who is educated to 8th grade level and layman's terms shall be used in the description of the research.
- For subjects whose native language is not English, informed consent must be obtained in a language that is understandable to the subject (or legally authorized representative). In accordance with this policy, the IRB requires that informed consent conferences include a qualified translator when the prospective subject does not understand the language of the person who is obtaining consent.
- After the written informed consent form and any other written information to be provided to participants, is read and explained to the participant or the participant's legally authorized representative, and after the participant or the participant's legally authorized representative has orally consented to the participant's participation in the trial and, if capable of doing so, has signed and personally dated the informed consent form, the person administering the consent should sign and personally date the consent form.
- By signing the consent form, the person administering the consent attests that the information in the consent form and any other written information was accurately explained to, and apparently understood by, the participant or the participant's legally authorized representative, and that informed consent was freely given by the participant or the participant's legally authorized representative.
- In accordance with the American Disabilities Act, Pennington Biomedical Research Center will provide any assistance in to any subject with a disability. For hearing impaired subjects Pennington Biomedical will provide hearing impaired equipment or a translator. For subjects with a visual impairment an impartial witness must be present during the informed consent process if the subject does not have a legally authorized representative.



- For subjects that are illiterate, an impartial witness to the subject will sign as a reader unless the subjects legally authorized representative is present.
- The informed consent process may not include any exculpatory language through which the subject is made to waive, or appear to waive any of the subject's legal rights or through which the Investigator, the Sponsor, the Institution or Pennington employees or institutional agents are released from liability for negligence, or appear to be so released. DHHS 45 CFR §46.116; FDA 21 CFR §50.20
- The investigator is ultimately responsible for ensuring that each prospective subject is adequately informed about all aspects of the research and understands the information provided. However, the IRB office, the research investigators and the research staff all share in the responsibility of ensuring that the informed consent process is adequate.
- Federal regulations do not specify how far in advance of study entry a subject can provide consent. The amount of time required by a subject to make a decision would presumably depend upon the nature of the study, taking into consideration the degree of risk, potential benefits, alternatives, and desire to consult with family. For the sake of clarification, consents are current for 30 days but it may be prudent to review information contained in the consent document with the research subject prior to initiating any research procedures.

Regulations & Guidance: DHHS 45 CFR §46.109(b); 45 CFR §46.116; FDA 21 CFR §50.25; 21 CFR §56.109(b); OHRP Guidance on Exculpatory Language in Informed Consents; FDA Information Sheets: A Guide to Informed Consents

## **5.5 Basic Elements of Informed Consent**

To be valid, the consent process must provide the following basic elements of information to potential subjects, which includes:

- A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental and done for research purposes; a description of any reasonably foreseeable risks or discomforts to the subject including privacy risks (legal, employment, etc.).
- A description of any benefits to the subject or to others which may reasonably be expected from the research.
- The alternative procedures or treatment that might be available to the participant, and their important potential benefits and risks.
- A statement describing the extent, if any, to which confidentiality of records identifying the subject must be maintained.



- For research involving more than minimal risk, an explanation as to the availability of medical treatment in the case of research related injury, including who will pay for the treatment and whether other financial compensation is available.
- An explanation of whom to contact on the research team for answers to pertinent questions about the research or to voice concerns or complaints about the research, and whom to contact in the event of a research-related injury to the subject.
- Contact information for the IRB to obtain answers to questions about the research; to voice concerns or complaints about the research; to obtain answers to questions about their rights as a research subject; in the event the research staff could not be reached; and in the event the subject wishes to talk to someone other than the research staff.
- A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.

Regulations & Guidance: DHHS 45 CFR §46.116(a); FDA 21 CFR §50.25(a); OHRP Guidance on Exculpatory Language in Informed Consents; FDA Information Sheets: A Guide to Informed Consents; Consent Template found on the HRPP website

### ***5.6 Additional Elements of Informed Consent to be applied, as appropriate:***

Additional situational-specific elements that an informed consent should include are:

- A statement that the particular treatment or procedure may involve risks to the subject, which are currently unforeseeable. (e.g., include when the research involves procedures in which the risks to subjects are not well known).
- A statement that if the subject is or becomes pregnant, the particular treatment or procedure may involve risks to the embryo or fetus, which are currently unforeseeable (e.g., include when the research involves pregnant women or women of childbearing potential and the risk to fetuses of the drugs, devices, or other procedures involved in the research is not well known).
- Anticipated circumstances under which the subject's participation may be terminated by the Investigator without regard to the subject's consent.
- Any additional costs to the subject that may result from participation in the research;
- The consequences of a subject's decision to withdraw from the research (e.g., include when withdrawal from the research is associated with adverse consequences).
- Procedures for orderly termination of participation by the subject.
- A statement that significant new findings developed during the course of the research which may relate to the subject's willingness to continue participation will



be provided to the subject ( e.g., include when the research is long term and interim information is likely to be developed during the conduct of the research).

- The approximate number of subjects involved in the study (e.g., include when the research involves more than minimal risk).
- Use of a written translation of the entire IRB approved English consent form is required for subjects who do not speak English or understand English and where researchers can reasonably expect that more than an incidental number of subjects speaking the same non-English language will be enrolled (e.g., if the Investigator is targeting a non-English speaking group). The IRB must approve all translated versions of the consent form. The IRB recommends the translation is done by a certified translator, however, the IRB will consider, on a case-by-case basis, allowing other translators to perform this function with verification that the translation is an accurate and acceptable presentation of the entire English version. The IRB may have added requirements in the review process to assure the translation is accurate.
- A statement that the monitor, the auditor, the IRB, and the regulatory authority will be granted direct access to the participant's original medical records for verification of clinical trial procedures or data, without violating the confidentiality of the participant, to the extent permitted by the applicable laws and regulations and that, by signing a written consent form, the participant or the participant's legally acceptable representative is authorizing such access.
- The approval of the IRB.
- For research regulated by FDA:
  - A statement that informs the subject of the possibility that FDA may inspect the records.
  - For applicable clinical trials, the following statement notifying the subject that clinical trial information has been or will be submitted for inclusion in the clinical trial registry databank: "A description of this clinical trial will be available on <http://www.ClinicalTrials.gov>, as required by U.S. law. This website will not identify you. At most, the website will include a summary of the results. You can search this website at any time."
  - Investigational New Drug Application (IND) submitted to FDA is not required to contain a copy of the consent document. For significant risk devices, the consent document is considered to be a part of the investigational plan in the application for an Investigational Device Exemption (IDE). Any substantive changes to the document made by an IRB must be submitted to the FDA (by the sponsor) for review and approval.
  - There is a statement noting the possibility that the FDA may inspect the records that will be provided to each participant.

Regulations & Guidance: DHHS 45 CFR §46.116(b); FDA 21 CFR §50.25(b)







## 5.7 Documentation of Informed Consent

The IRB will ensure that the consent will be appropriately documented according to legal requirements in accordance with, and to the extent required by 45 CFR §46.117 and 21 CFR §50.27.

- Except as provided in section 5.9, informed consent must be documented by the use of a written consent form approved by the IRB and personally signed and dated by the subject or the subject's legally authorized representative at the time of consent.
- The informed consent process must also be conducted and consent obtained in person in addition to reading and signing the informed consent document.
- Pennington Biomedical does not allow for obtaining informed consent over the phone or mail to ensure subject understanding and to allow for question/answer sessions.
- In addition to signing the consent document, the subject or representative should enter the date of signature on the consent document to permit verification that consent was actually obtained before the subject began participation in the study.
- If the consent is obtained on the same day as the subject's involvement in the study begins, the subject's medical records/source documentation should document that consent was obtained prior to participation in the study.
- Prior to a participant's participation in the trial, the written consent document should be signed and personally dated by the person who conducted the informed consent discussion.
- Participants or participant's legally authorized representative will be given adequate time to read the consent document before it is signed.
- If a participant is unable to read or if a legally acceptable representative is unable to read, an impartial witness should be present during the entire informed consent discussion.
  - After the written consent document and any other written information to be provided to participants, is read and explained to the participant or the participant's legally acceptable representative, and after the participant or the participant's legally acceptable representative has orally consented to the participant's participation in the trial and, if capable of doing so, has signed and personally dated the consent document, the witness should sign and personally date the consent document.
  - By signing the consent document, the witness attests that the information in the consent document and any other written information was accurately explained to, and apparently understood by, the participant or the participant's legally acceptable representative, and that consent was freely



given by the participant or the participant's legally acceptable representative.

- A copy of the signed and dated consent document will be provided to the participant or the participant's legally acceptable representative, a copy placed on all of the appropriate records, and the original signed consent document should be retained in the study records.
- To allow the use of the long form of consent documentation, the IRB will determine the following:
  - The required and appropriate additional elements of disclosure are included in the consent process
  - The consent document embodies the basic and required additional elements of disclosure.
  - The required disclosure will be provided to each participant or a legally authorized representative in accordance with legal requirements.
  - Whether additional disclosures are required for inclusion in the consent process.
  - The participant or the participant's legally authorized representative will sign the consent document
  - A copy of the consent document will be given to the person signing the consent document.
  - The researcher will give either the participant or the representative adequate opportunity to read the consent document before it is signed.

At this time Pennington Biomedical Research Center does not permit the informed consent documentation use of a "short form".

### ***5.8 Continued Use of Data Following Withdrawal or Termination***

- When a participant withdraws from a study, the data collected on the participant to the point of withdrawal remains part of the study database and may not be removed. The consent document cannot give the participant the option of having data removed.
- A researcher may ask a participant who is withdrawing whether the participant wishes to provide continued follow-up and further data collection subsequent to their withdrawal from the interventional portion of the study. Under this circumstance, the discussion with the participant distinguishes between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through non-invasive chart review, and address the maintenance of privacy and confidentiality of the participant's information.



- The researcher must obtain the participant's consent for this limited participation in the study (assuming such a situation was not described in the original consent document). The IRB must approve the consent document.
- If a participant withdraws from the interventional portion of a study and does not consent to continued follow-up of associated clinical outcome information, the researcher must not access for purposes related to the study the participant's medical record or other confidential records requiring the participant's consent. However, a researcher may review study data related to the participant collected prior to the participant's withdrawal from the study, and may consult public records, such as those establishing survival status.

### **5.8.1 FDA Regulated Studies**

It is the FDA policy that participant data collected up to the time of withdrawal must remain in the data set in order for the study to be scientifically valid.

## **5.9 Consent Monitoring**

In reviewing the adequacy of informed consent procedures for proposed research, the IRB may on occasion determine that special monitoring of the consent process by an impartial observer (consent monitor) is required in order to reduce the possibility of coercion and undue influence, ensure that the approved consent process is being followed, or ensure that subjects are truly giving informed consent.

Such monitoring may be particularly warranted for: high risk studies; studies that involve particularly complicated procedures or interventions; studies involving highly vulnerable populations (e.g., children); studies involving study staff with minimal risk experience in administering consent to potential study subjects, or other situations when the IRB has concerns that consent process is not being conducted appropriately.

Monitoring may also be appropriate as a corrective action where the IRB has identified problems associated with a particular Investigator or a research project.

If the IRB determines that consent monitoring is required, the HRPP Director will develop a monitoring plan and submit it to the IRB for approval. The consent monitoring may be conducted by HRPP Director, IRB staff, IRB members or another party, either affiliated or not with the institution. The investigator will be notified of the IRB determination and the reasons for the determination. Arrangements will be made with the investigator for the monitoring of the consent process for a specified number of subjects. When observing the consent process, the monitor will determine:



- Whether the informed consent process was appropriately completed and documented;
- Whether the subject had sufficient time to consider study participation;
- Whether the consent process involved coercion or undue influence;
- Whether the information was accurate and conveyed in understandable language; and
- Whether the subject appeared to understand the information and gave their voluntary consent.

Following the monitoring, a report of the findings will be submitted to the IRB, which will determine the appropriate action to be taken.

### ***5.10 Waiver of the Consent Process***

An IRB may approve a consent procedure that does not include, or that alters, some or all of the elements of informed consent set forth above; or waive the requirements to obtain informed consent, provided the IRB finds and documents that:

- The research involves no more than minimal risk tangible or intangible risk to the subjects;
- The waiver or alteration will not adversely affect the rights and welfare of the subjects;
- The research could not practicably be carried out without the waiver or alteration; and whenever appropriate, the subjects must be provided with additional pertinent information after participation.
- The IRB must determine the regulatory criteria for waivers or alterations of the consent process are met.
- The research is not regulated by the FDA.

In addition, an IRB may approve a consent procedure that does not include, or that alters, some or all of the elements of informed consent; or waive the requirements to obtain informed consent, provided the IRB finds and documents that the research or demonstration project is to be conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or otherwise examine:

- Public benefit or service programs;
- Procedures for obtaining benefits or services under those programs;
- Possible changes in or alternatives to those programs or procedures; or
- Possible changes in methods or levels of payment for benefits or services under those programs.
- The research is not FDA-regulated



### ***5.11 Waiver of Parental Permission***

In some cases the IRB is allowed to waive parental permission by determining the criteria for waivers or alterations is met.

- Research on Public Benefit or Service Programs
  - The IRB can waive or alter the requirements for parental permission for non-exempt research examining state or local public benefit or service programs or certain features of those programs if all of the following criteria are met:
    - The research or demonstration project is to be conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or otherwise examine public benefit or service programs, procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs
    - The research could not practicably be carried out without the waiver or alteration
    - The research is not FDA-regulated.
- Minimal Risk Research
  - The IRB can waive or alter the requirements for parental permission for non-exempt research that meets all of the following criteria:
    - The research involves no more than minimal risk to subjects
    - The waiver or alteration will not adversely affect the rights and welfare of subjects
    - The research could not practicably be carried out without the waiver or alteration
    - Whenever appropriate, subjects will be provided with additional pertinent information after participation
    - The research is not FDA-regulated.
- Research Designed to Study Conditions in Children
  - The IRB can waive or alter the requirements for parental permission for non-exempt research designed to study conditions in children or a subject population for which parental or guardian permission is not a reasonable



requirement to protect the subjects (e.g., neglected or abused children) when the following additional criteria are also met:

- An appropriate mechanism is in place to protect the children
- The waiver is not inconsistent with federal, state, or local law.
- The research is not FDA-regulated.

Note: IRBs may waive the requirement for obtaining parental or guardian permission as described above even if the research involves greater than minimal risk to the participants.

- When determining an appropriate mechanism for protecting child participants (e.g., appointment of an advocate or assent monitor), investigators and IRBs will consider the nature of the research (including any potential risks and anticipated benefits) and the children's ages, maturity, condition, and psychological/emotional states.

### ***5.12 Waiver of Documentation of Informed Consent***

The IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either that the:

- Only record linking the subject and the research would be the consent document and the principle risk would be potential harm resulting from a breach of confidentiality; Subjects must be asked whether they want documentation linking them with the research, and their wishes must govern.
- In order to waive written documentation of consent where the only record linking the subject and the research would be the consent document, the IRB has to determine that the research was not FDA-regulated.
- The research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context. Procedures such as non-sensitive surveys, questionnaires and interviews generally do not require written consent when conducted by non-researchers.
- The consent process does not involve a research study that is FDA-regulated.

In cases in which the documentation requirement is waived, the IRB requires the investigator to provide in the application materials a written summary of the information to be communicated to the subject; the IRB will consider whether to require the investigator to provide subjects with a written statement regarding the research.

The IRB Chair or primary reviewer will complete a review of the request for waiver of informed consent. In addition, the IRB minutes will document required determination



regarding waiver of requirements for written documentation of informed consent. The minutes also will document the protocol specific findings justifying the requirements.



## **6.0 Vulnerable Subjects in Research**

### **6.1 Policy**

The following procedures describe the requirements for involving vulnerable subjects in research under the purview of the Pennington Biomedical Research Center IRB.

### **6.2 Involvement of Vulnerable Populations**

When some or all of the subjects in a protocol are likely to be vulnerable to coercion or undue influence, the investigator should include additional safeguards to protect the rights and welfare of these subjects. Some of the vulnerable populations that might be involved in research include individuals who are educationally or financially disadvantaged, children, pregnant women, fetuses, neonates or economically or educationally disadvantaged, adults who lack the ability to consent, students, employees or homeless persons.

Additional requirements for IRB oversight of research involving vulnerable subjects can be found at 45 CFR §part 46, which includes the following: subpart B - Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in research; and subpart D - Additional Protections for Children Involved as Subjects in Research. Pennington Biomedical Research Center does not review research under Subpart C: Research Involving Prisoners.

DHHS-funded research that involves any of these populations must comply with the requirements of the relevant subparts. Research funded by other federal agencies may or may not be covered by the subparts.

Under Pennington Biomedical Research Center FWA the subparts only apply to DHHS-funded research and research funded by another federal agency that requires compliance with the subparts (FDA regulations include Subpart D, which applies to all FDA-regulated research). The following policies and procedures, which are based on the subparts, apply to all research regardless of funding. The individual sections describe how the subparts apply to DHHS-funded research.

### **6.3 Definitions**

Vulnerable population (or “vulnerable subjects”): This includes the following classes of potential or actual research subjects: children, pregnant women, cognitively-disabled persons, or economically or educationally disadvantaged persons.



## 6.4 IRB Responsibilities

- The investigator is responsible for identifying the enrollment of potential vulnerable subjects in the research proposal. The investigator is responsible for identifying patients who are at risk for impaired decisional capacity as a consequence of psychiatric illness, and who are being asked to participate in a research study with greater than minimal risk.
- The IRB shall include representation, either as members or ad hoc consultants, individual(s) interested in or who have experience with the vulnerable populations involved in a research proposal.
- The IRB reviews the investigator's justifications for including vulnerable populations in the research to assess appropriateness of the research proposal.
- The IRB must ensure that additional safeguards have been included in each study to protect the rights and welfare of vulnerable subjects as needed at the time of initial review of the research proposal.
- The IRB shall continue to review research at intervals appropriate to the degree of risk and determine whether the proposed research continues to fulfill criteria for approval. Information reviewed should include the number of subjects considered as members of specific vulnerable populations.
- The IRB needs to carefully review the DSMB plan for all research involving vulnerable subjects.
- The IRB should be knowledgeable about and experienced in working with populations who are vulnerable to coercion and undue influence. If the IRB requires additional qualification or expertise to review a protocol, it should obtain consultation.

## 6.5 Procedures

### 6.5.1 Initial Review of Research Proposal

The following steps are relevant with respect to initial review of a research proposal:

- The investigator should identify the potential to enroll vulnerable subjects in the proposed research at initial review and provide the justification for their inclusion in the study.
- The IRB evaluates the proposed plan for consent of the specific vulnerable populations involved. If the research involves adults unable to consent, the IRB evaluates the proposed plan for permission of legally authorized representatives.
- The IRB evaluates and approves the proposed plan for the assent of subjects.
- The IRB evaluates the research to determine the need for additional protections.



- The investigator should provide appropriate safeguards to protect the subject's rights and welfare, which may include the addition of an independent monitor. The independent monitor is a qualified individual not involved in the research study who will determine the subject's capacity to provide voluntary informed consent.
- The IRB assess the adequacy of additional protections for vulnerable populations provided by the investigator.

### 6.5.2 Continuing Review and Monitoring

At continuing review, the investigator should identify the number of vulnerable subjects enrolled and any that needed an independent monitor in the progress report.

## 6.6 Research Involving Pregnant Women or Fetuses

### 6.6.1 Definitions

**Delivery:** means complete separation of the fetus from the woman by expulsion, extraction, or any other means.

**Fetus:** is the product of conception from the time of implantation until delivery. [DHHS 45 CFR §46.202(c); LA R.S. 40:1299.35.1].

**Pregnant:** is the period of time from confirmation of implantation until expulsion or extraction of the fetus. [DHHS 45 CFR §46.202(f)].

### 6.6.2 Research Not Funded by DHHS

For research not funded by DHHS, no additional safeguards are required by the regulations and there are no restrictions on the involvement of pregnant women in research where the risk to the fetus is no more than minimal risk.

Pregnant women or fetuses may be involved in research not funded by DHHS involving more than minimal risk to fetuses if all of the following conditions are met:

- Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risks to pregnant women and fetuses;
- The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus;
- Any risk is the least possible for achieving the objects of the research;



- If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, then the consent of the pregnant woman is obtained in accordance with the provisions for informed consent;
- If the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accordance with the provisions for informed consent, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest;
- Each individual providing consent is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;
- For children who are pregnant, assent and permission are obtained in accordance with the provisions of permission and assent (see section [6.8.3.3](#));
- No inducements, monetary or otherwise, will be offered to terminate a pregnancy;
- Individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy; and
- Individuals engaged in the research will have no part in determining the viability of a neonate.

Regulations & Guidance: DHHS 45 CFR §46.204.

### **6.6.3 Research Funded by DHHS**

For DHHS-funded research, 45 CFR subpart B applies to all research involving pregnant women. According to 45 CFR subpart B, pregnant women or fetuses may be involved in research funded by DHHS if all of the following conditions are met:

- Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risk to pregnant women and fetuses.
- The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus or, if there is no such prospect of benefit, the risk to the fetus is not greater than minimal risk and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means;
- Any risk is the least possible for achieving the objects of the research;
- If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, or no



prospect of benefit for the woman nor the fetus when risk to the fetus is not greater than minimal risk and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means, then the consent of the pregnant woman is obtained in accordance with the provisions for informed consent.

- If the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accordance with the provisions for informed consent, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest.
- Each individual providing consent is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;
- For children who are pregnant, assent and permission are obtained in accord with the provisions of permission and assent in section 6.8.3.3;
- No inducements, monetary or otherwise, will be offered to terminate a pregnancy;
- Individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy; and
- Individuals engaged in the research will have no part in determining the viability of a neonate.

## **6.7 Research Involving Neonates**

### **6.7.1 Definitions**

**Neonate:** means newborn. [DHHS 45 CFR 46.202(d)].

**Neglect:** neglect of neonate means a medical finding by a Louisiana licensed physician that a neonate either is dependent upon or suffers from withdrawal symptoms from an illegal controlled dangerous substance. It also includes a medical finding by a physician that a neonate suffers from an illness, disease or condition attributable to the exposure of the newborn, in utero, of an illegal CDS.

**Non-Viable Neonate (or “Non-Viable Fetus”):** is a fetus ex utero that, although living, is not able to survive to the point of independently maintaining a heartbeat and respiration. [DHHS CFR 46.202(e)].

**Viable Neonate (or “Viable Fetus”):** means a fetus that is able, after delivery, to survive to the point of being able to independently maintain a heartbeat and respiration (given the benefit of available medical therapy). [DHHS 45 CFR §102(c) & (l); 45 CFR §46.202(h)].



### **6.7.2 General Requirement Regarding Research Involving Neonates**

Neonates of uncertain viability and non-viable neonates may be involved in research if all of the following conditions are met:

- Where scientifically appropriate, preclinical and clinical studies have been conducted and provide data for assessing potential risks to neonates;
- Each individual that's providing consent is fully informed regarding the reasonably foreseeable impact of the research on the neonate; and
- Individuals engaged in the research will have no part in determining the viability of a neonate.

The requirements of neonates of uncertain viability or non-viable neonates (see below in this section) have been met as applicable.

Regulations & Guidance: DHHS 45 CFR §46.205(a).

### **6.7.3 Neonates of Uncertain Viability**

Until it has been ascertained whether or not a neonate is viable, a neonate may not be involved in research covered by this subpart unless the following additional conditions have been met.

The IRB determines that:

- The research holds out the prospect of enhancing the probability of survival of the neonate to the point of viability, and any risk is the least possible for achieving that objective; or
- The purpose of the research is the development of important biomedical knowledge which cannot be obtained by other means and there will be no added risk to the neonate resulting from the research; and
- The legally effective informed consent of either parent of the neonate or, if neither parent is able to consent because of unavailability, incompetence, or temporary incapacity, the legally effective informed consent of either parent's legally authorized representative is obtained in accordance with the provisions of permission and assent, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.
- The IRB Chair will have the IRB determine and document individuals providing consent are fully informed regarding the reasonably foreseeable impact of the research on the neonate.

Regulations & Guidance: DHHS 45 CFR §46.205(b).



#### **6.7.4 Non-Viable Neonates**

After delivery, non-viable neonates may not be involved in research covered by this subpart unless all of the following additional conditions are met:

- Vital functions of the neonate will not be artificially maintained;
- The research will not terminate the heartbeat or respiration of the neonate;
- There will be no added risk to the neonate resulting from the research;
- The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means; and
- The legally effective informed consent of both parents of the neonate is obtained in accordance with the provisions of permission and assent, except that the waiver and alteration of the provisions of permission and assent do not apply.
- However, if either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the informed consent of one parent of a non-viable neonate will suffice to meet the requirements of this paragraph, except that the consent of the father need not be obtained if the pregnancy resulted from rape or incest. The consent of a legally authorized representative of either or both of the parents of a non-viable neonate will not suffice to meet the requirements of this paragraph.
- The IRB Chair will have the IRB determine and document individuals providing consent are fully informed regarding the reasonably foreseeable impact of the research on the neonate.

Regulations & Guidance: DHHS 45 CFR §46.205(c).

#### **6.7.5 Viable Neonates**

A neonate, after delivery, that has been determined to be viable may be included in research only to the extent permitted by and in accordance with the requirements of IRB review process and research involving children. [DHHS 45 CFR §46.205(d)].

#### **6.7.6 Research Involving, After Delivery, the Placenta, the Dead Fetus or Fetal Material**

Research involving, after delivery, the placenta; the dead fetus; macerated fetal material; or cells, tissue, or organs excised from a dead fetus, must be conducted only in accordance with any applicable federal, state, or local laws and regulations regarding such activities.



If information associated with material described above in this section is recorded for research purposes in a manner that living individuals can be identified, directly or through identifiers linked to those individuals, those individuals are research participants and all pertinent sections of this document are applicable. [DHHS 45 CFR §46.206].

### **6.7.7 Research Not Otherwise Approvable**

#### ***6.7.7.1 Research Not Funded by DHHS***

If the IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates; and the research is not approvable under the above provisions, then the IRB will consult with a panel of experts in pertinent disciplines (e.g., science, medicine, ethics, and law). Based on the recommendation of the panel, the IRB may approve the research based on either:

- That the research in fact satisfies the conditions of Section 6.6, as applicable; or
- The following:
  - The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant Women, fetuses or neonates;
  - The research will be conducted in accordance with sound ethical principles; and
  - Informed consent will be obtained in accordance with the provisions for informed consent and other applicable sections of this document.

Regulations & Guidance: DHHS 45 CFR §46.207.

#### ***6.7.7.2 Research Funded by DHHS***

DHHS-funded research that falls in this category must be approved by the Secretary of DHHS. If the IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates; and the research is not approvable under the above provisions, then the research will be sent to OHRP for DHHS review.



Newborns are only considered neonates until they are determined to be viable (able to survive outside of the uterus). Once they are determined to be viable, they are considered children; the IRB will follow guidelines 6.8 Research Involving Children.

## **6.8 Research Involving Children**

The following applies to all research involving children, regardless of funding source. The requirements in this section are consistent with subpart D of 45 CFR 46 (applicable to DHHS-funded research) and subpart D of 21 CFR 50 (applies to FDA-regulated Research involving Children).

Regulations & Guidance: FDA 21 CFR §56.109(h); 21 CFR §56.111(c)].

### **6.8.1 Definitions**

**Assent:** means a child's affirmative agreement to participate in research. Mere failure of a child to object may not, absent affirmative agreement, be construed as assent.

[FDA 21 CFR §50.3(n)].

**Child:** are persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted. [DHHS 45 CFR §46.402(s); FDA 21 CFR §50.3(o)].

According to Louisiana Law, the legal age for consent for treatment or medical procedures is 18 years or older. [LA Children's Code 116; LA R.S. 40:1095]. Louisiana law is silent with respect to the legal age to consent with respect to research. For purposes of these SOPs, any person who is under the age of 18 generally is unable to consent for him/herself. Several important exceptions exist under Louisiana law that effectively treat children as adults and gives them the capacity to consent to their own medical care and to participate in research. They include the following: for a child to receive medical and/or surgical care at a hospital and/or to receive physicians' services [LA R.S. 40:1095]. This may or may not overlap with the proposed research; if a child is emancipated by marriage. Regardless of age, a child is fully emancipated upon his or her marriage [LA Children's Code Art 379]; if a child is judicially emancipated. This requires a court order for child older than 16 years of age [LA Children's Code Art 366 and 1922];

If a child is emancipated by authentic act this requires a child older than 16 years of age and the child's parents to execute a written document of emancipation, signed before two witnesses and a notary [LA Children's Code Art 368]; if a child seeks to be



treated for venereal disease [LA R.S. 40:1065.1]; and if a child seeks to be treated for drug abuse [LA R.S. 40:1096].

Because Louisiana law does not specifically address consent of children with majority status to research, the institutions IRB will review issues of consent related to enrollment of these children in research on a case-by-case basis.

**Guardian (or legal guardian):** means an individual who is authorized under applicable state or local law to consent on behalf of a child to (a) general medical care when general medical care includes participation in research; or (b) to participate in research. [DHHS 45 CFR §46.402(e); FDA 21 CFR 50.3(s); LA. Children's Code 116(12.1)(a)(i)(b)]. A guardian of a minor retains the duty and authority to (1) act in the best interests of the minor, subject to residual parental rights and responsibilities (if any); (2) make important decisions in matters having a permanent effect on the life and development of the minor; and (3) to be concerned with the minor's general welfare. For research conducted in jurisdictions other than Louisiana, the research must comply with the laws regarding guardianship in all relevant jurisdictions where the research will take place.

**Health Agent:** is an authorized representative legally acting for a person pursuant to a Durable Power of Attorney for Health Care (Medical Power of Attorney) or other legal document permitted within a jurisdiction that allows a person to appoint another person(s) to make medical decisions for the patient if the patient should become temporarily or permanently unable to make those decisions for himself/herself. Any adult (18 or older) can be granted this power. [LA R.S.40:1299.53(A)(13)].

**Legally Authorized Representative:** is an individual, judicial, or other body authorized under applicable law to consent or otherwise provide permission on behalf of a subject, either prospectively or during the course of research, to the subject's participation in the procedure(s) involved in the research. [DHHS 45 CFR §46.102(c); FDA 21 CFR §50.3(l)]. For the purposes of this document, a legally authorized representative includes a person appointed as a health agent, a court-appointed legal guardian of the person, as well as next-of-kin in the following order of priority unless otherwise specified by applicable state law: the subject's spouse; adult child(ren) of subject (18 years of age or older); parent of subject; adult sibling(s) of subject (18 years of age or older); grandparent(s) of subject; or adult grandchild(ren) of subject (18 years of age or older). If there is more than one person within the above named class, the consent shall be given by a majority of those members of the class available for consultation. [LA R.S. 40:1299.53] legally authorized representative should not be confused with legal guardian.



**Minor:** means any person under the age of 18 years. [LA Children's Code Art 116]. Do not confuse the definitions of minor (pertaining to a person's age) with child/children (pertaining to a person's ability to assent).

**Parent:** means a child's biological or adoptive parent.

[FDA 21 CFR §50.3(p)].

### 6.8.2 Allowable Categories

Research on children must be reviewed and categorized by the IRB into one of the following groups:

1. Not greater than minimal risk: research on children not involving physical or emotional risk greater than that ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests (i.e., minimal risk). This includes adequate provisions are made for soliciting the assent of children and the permission of their parents or legal guardians as set forth in section 6.8.3.
2. Greater than minimal risk: research on children involving greater than minimal risk but presenting the prospect of direct benefit to the individual subject.
  - The risk is justified by the anticipated benefit to the subjects;
  - The relation of the anticipated benefit to the risk is at least as favorable to the subjects as that presented by available alternative approaches; and
  - Adequate provisions are made for soliciting the assent of children and the permission of their parents or legal guardians as set forth in section 6.8.3.
3. Greater than minimal risk and no prospect of direct benefit: research on children involving greater than minimal risk and no reasonable prospect of direct benefit to the individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition.
  - The risk represents a minor increase over minimal risk;
  - The intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations;
  - The intervention or procedure is likely to yield generalizable knowledge about the subjects' disorder or condition which is of vital importance to the understanding of amelioration of the subjects' disorder or condition; and



- Adequate provisions are made for soliciting the assent of children and the permission of their parents or legal guardians as set forth in section 6.8.3.
4. Research Not Otherwise Approvable: research on children not otherwise approvable which presents an opportunity to understand, prevent, or alleviate serious problems affecting the health or welfare of children. Federally-funded research in this category must be approved by the DHHS Secretary, and requires consent of either both parents and the legal guardian. FDA-regulated research in this category must be approved by the FDA Commissioner. For non-federally funded research, the IRB Chair will consult with a panel of experts in pertinent disciplines (e.g., science, medicine, ethics, or law) and following opportunity for public review and comment, determine either:
- That the research in fact satisfies the conditions of the previous categories, as applicable; or
  - The following:
    - The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children;
    - The research will be conducted in accordance with sound ethical principles; and
    - Informed consent will be obtained in accordance with the provisions for informed consent and other applicable sections of this document. Adequate provisions are made for soliciting the assent of children and the permission of their parents or legal guardians as set forth in section 6.9.3.

Regulations & Guidance: DHHS 45 CFR §46.404; 45 CFR §46.405; 45 CFR §46.406; 45 CFR §46.407.

### **6.8.3 Parental Permission and Assent**

#### **6.8.3.1 Parental Permission**

Since a child cannot consent for him/herself, the IRB must determine that adequate provisions have been made for soliciting the permission of each child's parent or legal guardian, as documented in the consent (the sample minor document can be found at [www.pbrc.edu/HRPP/Forms](http://www.pbrc.edu/HRPP/Forms))

Consent should be obtained as follows in this order of priority: mother and father [LA Children's Code Art 216] or adoptive foster parents [LA R.S. 40:1299.55]. The right first rests with married parents of the child. If they consent, comply with their wishes (subject to the assent requirements below). If they do not agree, the



father's choice prevails [LA Children's Code Art 216]. A power of attorney from the child's parents to another adult [LA Children's Code Art 216 The court recognized tutor [LA Children's Code Art 246 and 253]; or a power of attorney from the child's tutor to another adult [LA R.S. 9:951].

For research conducted in jurisdictions other than Louisiana, the research must comply with the laws regarding the legal age of consent in all relevant jurisdictions. The institutions legal department will provide assistance to the IRB office and investigators with regard to the laws in other jurisdictions.

Parents or legal guardians must be provided with the basic elements of consent and any additional elements the IRB deems necessary, as described in section 5.5.

In addition to the requirements under Louisiana law, the IRB may find that the permission of one parent is sufficient for research to be conducted under categories 6.8.2.1 and 6.8.2.2 above. Consent from both parents is required for research to be conducted under categories 6.8.2.3 and 6.8.2.4 above unless:

- One parent is deceased, unknown, incompetent, or not reasonably available; or
- When only one parent has legal responsibility for the care and custody of the child.

For research not covered by the FDA regulation, the IRB may waive the requirement for obtaining consent from a parent or legal guardian if: The research meets the provisions for waiver in section 5.8 or if the IRB determines that the research protocol is designed for conditions or a subject population for which parental or legal guardian permission is not a reasonable requirement to protect the subjects (e.g., neglected or abused children) provided an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and that the waiver is not inconsistent with federal, state or local laws. The choice of an appropriate mechanism would depend upon the nature and purpose of the activities described in the protocol, the risk and anticipated benefit to the research subjects, and their age, maturity, status, and condition.

For research that involves no more than minimal risk or more than minimal risk with the prospect of direct benefit to the individual children, the IRB determines whether:

- The permission of both parents is required unless one parent is deceased, unknown, incompetent, or not reasonably available, or when only one



parent has legal responsibility for the care and custody of the child, or the permission of one parent is sufficient.

- For research that involves more than minimal risk without the prospect of direct benefit to the individual children, the IRB determines that the permission of both parents is required unless one parent is deceased, unknown, incompetent, or not reasonably available, or when only one parent has legal responsibility for the care and custody of the child.

Parental permission may not be waived for research covered by the FDA regulations.

Permission from parents or legal guardians must be documented in accordance with and to the extent required by sections 5.7 and 5.10.

Regulations & Guidance: DHHS 45 CFR §46.408

#### ***6.8.3.2 Assent from Children***

Because assent means a child's affirmative agreement to participate in research, the child must actively show his or her willingness to participate in the research, rather than just complying with directions to participate and not resisting in any way. When judging whether children are capable of assent, the IRB is charged with taking into account the ages, maturity, and psychological state of the children involved.

The IRB should take into account the nature of the proposed research activity and the ages, maturity, and psychological state of the children involved when reviewing the proposed assent procedure and the form and content of the information conveyed to the prospective subjects. For research activities involving adolescents whose capacity to understand resembles that of adults, the assent procedure should likewise include information similar to what would be provided for informed consent by adults or for parental permission. For children whose age and maturity level limits their ability to fully comprehend the nature of the research activity but who are still capable of being consulted about participation in research, it may be appropriate to focus on conveying an accurate picture of what the actual experience of participation in research is likely to be (e.g., what the experience will be, how long it will take, whether it might involve any pain or discomfort). The assent procedure should reflect a reasonable effort to enable the child to understand, to the degree they are capable, what their participation in research would involve.



The IRB presumes that children ages 9 and older should be given an opportunity to provide assent. Generally, oral assent through the use of a script should be obtained from children 9 -11 years of age. Written assent using a written document for the children to sign may be sought for older children. This opportunity can be extended to children at age 7, provided the child's age and maturity level enables the child to comprehend the nature of the research activity.

At times there may be inconsistency between parent permission and child assent. Usually a "no" from the child overrides a "yes" from a parent, but a child typically cannot decide to be in research over the objections of a parent. Obviously, there are individual exceptions to these guidelines (such as when the use of an experimental treatment for a life threatening disease is being considered). The general idea, however, is that children should not be forced to be research subjects, even when their parents' consent to it.

If the IRB determines that the capability of some or all of the children is so limited that they cannot reasonably be consulted or that the intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health or well-being of the children and is available only in the context of the research, the assent of the children is not a necessary condition for proceeding with the research.

The IRB will determine and document that assent is a requirement of: all children, some children or none of the children. When the IRB determines that assent is not a requirement of some children, the IRB determines and documents which children are not required to assent.

#### **6.8.3.2.1 Determination by the IRB Assent is not a Requirement**

When the IRB determines that assent is not a requirement for some or all children, the IRB determines and documents one or more of the following:

- The children are not capable of providing assent based on the age, maturity, or psychological state.
- The capability of the children is so limited that they cannot reasonably be consulted.
- The intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health or well-being of the child and is available only in the context of the research.
- Assent can be waived using the criteria for waiver of the consent process.



#### 6.8.3.2.2 Determination by the IRB Assent is a Requirement

When the IRB determines that assent is a requirement, the IRB determines whether:

- Assent will be documented.
- If so, the process to document assent.

Even when the IRB determines that the subjects are capable of assenting, the IRB may still waive the assent requirement under circumstances detailed in Section 5.10 Waiver of Informed Consent.

Regulations & Guidance: DHHS 45 CFR §46.408.

#### 6.8.3.3 Consent from Pregnant Minors

A minor may consent to medical care or the administration of medication by a hospital licensed to provide hospital services or by a physician licensed to practice medicine for the purpose of alleviating or reducing pain, discomfort, or distress of and during labor and childbirth. [LA R.S. 40:1095(A)(2)]. This consent shall be valid and binding as if the minor had achieved her majority, and it shall not be subject to a later disaffirmance by reason of her minority.

If research pertains to such permitted minor consent, then the minor may consent to the involved research. If not and the IRB has not waived the consent requirement, then assent from the minor is required, as well as parental permission.

#### 6.8.4 Assent Form

When the IRB determines that assent is required, it shall also determine whether and how assent must be documented.

Researchers should try to draft a form that is age appropriate and study specific, taking into account the typical child's experience and level of understanding, and composing a document that treats the child respectfully and conveys the essential information about the study. The assent form (Sample Child's Assent on the HRPP website) should:

- Tell why the research is being conducted;
- Describe what will happen and for how long or how often;
- Say it's up to the child to participate and that it is permissible to say no;
- Explain if it will hurt and if so for how long and how often;
- Say what the child's other choices are;



- Describe any good things that might happen;
- Say whether there is any compensation for participating; and
- Ask for questions.

For younger children, the document should be limited to one page if possible. Illustrations might be helpful, and larger type makes a form easier for young children to read. Studies involving older children or adolescents should include more information and may use more complex language.

### **6.8.5 Children who are Wards of the State**

Children who are wards of the state or any other agency, institution, or entity can be included in research involving greater than minimal risk where there is no prospect of direct benefits to individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition, only if such research is:

- Related to their status as wards; or
- Conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.

If the research meets the condition(s) above, the IRB Chair will determine an advocate must be appointed by the IRB or institution for each child who is a ward (one individual may serve as advocate for more than one child), in addition to any other individual acting on behalf of the child as legal guardian or *in loco parents*.

The advocate must be an individual who has the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except in the role as advocate or member of the IRB) with the research, the investigator(s), or the guardian organization.

Regulations & Guidance: DHHS 45 CFR §46.409.

## **6.9 Persons with Impaired Decision Making Capacity**

The requirements in this section apply to all research involving persons with mental disabilities or persons with impaired decision-making capacity regardless of funding source.

Research involving persons with impaired decision-making capability may only be approved when the following conditions apply:



- Only incompetent persons or persons with impaired decision making capacity (as determined by licensed health care professionals who are qualified to make such determinations consistent with the scope of their license) are suitable as research subjects. Competent persons are not suitable for the proposed research. The investigator must demonstrate to the IRB that there is a compelling reason to include incompetent individuals or persons with impaired decision-making capacity as subjects. Incompetent persons or persons with impaired decision-making capacity must not be subjects in research simply because they are readily available.
- The proposed research entails no significant risks, tangible or intangible, or if the research presents some probability of harm, there must be at least a greater probability of direct benefit to the subject. Incompetent people or persons with impaired decision-making capacity are not to be subjects of research that imposes a risk of injury, unless that research is intended to benefit that subject and the probability of benefit is greater than the probability of harm.
- Procedures have been devised to ensure that subject's representatives are well informed regarding their roles and obligations to protect incompetent subjects or persons with impaired decision making capacity. Health agents (appointed under Medical Power of Attorney) and next-of-kin, or legal guardians, must be given descriptions of both proposed research studies and the obligations of the person's representatives. They must be told that their obligation is to try to determine what the subject would do if competent, or if the subject's wishes cannot be determined, what they think is in the incompetent person's best interest. In addition and as appropriate, if assent can be obtained by a subject/potential subject with diminished decision making capacity (versus impaired), then the investigator should obtain such assent. The determination as to whether an individual retains capacity to assent must be determined by a duly qualified health care provider, consistent with the provider's scope of licensure.
- A non-therapeutic clinical trial (i.e., a trial in which there is no anticipated direct clinical benefit to the subject) should be conducted in subjects who personally give consent and who sign and date the written consent document. Non-therapeutic clinical trials may be conducted in subjects with consent of a legally authorized representative provided the following conditions are fulfilled:
  - The objectives of the trial cannot be met by means of a trial in subjects who can give consent personally;
  - The foreseeable risks to the subjects are low.
  - The negative impact on the subject's well-being is minimized and low.
  - The trial is not prohibited by law.
  - The opinion of the IRB is expressly sought on the inclusion of such subjects, and the written opinion covers this aspect.



- Unless an exception is justified, the trial should be conducted in patients having a disease or condition for which the investigational product is intended. Subjects in such trials should be particularly closely monitored and should be withdrawn if they appear to be unduly distressed.

### **6.9.1 IRB composition**

The IRB membership must include at least one member who is an expert in the area of the research. Consideration may be given to adding another member who is a member of the population, a family member of such a person or a representative of an advocacy group for that population. The IRB may utilize ad hoc members as necessary to ensure appropriate scientific expertise.

### **6.9.2 Determination of Decision-Making Capacity**

The decision-making capacity of a potential research subject should be evaluated when there are reasons to believe that the subject may not be capable of making voluntary and informed decisions about research participation.

The investigator and research staff must have adequate procedures in place for assessing and ensuring subjects' capacity, understanding, and informed consent or assent. The IRB will evaluate whether the proposed plan to assess capacity to consent is adequate.

For research protocols that involve subjects with mental disorders that may affect decision-making capacity, the IRB may determine that capacity assessments are necessary, unless the investigator can justify why such assessments would be unnecessary for a particular group.

For research that poses greater than minimal risk, the IRB may require investigators to use independent and qualified professionals to assess whether potential subjects have the capacity to give voluntary, informed consent. Even in research involving only minimal risk, the IRB may require that the study include a capacity assessment if there are reasons to believe that potential subjects' capacity may be impaired. It is not necessary to require a formal capacity assessment by an independent professional for all potential research subjects with mental disorders. See the next section for details with respect to determining capacity to consent.

For research protocols involving subjects who have fluctuating or limited decision making capacity the IRB may ensure that Investigators establish and maintain ongoing communication with involved caregivers. Periodic re-consent should be considered in some cases. Third party consent monitors may be used during the recruitment and consenting process, or waiting periods may be required to allow more time for the



subject to consider the information that has been presented. For subjects with fluctuating decision making capacity or those with decreasing capacity to give consent, a re-consenting process with health agent may be necessary.

It is often possible for Investigators and others to enable persons with some decisional impairment to make voluntary and informed decisions to consent or refuse participation in research. Potential measures include repetitive teaching, group sessions, audiovisual presentations, and oral or written recall tests. Other measures might include follow-up questions to assess subject understanding, videotaping or audio-taping of consent interviews, second opinions, use of independent consent observers, interpreter for hearing-impaired subjects, allowing a waiting period before enrollment, or involvement of a trusted family member or friend in the disclosure and decision making process.

Although incompetent to provide informed consent, some persons may resist participating in a research protocol approved by their representatives. Under no circumstances may subjects be forced or coerced to participate.

In the event research subjects become incompetent or impaired in decision making capacity after enrollment, the investigator is responsible for notifying IRB staff. The investigator is responsible for developing a monitoring plan which follows the guidelines outlined above for incompetent and impaired decision making research subjects.

### **6.9.3 Determining Capacity to Consent**

The majority of studies conducted at the institution only allow enrolling subjects who have the capacity to consent. For studies that have been approved for enrolling vulnerable populations who may lack capacity to consent, there must be someone who is able to assess capacity of each potential subject to consent. The investigator may determine after appropriate medical evaluation that the prospective research subject lacks decision-making capacity and is unlikely to regain it within a reasonable period of time. Additionally, if the reason for lack of capacity is because of mental illness then a psychiatrist or licensed psychologist must confirm this judgment and document in the individual's medical record in a signed and dated progress note.

Decisional capacity in the research context has been interpreted by the American Psychiatric Association as requiring: ability to evidence a choice; ability to understand relevant information; ability to appreciate the situation and its likely consequences; and ability to manipulate information rationally.



A range of professionals and methods may be utilized to assess capacity. In general the consent assessor should be a researcher or consultant familiar with dementias and qualified to assess and monitor capacity and consent in such subjects on an ongoing basis. The IRB will consider the qualifications of the proposed individual(s) and whether he or she is sufficiently independent of the research team and/or institution.

A person who has been determined to lack capacity to consent to participate in a research study must be notified of that determination before permission may be sought from his or her legally authorized representative to enroll that person in the study. If permission is given to enroll such a person in the study, the potential subject must then be notified. If a person objects to participating, this objection should be respected.

#### **6.9.4 Informed Consent and Assent**

Whenever the subjects have the capacity to give consent (as determined by licensed health care professionals who are qualified to make such determinations consistent with the scope of their license), informed consent should be obtained and documented in accordance with section 5.0. When subjects lack the capacity to give consent, investigators may obtain consent from the legally authorized representative of a subject as described below.

A person who is incompetent or has been determined to lack capacity to consent to participate in a research study should be informed about the trial to the extent compatible with the subject's understanding and, if possible, the subject should give their assent to participate, sign and date the written informed consent or a separate assent form. If the person objects to participating, this objection should be heeded.

Both investigators and IRB members must be aware that for some subjects, their decision-making capacity may fluctuate. For subjects with fluctuating decision making capacity or those with decreasing capacity to give consent, a re-consenting process with legally authorized representative may be necessary. Although incompetent to provide informed consent, some persons may resist participating in a research protocol approved by their representatives. Under no circumstances may subjects be forced or coerced to participate.

#### **6.9.5 Consent by Legally Authorized Representative**

The regulations generally require that the investigator obtain informed consent from subjects. Under appropriate conditions, investigators also may obtain informed consent from a legally authorized representative of a subject (legally authorized representative).



This policy is designed to protect human subjects from exploitation and harm and, at the same time, make it possible to conduct essential research on problems that are unique to persons who are incompetent, or who have an impaired decision-making capacity.

Legally authorized representative may be obtained from a court appointed legal guardian of the person or a health agent appointed by the person in a Medical Power of Attorney. For example, a subject might have designated an individual to provide consent with regard to health care decisions through a durable power of attorney and have specified that the individual also has the power to make decisions on entry into research.



## 7.0 Drugs and Devices in Research

### 7.1 Drug Policy

All drugs, agents and/or biologics used in human subjects research under the purview of Pennington Biomedical Research Center IRB shall be stored, handled, and dispensed in compliance with regulations or requirements of the FDA, the Louisiana Board of Pharmacy (LABP), federal, state and other laws and regulations, and the policies and procedures of the HRPP. Furthermore, if research is conducted on Pennington Biomedical Research Center premises, such research shall be conducted in accordance with applicable institution and medical staff policies and guidelines.

Pennington Biomedical Research Center Pharmacy provides administrative and clinical services to investigators and research staff involved in drug-related research conducted at Pennington Biomedical facility under the purview of Pennington Biomedical Research Center's IRB. Furthermore, a Pennington Biomedical research pharmacist may be consulted by the IRB to have complete information about all IRB approved research that takes place at the facility.

Regardless of whether investigators conduct drug studies for inpatients or outpatients, the institution's policy requires that the IRB review and approve all drug research involving human subjects prior to initiation of the study and prior to enrollment of subjects. The IRB is also responsible for confirming that research involving an investigational drug where the FDA requires an IND, the research does not commence until a valid IND is in place. This includes recruiting, obtaining consent and screening participants for a specific study that is subject to the IND.

Regulations & Guidelines: FDA 21 CFR §11; 21 CFR §54; 21 CFR §210; 21 CFR §211; 21 CFR §312; 21 CFR §314; 21 CFR §320; 21 CFR §330; 21 CFR §601; 21 CFR §807; 21 CFR §812; 21 CFR §814; 21 CFR §820; 21 CFR §860

### 7.2 Definitions

**Administer:** Means the direct application of a drug to the body of a research subject by injecting, inhalation, ingestion, or any other means. (LA R.S. 37:1164).

**Agents):** are chemical agents that affect the function of living things.

**Biologic:** a substance made from a living organism or its products and used in the prevention, diagnosis, or treatment of certain health conditions.



**Biological Products:** are subsets of drugs used for the treatment, prevention or cure of disease in humans. FDA regulations and policies have established that biological products include blood-derived products, vaccines, in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products. Biological products, like other drugs, can be studied in clinical trials involving humans subjects under an IND in accordance with the regulations at 21 CFR §312.

**Clinical Investigation:** means any experiment that involves a test article and one or more human subjects and that either is subject to requirements for prior submission to the FDA under section 505 of the Federal Food, Drug, and Cosmetic Act the FDA Act) (21 U.S.C. §355) or to, or held for inspection by the Food and Drug Administration FDA) as part of an application for a research or marketing permit. (21 CFR §50.3)

**Dispense:** means the interpretation, evaluation, and implementation of a prescription drug order, including the preparation and delivery of a drug or device to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, a patient. Dispense necessarily includes a transfer of possession of a drug or device to the patient or the patient's agent. (LA R.S. 37:1164). Louisiana law requires that dispensing may only be done by a licensed pharmacist or a physician who is registered with the board as a dispensing physician. (LA R.S. 37:1201).

**Distribute or Distribution):** means the delivery of a drug or device other than by administering or dispensing.

**Drug:** means: a) any substance recognized in the official compendium, or supplement thereto, designated by the Louisiana Board of Pharmacy or other appropriate jurisdiction) for use in the diagnosis, cure, mitigation, treatment or prevention of diseases in humans, b) any substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans, or c) any substance other than food intended to affect the structure or any function of the body of humans. (LA-R.S. 37:1164).

**Investigational Drug:** means a new drug or biological that is used in research. It also includes a biologic used *in vitro* for diagnostic purposes. The FDA considers the term investigational new drug or investigational drug to be synonymous with investigational drug (FDA 21 CFR §312.2). However, for purposes of this document, an investigational drug includes the following:

- An approved drug that is being studied for an unapproved or approved use in a controlled, randomized or blinded clinical trial.



- Those new drugs for which the investigator or a sponsor has filed an IND application (FDA 21 CFR §312) which are exempt from pre-marketing approval requirements and may be lawfully shipped for use in clinical investigations in human subjects.

A drug that is lawfully marketed in the U.S. that may still be considered investigational and required that an IND be filed if the proposed use of such a drug involves a controlled study aimed towards seeking a significant change in labeling, advertising, route of administration, dosage level, or other factor that affects the risks associated with the use of the product (FDA 21 CFR §312.3 (b)).

**Investigational Drug Application or “IND”:** refers to either an investigational new drug application or to a new drug that is used in clinical investigations. IND is synonymous with Notice of Claimed Investigational Exemption for a New Drug (FDA 21 CFR §312).

**Test Article:** Is any drug including a biological for human use), medical device for human use, human additive, color additive, electronic product, or any other article subject to FDA regulation (FDA 21 CFR §50.3j; 21 CFR §56.102 (I)).

### 7.3 FDA Exemptions

The following categories of clinical investigations are exempt from the requirements of FDA regulations for IRB review:

1. Taste and food quality evaluations and consumer acceptance studies, if wholesome foods without additives are consumed or if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural, chemical, or environmental contaminant at or below the level found to be safe, by the FDA or approved by the EPA or the Food Safety and Inspection Service of the U.S. DOA (FDA 21 CFR §56.104 (d)).

### 7.4 IND Requirements

The investigator must indicate on the initial IRB application whether the research involves investigational drugs. If so, the investigator must indicate if there is an IND for the research and provide documented assurance from the sponsor that the manufacture and formulation of investigational or unlicensed test articles conform to federal regulations. Documentation of the IND could be:

- Industry sponsored protocol with IND.
- Letter from FDA.



- Letter from industry sponsor.

If the research involves drugs and there is no IND, the investigator must provide a rationale why it is not required.

The IRB staff will review the application and determine:

- Whether there is an IND and if so, whether there is appropriate supporting documentation.
- If the research involves drugs or devices with no IND, and whether the research meets the criteria below.

#### 7.4.1 IND Exemption

For drugs, an IND is not necessary if all seven of the following conditions are met:

- The drug being used in the research is lawfully marketed in the U.S.
- The research is not intended to be reported to FDA in support of a new indication for use or to support any other significant change in the labeling for the drug
- The research is not intended to support a significant change in the advertising for the product
- The research does not involve a route of administration or dosage level, use in a subject population, or other factor that significantly increases the risks or decreases the acceptability of the risks) associated with the use of the drug product
- The research is conducted in compliance with the requirements for IRB review and informed consent FDA 21 CFR §56 and §50)
- The research is conducted in compliance with the requirements concerning the promotion and sale of drugs (FDA 21 CFR §312.7)

Note: The following are also exempt from the IND requirements : a) a clinical investigation involving use of a placebo if the investigation does not otherwise require submission of an IND; and b) a drug intended solely for tests in vitro or in laboratory research animals if shipped in accordance with 21 CFR §312.160.

For clinical investigations involving an in vitro diagnostic biological product, an IND is not necessary if:

- It involves one or more of the following: a) Blood grouping serum, b) Reagent red blood cells or c) Anti-human globulin;



- It is intended to be used in a diagnostic procedure that confirms the diagnosis made by another, medically established, diagnostic product or procedure; and
- It is shipped in compliance with 21 CFR §312.160.

## 7.4.2 Responsibilities

This section describes the responsibilities and related responsibilities for handling investigational drugs or unlicensed test articles with respect to pharmacy, inventory control, reporting and documentation.

Regulations & Guidelines: FDA 21 CFR §312.61; 21 CFR §312.62; 21 CFR §312.69

### 7.4.2.1 *Principal Investigator*

The investigator is responsible for ensuring that the research is conducted according to all regulatory guidelines and Pennington Biomedical policies and procedures.

For Pennington Biomedical Research Center inpatients and outpatients, investigational drugs for research studies must be dispensed by the Pennington Biomedical research pharmacy. If a licensed investigator by the Louisiana Board of Pharmacy requests to have control of the investigational drug agent or biologic then the investigator must submit for IRB approval a plan for the distribution, storage, dispensing, accountability and destruction or return of drug at completion of the study for the investigational drug products).

- **Dispensing to inpatients:** For participants in the inpatient unit of Pennington Biomedical Research Center, the investigator must use the research pharmacy as the coordinating and control center for the research drug. As the coordinating and control center, the research pharmacy assumes the responsibility for maintaining records of the drugs delivered to the research pharmacy, inventory of the drug, dispensing of drugs to research subjects, and then return to the sponsor or disposition of unused product. The Pennington Biomedical research pharmacy will store and dispense the investigational drug as specified by the sponsor and in accordance with applicable regulatory requirements.

Pennington Biomedical's research pharmacy may initiate or adjust drug therapy and/or order laboratory tests associated with a research protocol when requested to do so by the investigator. Any pharmacist participating in such a protocol must be trained and deemed competent to participate by the investigator or his/her designee). Specific details on the adjustment of drug



therapy or ordering of laboratory tests should be reviewed during the protocol initiation visit.

When Pennington Biomedical research pharmacy is the coordinating and control center for the research drug, the research pharmacy will store the returned dispensed investigational drug in a designated return area when a study protocol requires the subject to return the empty investigational drug container or any amount of the unused investigational drug. However, it is the responsibility of the investigator or investigator staff to deliver the returned dispensed investigational drug to research pharmacy when subjects leave the dispensed investigational drug in the outpatient clinic.

In coordinating the control of the research drug, the investigator will forward a copy of the complete research protocol, a copy of the investigator's drug brochure, research pharmacy manual, ordering procedures, any special storage, handling or preparation requirements, and any pertinent dispensing information to the research pharmacist.

A cost estimate should be obtained from research pharmacy during the initial stages of budget development. A pharmacy fee will be applied to all research involving investigational drugs. The research pharmacy will prepare a cost estimate of pharmacy fees after review of the above material.

- **Dispensing Controlled Substances:** controlled substances must be securely stored and must be dispensed by a duly licensed pharmacist.
- **Dispensing to Outpatients:** If a licensed investigator by the Louisiana Board of Pharmacy requests to have control of the investigational drug agent or biologic then the investigator must submit for IRB approval a plan for the distribution, storage, dispensing, accountability and destruction or return of drug at completion of the study for the investigational drug products).
  - **Drug Accountability Record** - The investigator must maintain records of the product's delivery to the study site, the inventory at the site, the use by each subject, and the return to the sponsor or alternative disposition of unused product. These records should include dates, quantities, batch/serial numbers, expiration dates, and the unique code numbers assigned to the investigational products) and trial subjects. The investigator should maintain records that document adequately that the subjects will provide the doses specified by the protocol and reconcile all investigational products) received from the sponsor. The investigational drug supply is subject to audit by the IRB.



In regard to the use by each subject, investigators should maintain drug accountability records that document adequately which subjects) received the drug; when the subjects) received the drug; the specific dosage the subjects) received; and any returned amount of the dispensed investigational drug.

- **Drug Storage** - Investigational products should be stored as specified by the Sponsor and in accordance with applicable regulatory requirements). Storage guidelines, include:
  - Storage area is large enough for the supply of study drug.
  - Storage area can be locked.
  - Investigational drug is stored separately from other compounds.
  - Non-dispensed drug is stored separately from returned dispensed drug.
    - If the study protocol requires the subject to return the empty investigational drug container or any amount of the unused investigational drug, it is the investigators responsibility to store the returned dispensed Investigational drug separately from the non-dispensed investigational drug.
    - It is the responsibility of the investigator to deliver the returned dispensed investigational drug to the research pharmacy if it is the coordinating and control center for the research drug.
  - Inventory control procedures are used.
  - Any environmental controls are maintained.
  - Access is limited to study staff.
  - Controlled substances are not allowed to be stored outside Pennington Biomedical Research Center research pharmacy.
- **Drug Labeling for Investigational Drugs** - The following labeling requirements are required for investigational new drugs:
  - The immediate package of an investigational new drug intended for human use shall bear a label with the statement, *Caution: New Drug – Limited by Federal or U.S. law to investigational use* (FDA 21 CFR §312.6).
  - The label or labeling of an investigational new drug shall not bear any statement that is false or misleading in any particular way and shall not represent that the investigational new drug is safe or effective for the purposes for which it is being investigated (FDA 21 CFR §312.6).
  - Participant Identifier



- Protocol number or name
- Strength of drug
- Dose
- Directions for use or administration
- Quantity dispensed
- **Drug Labeling for Drugs:** Louisiana rules and Pennington Biomedical Research Center require that all drugs dispensed shall contain a medication label with the following:
  - Pharmacy name, address and phone number
  - Prescription number
  - Name of prescriber
  - Patient's name
  - Date dispensed
  - Drug name and strength
  - Directions for use or administration
  - Pharmacist's name or initials
  - Auxiliary labels, if applicable
  - Indication that it is an investigational drug, if applicable
- **Drug Administration** – Investigational drugs shall be administered in accordance with any applicable federal or state laws and regulations and in accordance with any policies or procedures set forth by Pennington Biomedical Research Center. An informed consent document signed and dated by the subject and the investigator must be in place before administering the drug.

A person licensed within State of Louisiana and so authorized by their professional scope of practice shall administer an investigational drug to a subject. An investigator may designate the responsibility of administering the drug only after the designee has been given and has demonstrated an understanding of basic information about the drug according to the protocol. This education and delegation of responsibility must be documented.

Regulations & Guidelines: FDA 21 CFR §312.61

- The investigator shall report all unanticipated problem involving risks to subjects or others to the IRB according to the procedures outlined in section 8 and all protocol violations and protocol deviations see section 9.0 (FDA 21 CFR §312.64). For research involving investigational new drugs:



- The investigator is required to inform research pharmacy that the IRB has approved the protocol through submission of the IRB approval letters.
- The investigator must inform the IRB and pharmacy when a study involving investigational drugs has been terminated by the sponsor.
- The investigator will report to the sponsor any adverse effect that may reasonably be regarded as caused by, or probably caused by, the drug (21 CFR §312 (b)) according to the procedures in the protocol.
- The investigator will insure the investigational products are manufactured, handled and stored in accordance with applicable good manufacturing practice.
- Where allowed or required, the investigator may assign some or all duties for investigational articles accountability at the trial sites to an appropriate pharmacist or another appropriate individual who is under the supervision of the investigator.
- The investigator, pharmacist, or other designated individual will maintain records of the product's delivery to the trial site, the inventory at the site, the use by each participant, and the return to the sponsor or alternative disposition of unused products. These records will include dates, quantities, batch/serial numbers, expiration dates (if applicable), and the unique code numbers assigned to the investigational products and trial participants.
- Investigators should maintain records that document adequately that the participants are provided the doses specified by the protocol and reconcile all investigational products received from the sponsor.
- The investigator will maintain the following:
  - Current curriculum vitae CV)
  - Protocol
  - Records of receipt and disposition of drugs
  - List of any co-investigators with their CV
  - Certification that all physicians, dentists, physician's assistants, and/or nurses responsible in the study have appropriate valid licenses for the duration of the investigation, and
  - Emphasis is on toxicity and possible untoward happenings. All unexpected adverse effects are reportable; even if the investigator considers that the event is not related to the drug. All unexpected, serious adverse effects shall be reported immediately to the IRB in the manner defined by the protocol and this document.



- IRB letters of approval.
  - Other documents as outlined in the human subject protection program standard operating procedures.
- Investigator-sponsor or investigator-initiated studies – When an investigator files an IND or IDE, the investigator is considered the sponsor and as such is accountable for all of the FDA regulatory responsibilities and reporting obligations of both the PI and the sponsor, as described in the FDA regulations.

An individual or group of individuals or organization is considered a sponsor for an investigation if they hold the IND or IDE.

The research plan asks the investigator if he/she also acts as the sponsor of the research and, if so, asks him/her to affirm that he/she has reviewed and will comply with the regulatory responsibility of a sponsor.

The sponsors' or the investigator as a sponsor's responsibilities includes the following:

- Selecting qualified investigators
- Providing investigators with the information they need to conduct the investigation properly
- Ensuring proper monitoring of the investigation
- Ensuring that the FDA and for devices) any reviewing IRB or for drugs all participating investigators are promptly informed of significant new information about an investigation.

Additionally, if the IND or IDE product will be manufactured or produced at Pennington Biomedical Research Center, the PI must submit documentation that:

- The product preparation and manufacture meets the standards for current Good Manufacturing Practice (GMP), or any modification to those standards approved by the FDA in issuing the IND or IDE.
- The IND goes into effect 30 days after the FDA receives the IND, unless the sponsor receives earlier notice from the FDA.

The IRB will assist investigators holding an IND or IDE on the sponsor regulations and periodically conduct random audits of investigators holding an IND or IDE.

#### **7.4.2.2 IRB**

The IRB will review the research using the same criteria it would use in considering approval of any research involving an FDA-regulated product (FDA 21 CFR §56.111).



All test articles that are 1. dispensed by a pharmacist 2. administered in a capsule or in a tablet form will be reviewed by the convened board to ensure the safety of the product is reviewed by IRB members with appropriate expertise. Test articles include: drug, biological product for human use, medical device for human use and human food additives.

### **7.4.3 Expanded Access of Investigational Drugs**

FDA regulations allow certain individuals not enrolled in clinical trials to obtain expanded access to investigational drugs, agents, or biologics. Pennington Biomedical Research Center is not a treatment facility, due to these constraints; this institution will not take part in expanded access of investigational drugs.

### **7.4.4 Emergency Waiver of IND**

FDA regulations at 21 CFR §312.34, §312.35, and §312.36 address the need for an Investigational Drug to be used in an emergency situation that does not allow time for submission of an IND. Pennington Biomedical Research Center is not a treatment facility and does not treat patients in an emergency.

### **7.4.5 Waiver of Informed Consent for Planned Emergency Research**

Pennington Biomedical Research Center is a research facility, not a treatment facility; therefore a waiver of informed consent for planned emergency research will not apply to any research completed at this institution.

## ***7.5 Investigational Devices in Research***

### **7.5.1 Policy**

Use of an investigational device in a clinical trial to obtain safety and effectiveness data must be conducted according to FDA's IDE regulations found at 21 CFR §812 and other applicable FDA regulations.

The following procedures describe the use of investigational devices in research under the purview of the institution's IRB.

Regulations & Guidelines: FDA 21 CFR §812.00; 21 CFR §812.110; 21 CFR §812.140  
(a)



## 7.5.2 Definitions

**Adverse Device Effect or “ADE”:** is any adverse event or adverse effect caused by or associated with the use of a device that is unanticipated and has not been included in the protocol or the investigator’s brochure.

**Device:** is an instrument, apparatus, implement, machine, contrivance, implant, *in vitro* reagent, or other similar or related test article, including a component part, or accessory which is a) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in humans, or b) intended to affect the structure or any function of the body, and which does not achieve any of its primary intended purposes through chemical action within or on the body, and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.

**Investigational Device:** as defined by the FDA, an investigational device is a device that is the object of a clinical study designed to evaluate the safety or effectiveness of the device (21 CFR §812.3 (g)). Investigational devices include transitional devices (21 CFR §812.3 (r)) that are objects of investigations. However, for the purposes of this document, an investigational device may be an approved device that is being studied for an unapproved use or efficacy.

**Investigational Device Exemption (“IDE”):** is an FDA-approval of the application for an exemption that permits an unmarked device to be shipped for the purpose of doing research on the device (See 21 CFR §812.1 and §812.2 for the scope and applicability).

**Non-Significant Risk Device or NSR Device:** is an investigational device other than a significant risk device.

**Significant Risk Device “SR Device”:** is an investigational device that:

- Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a human subject;
- Is purported or represented to be for a use in supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a human subject;
- Is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health and presented a potential for serious risk to the health, safety, or welfare of a human subject;
- Otherwise presents a potential for serious risk to the health, safety, or welfare of a human subject.



### 7.5.3 IDE Requirements

The investigator must indicate on the initial IRB Application whether the research involves investigational drugs or devices. If so, the investigator must indicate if there is an IND/IDE for the research and provide documented assurance from the sponsor that the manufacture and formulation of investigational or unlicensed test articles conform to federal regulations. Documentation of the IND/IDE could be a:

- Industry sponsored protocol with IND/IDE;
- Letter from the FDA;
- Letter from industry sponsor

For investigational devices, NSR device studies follow abbreviated IDE requirements and do not have to have an IDE application approved by the FDA. If a sponsor has identified a study as non-significant risk, then the investigator must provide an explanation of the determination. If the FDA has determined that the study is non-significant risk, documentation of that determination must be provided.

If the research involves drugs or devices and there is no IND/IDE, the investigator must provide a rationale why it is not required.

The IRB staff will review the application and determine:

- Whether there is an IND/IDE and is so, whether there is appropriate supporting documentation; and
- If the research involves drugs or devices with no IND/IDE, and whether the research meets the criteria below.
- The IRB staff confirms the test article has an IDE or meets an exemption
- The IRB staff will confirm the IDE number is valid

### 7.5.4 Determination of the Safety and Effectiveness of a Device

The device fulfills the requirements for an abbreviated IDE.

- The device is not a banned device.
- The sponsor labels the device in accordance with 21 CFR 812.5.
- The sponsor obtains IRB approval of the investigation after presenting the reviewing IRB with a brief explanation of why the device is not a significant risk device, and maintains such approval.
- The sponsor ensures that each investigator participating in an investigation of the device obtains from each subject under the investigator's care, consent under 21 CFR 50 and documents it, unless documentation is waived.



- The sponsor complies with the requirements of 21 CFR 812.46 with respect to monitoring investigations;
- The sponsor maintains the records required under 21 CFR 812.140(b) (4) and (5) and makes the reports required under 21 CFR 812.150(b) (1) through (3) and (5) through (10);
- The sponsor ensures that participating investigators maintain the records required by 21 CFR 812.140(a)(3)(i) and make the reports required under 812.150(a) (1), (2), (5), and (7); and
- The sponsor complies with the prohibitions in 21 CFR 812.7 against promotion and other practices.

### 7.5.5 Exempted IDE Investigations

For devices, an IDE is not necessary if:

- The research involves a device, other than a transitional device, in commercial distribution immediately before May 28, 1976, when used or investigated in accordance with the indications in labeling in effect at that time;
- The research involves a device other than a transitional device, introduced into commercial distribution on or after May 28, 1976, that FDA has determined to be substantially equivalent to a device in commercial distribution immediately before May 28, 1976, and that is used or investigated in accordance with the indications in the labeling FDA reviewed under subpart E of 21 CFR §807 in determining substantial equivalence;
- The research involves a diagnostic device, if the sponsor complies with applicable requirements in 21 CFR §809.10 (c) and if the testing:
  - Is noninvasive;
  - Does not require an invasive sampling procedure that presents significant risk;
  - Does not by design or intention introduce energy into a subject; and
  - Is not used as a diagnostic procedure without confirmation of the diagnosis by another, medically established diagnostic product or procedure;
- The research involves a device undergoing consumer preference testing, testing of a modification, or testing of a combination of two or more devices in commercial distribution, if the testing is not for the purpose of determining safety or effectiveness and does not put subjects at risk;
- The research involves a device intended solely for veterinary use;
- The research involves a device shipped solely for research on/or with laboratory animals and labeled in accordance with 21 CFR §812.5 (c); and/or



- The research involves a custom device as defined in 21 CFR §812.3 (b), unless the device is being used to determine safety or effectiveness for commercial distribution.

## 7.5.5 Responsibilities

### 7.5.5.1 Principal Investigator

The Investigator is responsible for ensuring that the research is conducted according to all regulatory guidelines, this document, and institutional policies and procedures. The investigator must obtain approval from the IRB before initiating any research activities or enrolling any subjects in the research.

The investigator proposing the device research will be required to provide a plan to be evaluated by the IRB that includes storage, security, and dispensing of the device. Elements of a sound control plan include the following:

- **Storage:** All devices received for a study must be stored in a locked environment under secure control with limited access. The area must be within an area of PI's control. Proper instructions on the use of the device must be provided to the subjects. A log must be kept regarding the receipt, use, and/or dispensing of the device and the disposition of remaining devices at the conclusion of the investigation.
- **Reporting:** The PI shall report all unanticipated problems involving risk to subjects or others to the IRB according to the procedures outlined in Section 8.
- **New Device Requirements:** For research involving investigational new drugs:
  - If a device is considered a NSR device by the PI or sponsor, but after review the IRB determines the device to have significant risk, upon receipt of written notice the PI is responsible for notifying the sponsor of the IRB's determination. The PI must provide the IRB with confirmation of this action.
  - If the PI is storing the devices, he/she must maintain a log indicating the identification/serial number of the device, name of subject, date dispensed, by whom it was dispensed, and amount remaining.
  - The PI will maintain the following:
    - Current curriculum vitae CV;
    - Protocol of the study;
    - Records of receipt and disposition of devices;
    - List of any co-investigators with their CV;



- Certification that all physicians, dentists, and/or nurses responsible in the study have appropriate valid licenses for the duration of the investigation;
- Case histories with particular documentation on evidence of effects. Emphasis is on safety and possible untoward happenings. All adverse device effects are reportable;
- IRB letters of approval.
- Device training; and
- Other documents as outlined in the Human Subject Protection Program Standard Operating Procedures.
- 

***Logs:***

- The device accountability log must be completed regarding the receipt, use and/or dispensing of the device and the disposition of remaining devices at the conclusion of the investigation; and
- After use, the investigator must maintain a log regarding the receipt, use and/or re-dispensing of the device and the disposition of remaining devices at the conclusion of the investigation
- ***Reporting:*** The investigator will submit to the sponsor and to the IRB a report of any unanticipated adverse device effect occurring during an investigation as soon as possible, but in no event later than 10 working days after the investigator first learns of the effect;
- ***Investigator-Sponsor or Investigator-Initiated Studies:*** When a PI files an IND or IDE; the PI is considered the sponsor and as such is accountable for all of the FDA regulatory responsibilities and reporting obligations of both the PI and the Sponsor, as described in the FDA regulations.

An individual or group of individuals or medical center is considered a sponsor for an investigation if they hold the IND or IDE. At Pennington Biomedical these studies are typically called “investigator initiated studies” when they involve the use an investigational drug or device or use an approved drug or device for investigational purposes.

The research plan asks the PI if he/she also acts as the sponsor of the research and, if so, asks him/her to *affirm* that he/she has reviewed the **Guidance Document on Requirements of Un-sponsored/Investigator-Initiated Research** and will comply with the regulatory responsibilities of a sponsor.



The sponsors' or the investigator as a sponsor's responsibilities includes the following:

- Selecting qualified Investigators;
- Providing Investigators with the information they need to conduct the investigation properly;
- Ensuring proper monitoring of the investigation; and
- Ensuring that the FDA and for devices) any reviewing IRBs) or for drugs) all participating investigators are promptly informed of significant new information about an investigation.

Additionally, if the IND or IDE product will be manufactured or produced at Pennington Biomedical Research Center, the PI must submit documentation that: The product preparation and manufacture meets the standards for current Good Manufacturing Practice GMP), or any modification to those standards approved by the FDA in issuing the IND or IDE.

The GMP plan has been approved by the applicable institutional official. The GMP plan has been reviewed and accepted by LSU's Risk Management and Compliance Office. The IRB will assist investigators holding an IND or IDE on the sponsor regulations and periodically conduct random audits of PIs holding an IND or IDE as part of ongoing research compliance efforts.

#### **7.5.5.2 IRB**

The IRB will review the research involving investigational devices in accordance with the following requirements and the same criteria it would use in considering approval of any research involving an FDA-regulated product (21 CFR §56.111).

- Control plan;
- Unless the FDA has already made a risk determination for the study, the IRB will review NSR Device studies and determine if the device represents significant or non-significant risk and report the findings to the PI in writing. The IRB will consider the risks and benefits of the medical device compared to the risks and benefits of alternative devices or procedures. NSR Device studies do not require submission of an IDE application but must be conducted in accordance with the abbreviated requirements of IDE regulations. If the study that has been submitted as non-significant risk is considered SR, the IRB may approve the study, but the study cannot begin until an IDE is obtained;
- The IRB will not review protocols involving SR devices under expedited review;



- The IRB determines whether or not the device is a significant risk device.
- The IRB will document in the minutes and provide written documentation to the PI of the rationale for determining whether a device is classified as NSR device/SR device; and
- If the FDA has already made the SR device or NSR device determination for the study, the agency's determination is final and the IRB does not need to make a risk determination.
- If the IRB makes a NSR determination, the IRB will confirm whether the test article met the requirements for an abbreviated IDE

#### **7.5.6 Emergency Use of Unapproved Medical Devices**

An unapproved medical device is defined as a device that is used for a purpose or condition for which the device requires, but does not have, an approved application for pre-market approval under section 515 of the FDA Act (21 U.S.C. 360 (e)). Pennington Biomedical Research Center is not a treatment facility; this institution does not conduct the emergency use of unapproved medical devices.

#### **7.5.7 Humanitarian Use Devices HUD)**

Pennington Biomedical Research Center is not a treatment facility; this institution does not conduct research using humanitarian use devices.



## 8.0 Unanticipated Problems Involving Risks to Subjects or Others

### 8.1 Policy

Pennington Biomedical Research Center complies with DHHS and FDA regulations which state that institutions must have written policies on reporting unanticipated problems involving risks to subjects or others (as defined below) to the IRB, institutional officials and relevant federal agencies and departments.

The following procedures describe how unanticipated problems involving risk to subjects or others are handled in research under the purview of the Pennington Biomedical Research Center IRB.

### 8.2 Definitions

**Adverse Event:** is any untoward physical or psychological occurrence in a human subject participating in research, including any abnormal sign (e.g., abnormal physical exam or laboratory finding, symptoms or disease associated with the research or the use of a medical investigational test article), symptom, or disease, temporally associated with the subject's participation in the research. An adverse event does not necessarily have to have a causal relationship with the research, or any risk associated with the research or the research intervention, or the assessment.

**Serious Adverse Event:** An adverse event that is fatal or life-threatening, permanently disabling, requires or prolongs hospitalization or results in significant disability, congenital anomaly or birth defect.

**Unexpected Adverse Event:** means the incident, experience or outcome is not expected (in terms of nature, severity, or frequency) given the research procedures that are described in the protocol-related documents, such as the IRB approved research protocol and informed consent documents; and the characteristics of the subject population being studied;

**Others:** means individuals other than research participants (e.g., investigators, research assistants, students, the public, etc.).

**Related (or "Possibly Related"):** means that there is a reasonable possibility that the event, incident, experience or outcome may have been caused by the procedures involved in the research, underlying disease, disorder, or condition of the subject, or other circumstances unrelated to either the research or any underlying disease, disorder, or condition of the subject. OHRP 7/15/2007 Guidelines



**Unrelated:** Unassociated or without a timely relationship; evidence exists that an outcome is definitely related to a cause other than the event in questions.

**Unanticipated Problem Involving Risks to Participants or Others:** means any incident, experience, outcome, or new information where all three elements exist:

- Is unexpected;
- Is related or possibly related to participation in the research, and
- Indicates that subjects or others are at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

**Unanticipated Adverse Device Effect:** Any serious adverse effect on health or safety or any life-threatening problem or death caused by (or associated with) a device, if that effect, problem or death was not previously identified in nature, severity or degree of incidence in the investigational plan or application; any other unanticipated, serious problem associated with a device that relates to the rights, safety or welfare of subjects.

## 8.3 Procedures

### 8.3.1 Reporting

All adverse events must be reported to the sponsor. Federal guidelines do not require reporting adverse events to IRBs. They do require that Unanticipated Problems Involving Risks to Subjects or Others [21 CFR 56.108(b)] and Unanticipated Adverse Device Events [21 CFR 812.150(a)(1)] be reported to the IRB [45 CFR 46.103(b)(5)].

Some adverse events qualify as unanticipated problems that must be reported to the IRB; however, most adverse events do not. When Unanticipated Problems Involving Risks to Subjects or Others or Unanticipated Adverse Device Events are reported to the IRB, and the IRB agrees that they fall into these categories, then the IRB notifies the institution about these events, and the institution notifies FDA and OHRP (as applicable) that these unanticipated problems have occurred when the studies are under their oversight.

Generally, an analysis of adverse event(s) that are an increased risk of harm, related, and unexpected (all three) is the basis for concluding there is an unanticipated problem. These unanticipated problems must be reported to the IRB and usually require some change in the study (revised consent, protocol, or investigational brochure; stopping enrollment; terminating an arm of the study; etc.). These types of analyses are often done by Data Monitoring Committees or similar groups set up by the sponsor.



### 8.3.2 Problems to Report to the IRB

The following events may represent unanticipated problems involving risks to subjects or others and should be promptly reported to the IRB.

- Adverse device effects that are unanticipated
- Adverse events or injuries that are an increased risk of harm, unexpected and related
- Breach of confidentiality involving risks
- Data and Safety Monitoring Board (DSMB) report, interim analysis, or other oversight committee/monitoring report (Report information altering the risk/benefit profile.)
- Event requiring prompt reporting (Report only when required by the protocol, sponsor, or funding agency.)
- New information (Report information indicating an unexpected change in risks or potential benefits, e.g., literature/scientific report or other published finding.)
- Subject complaint (complaints indicating unanticipated risks or those that cannot be resolved by the research staff.)
- Unapproved change made to the research to eliminate an apparent immediate hazard
- Expected adverse events that have an unexpected increase in incidence or severity.
- Adverse events that involve new or increased risks.
- Other problem or finding (e.g., loss of study data, a subject becomes a prisoner while participating in research)
- New information that may affect adversely the safety of the participants or the conduct of the clinical trial. Any changes significantly affecting the conduct of the clinical trial or increasing the risk to participants.

Both internal events and external events that may represent unanticipated problems involving risks to subjects or others should be promptly reported.

### 8.3.3 Local SAEs vs. External (non-local) SAEs / Medwatch Safety Reports

To maximize subject protection, when local adverse events occur that are in the judgment of the investigator related + unexpected + increased risk of harm, these should be reported along with the investigator opinion/analysis of whether this rises to the level of an unanticipated problem involving risks to subjects or others, and what if anything should change in the study.



To avoid taking valuable time away from more useful subject protection activities, do not report external adverse events unless there has been an analysis or a judgment made that a particular adverse event or events that are related + unexpected + increased risk of harm have created a signal that has been determined to be an unanticipated problem involving risks to subjects or others. Generally this will mean that something changes in the study (consent form, protocol, investigator brochure, stop enrollment, one arm will be closed, etc.). This type of analysis is usually done by the sponsor or a Data Monitoring Committee. The local Principal Investigator will rarely have enough data or a denominator to make appropriate conclusions whether there is a signal that rises to the level of an unanticipated problem involving risks to subjects or others.

#### **8.3.4 Events Not Requiring Prompt Reporting**

Potential risks and adverse events that may be reasonably anticipated (i.e., “expected”) should be described in the informed consent form.

Potential risks and adverse events that may be reasonably anticipated (i.e., “expected”) do not require prompt reporting to the IRB by investigators and/or research staff. Below are other examples of events that do not require prompt reporting:

- Adverse device effects that are not an increased risk of harm, anticipated, or unrelated
- Adverse events or injuries that are not an increased risk of harm, expected, or unrelated
- Deaths not attributed to the research, e.g., from “natural causes,” accidents, or underlying disease and the investigator has ruled out any connection between the study procedures and the participant’s death
- DSMB reports; interim analyses; or other reports, findings, or new information not altering the risk/benefit profile
- Subject complaints that were resolved or complaints not involving risks
- Problems or findings not involving risk (unless the investigator or research staff member believes the information could affect participants’ willingness to continue in the research).

Related internal and external events involving risk but not meeting the prompt reporting requirements should be reported to the IRB in summary form at the time of continuing review. In lieu of a summary of external events, a current DSMB report can be submitted for research subject to oversight by a DSMB (or other monitoring entity).

External events that do not meet the reporting requirements (e.g., not related or not involving risk) and that are not relevant to the protection of participants at Pennington



Biomedical Research Center should not be reported. Investigators should retain copies of all individual event reports on file.

#### ***8.4 Time Frame for Reporting Unanticipated Problems Involving Risks to Subjects or Others***

These should be reported within 10 working days of the Principal Investigator or research staff becoming aware of the unanticipated problem. Most often an analysis is required of multiple adverse events to determine there is a signal that is an unanticipated problem for the study. The 10 working days timer starts when the analysis or determination is made that there is an unanticipated problem, which may be more than 10 days past the adverse events that are some of the data points used in determining there is an unanticipated problem involving risks to subjects or others.

In device studies, the unanticipated adverse device event (UADE) evaluation by the sponsor must be reported by the sponsor to the IRB within 10 working days after the sponsor first receives notice of the UADE. If the UADE occurred at Pennington Biomedical Research Center, the investigator must report it to the IRB and the sponsor within 10 working days.

Events resulting in temporary or permanent interruption of study activities by the investigator or sponsor to avoid potential harm to subjects should be reported within 48 hours when possible.

#### ***8.5 Review Process***

##### ***8.5.1 Expedited Review***

Event reports and accompanying information will be forwarded by IRB staff members to the IRB Chair or one of the experienced members with relevant expertise designated by the Chair for expedited review. Reviewers will have access to the complete protocol file, including previously reported events, for review. The Chair or designee will determine if the report raises new concerns about risks and will recommend further review by the convened IRB, as necessary, for a final determination. The IRB Chair may suspend or terminate approval of an investigator's research if necessary to assure the protection of research participants. The Chair will consider the rights and welfare of participants when suspending, terminating, or modifying research. If an unanticipated problem involving no more than a minimal risk to participants, the IRB Chair or designee will review the unanticipated problem, document the unanticipated problem and send the investigator an acknowledgement letter. The convened IRB will be notified at the next IRB meeting via the expedited report in the agenda and minutes.



### 8.5.2 Convened Review

Reports of events determined during screening or expedited IRB review to represent possible unanticipated problems involving risks to subjects or others will be forwarded to the IRB for convened review. Modifications proposed by the investigator or IRB reviewer that represent more than minor changes will also be reviewed by the convened IRB. The Chair or other member with relevant expertise will serve as the primary reviewer. Copies of the reports, all other information provided by the investigator, and current consent documents (or verbal scripts) with any proposed changes will be included in the review materials for each IRB member. Sections from the protocol, previous event reports and other relevant information or reference materials will also be included, as applicable. The complete protocol file will be available to any IRB member upon request prior to or during the convened IRB meeting.

The IRB will determine by convened review whether the event is an unanticipated problem involving risks to subjects or others and if further action is necessary. Action(s) will be based on the nature of the event, degree to which research participants are placed at risk, occurrence of previous problems, etc. The IRB will consider the rights and welfare of participants when suspending, terminating, or modifying research.

### 8.6 IRB Actions

1. If the IRB finds that the event is not an unanticipated problem, according to the definition in the policy, the IRB may recommend any of the following actions:
  - No action
  - Requiring modifications to the protocol
  - Revising the continuing review timetable
  - Modifying the consent process
  - Modifying the consent document
  - Providing additional information to current participants (e.g. whenever the information may relate to the participant's willingness to continue participation)
  - Providing additional information to past participants
  - Requiring additional training of the investigator and/or study staff
  - Other actions appropriate for the local context
2. If the IRB finds that the event is an unanticipated problem, according to the definition in the policy, the IRB may recommend any of the following actions:
  - Requiring modifications to the protocol



- Revising the continuing review timetable
  - Modifying the consent process
  - Modifying the consent document
  - Providing additional information to current participants (e.g. whenever the information may relate to the participant's willingness to continue participation)
  - Providing additional information to past participants
  - Requiring additional training of the investigator and/or study staff
  - Reconsidering approval
  - Requirement that current participants re-consent to participation
  - Monitoring of the research
  - Monitoring of the consent
  - Referral to other organizational entities
  - Suspending the research
  - Terminating the research
  - Other actions appropriate for the local context
3. If a report suggests that participant safety is at risk, the IRB may immediately suspend or terminate the research. Any suspension or termination of research by the IRB must be promptly reported to OHRP and FDA (if FDA-regulated research). This should be done in writing.
4. If, after reviewing a report, the IRB finds that the event is an unanticipated problem or that suspension or termination of approval is warranted, the IRB will within 14 days of the determination:
- Notify the investigator in writing of its findings.
  - Report its findings and recommendations to the institutional official for further reporting to the appropriate federal officials (e.g., OHRP or FDA).



## **9.0 Protocol Deviations**

### ***9.1 Planned Changes to Research Protocol***

With regard to planned changes to a research protocol, the most common occurs through the submission of a modification. Examples include an increase in subject number, changes in investigators or key personnel, a change to the funding source, changes in procedures and revised consent documents. These all involve planned changes through an amended protocol and are not protocol deviations themselves (although they may result from a protocol deviation).

Another type of planned change to a protocol is a change made to eliminate apparent immediate harm to a subject. This type of change can be initiated without prior IRB approval, provided that subsequent IRB approval is obtained.

### ***9.2 Unplanned Changes to Research Protocol***

The next category involves unplanned changes to a research protocol not otherwise approved by the IRB. Such unplanned changes are protocol deviations.

### ***9.3 Protocol Deviations***

A protocol deviation is any change or alteration from the procedures stated in the study protocol, consent document, recruitment process, and/or study materials (e.g. questionnaires) approved by the IRB. Protocol deviation is a general term and includes changes made to avoid immediate harm to subjects and protocol violations. [45 CFR §46.103 (b) (4) (iii), 21 CFR §56.108 (a) (4)]. Protocol deviations can be either major or minor. Protocol deviations can be considered either non-serious or serious non-compliance. See Policy 10.0 – Non-Compliance.

Repeated failure by an investigator to not report protocol deviations may be viewed as non-compliance with the federal regulations, the guidelines that govern ethical conduct of research and Pennington Biomedical Research Center IRB.

### ***9.4 Protocol Violation***

The Common Rule and the FDA regulations do not define this term. For the purpose of this policy a violation will be referred to as a deviation.



## ***9.5 Participant Initiated Deviations and Investigator Initiated Deviations***

### **9.5.1 Participant Initiated Deviations**

Participant initiated deviations are due to a study participant's non-adherence to the protocol. Participant initiated deviations can be considered major or minor deviations depending on whether the event impacts safety. Participant initiated deviations only need to be reported to the IRB if the event impacts participant safety, or if a pattern of protocol departure indicates a need for a change in the protocol or informed consent documents. This is left to the investigator's discretion. Regardless of whether the deviation is considered major or minor the deviation should be recorded in the participant record. See 9.6 and 9.7 for specific reporting time frame.

### **9.5.2 Investigator Initiated Deviations**

Investigator initiated deviations are the result of the investigator, research staff or other party involved in the conduct of the research intentionally or unintentionally deviating from the approved protocol. Investigator initiated deviations can be considered major or minor depending on whether the deviation has an impact on subject safety, may alter the risks to subjects or may affect the participant's willingness to participate in the study. All investigator initiated deviations should be reported to the IRB. See 9.6 and 9.7 for specific reporting time frame.

## ***9.6 Major Protocol Deviation***

A major protocol deviation is a deviation that has an impact on subject safety, may substantially alter risks to subjects, may have an effect on the integrity of the study data, or may affect the subject's willingness to participate in the study. Major protocol deviations can vary in the degree of seriousness according to how the changes impact subject safety, the degree of non-compliance with federal regulations, state laws, the Pennington Biomedical Research Center's IRB and the degree of foreknowledge of the event.

### **9.6.1 Reporting Time Frame of Major Protocol Deviation**

All major protocol deviations, no matter whether participant initiated or investigator initiated, must be reported by the investigator to the IRB within seven (7) working days of learning of the deviation. If it is necessary to make a permanent change to the study procedures in order to avoid harm to other subjects, then a protocol modification should be submitted as soon as possible by the investigator. If appropriate to maintain safety of the subjects, new subject



enrollment should be temporarily stopped by the investigator until the modification is approved.

No matter who discovers a major protocol deviation (e.g., sponsor or their agent during a monitoring visit), the investigator is responsible for reporting it to the IRB.

## **9.7 Minor Protocol Deviation**

A minor protocol deviation is one that does not impact subject safety, compromise the integrity of the study data, or affect the subject's willingness to participate in the study.

### **9.7.1 Reporting Time Frame of Investigator-Initiated Minor Protocol Deviations**

A minor investigator initiated deviation should be reported to the IRB not more than fourteen (14) working days after the PI first learns of the event.

### **9.7.2 Reporting Time Frame of Participant-Initiated Minor Protocol Deviations**

A minor participant initiated deviation does not need to be reported; however, the participant record should have a record of the deviation.

## **9.8 IRB Review Process**

### **9.8.1 Protocol Deviations**

The IRB Chair or designee will review all the deviation and determine whether it should be reviewed via expedited or requires convened IRB review. All major protocol deviations should be summarized in the appropriate section of the continuing review form.

Each protocol deviation reported to the IRB should discuss what measures have been put in place to prevent future re-occurrences of the same event. The investigator should also evaluate protocol deviations for any trends or patterns that would require additional corrective actions or submission of a protocol modification to prevent future. Repeated deviations of a similar nature may be a clear indication that a permanent change (i.e. a modification) to the study procedures is necessary.

All protocol deviations should be reported to the research sponsor or funding agency in a timely fashion and according to that company's or agency's policy.



### 9.8.2 Full Board Review of Deviations

For protocol deviations that require fully convened IRB review, the assigned IRB reviewer will document the determinations and outcomes. The determinations and outcomes will be reported on the IRB minutes. The potential determinations are as follows:

- No further action is required.
- Request additional information.
- The deviation appears to be serious or continuing non-compliance may be involved.
- The report represents an unanticipated problem involving risks to participants or others
- Suspend IRB approval of the research
- Other (e.g., modify the protocol, observe informed consent process, alter continuing review timeline, require additional training of investigators). The reviewer must specify the action and document the determination.

For Federal reporting purposes the IRB will need to determine whether the protocol deviation constitutes an instance of serious or continuing non-compliance. If the protocol deviation is an event involving a change in the protocol to eliminate immediate hazard or harm to subjects, the IRB should ensure that the event was reported in the required 7-day period. Also, the IRB should make certain that the investigator implemented appropriate measures to alleviate or eliminate the harm to current and future subjects in the research.

The fully convened IRB discusses the event at the convened meeting and the IRB meeting minutes document the discussion and final determination of the convened IRB regarding the protocol deviation. The documentation of review is placed in the IRB protocol file. Once a determination is made by the IRB, the investigator will receive a notification of determination from the IRB.

Pennington Biomedical Research Center investigators are not required to report protocol deviations to the IRB that occur at other research sites in multi-center research trials. The investigator may have other reporting requirements such as reporting to Institutional Biosafety Committee, and/or other appropriate institutional entities that are not covered in this policy.

### 9.8.3 Expedited Review of Protocol Deviations

If the deviation qualifies for an expedited review, the IRB Chair or designated reviewer will document their determination and the determination/outcome will be documented on the expedited review portion of the IRB minutes. The possible determinations the



IRB Chair or designee reviewer may make about the event through expedited review are as follows:

- Acknowledged - no further information or action required
- Additional information required – additional information is needed in order to appropriately evaluate the event or changes to the research that are minor in nature are being required based upon the event;
- Refer for full board review – the IRB Chair or designated reviewer may determine the event is not eligible for expedited review.
- The deviation appears to be serious or continuing non-compliance may be involved.
- The report represents an unanticipated problem involving risks to participants or others

Additional information or materials may also be requested. If there are safety issues or concerns related to the event, the IRB may make additional determinations as described below for convened review:

- Suspend IRB approval of the research; and refer events or concerns regarding the research for non-compliance (see 10.0 – Complaints and Non-Compliance) for review of non-compliance.



## 9.9 Examples of Deviations

### Participant-Initiated Deviations

This list of examples is intended as a guide and is not exhaustive.

<b>Major Participant Initiated Deviations Examples</b>	<b>Minor Participant Initiated Deviations Examples</b>
<ul style="list-style-type: none"><li>• Participant discontinued study meds</li><li>• Participant misses visits involving study drug</li><li>• Participant did not disclose metal and had MRI</li></ul>	<ul style="list-style-type: none"><li>• Participant misses visits due to following:<ul style="list-style-type: none"><li>○ Inclement weather</li><li>○ Employment change</li><li>○ Rescheduling for other reasons that do not involve safety and do not compromise the integrity of the data</li><li>○ Procedures not completed at participant's request</li></ul></li><li>• Testing outside of protocol timeframe due to the following:<ul style="list-style-type: none"><li>○ Inclement weather</li><li>○ Time and burden</li><li>○ Rescheduling for other reasons that do not involve safety and do not compromise the integrity of the data</li></ul></li></ul>



## Investigator-Initiated Deviations

This list of examples is intended as a guide and is not exhaustive.

<b>Major Investigator Initiated Deviations Examples</b>	<b>Minor Investigator Initiated Deviations Examples</b>
<ul style="list-style-type: none"> <li>• There should be no deviation from inclusion/exclusion criteria.</li> <li>• Breach of human participants protection regulations               <ul style="list-style-type: none"> <li>○ Failure to obtain informed consent prior to initiation of study –related procedures</li> <li>○ Inadequate or improper informed consent procedures (including no documentation of informed consent process)</li> <li>○ Performing tests or procedures beyond those anticipated in the protocol unless performed to rule out a medical condition</li> <li>○ Falsifying research or medical records</li> <li>○ Working under an expired professional license or certification</li> <li>○ Breach of confidentiality/privacy</li> <li>○ Inappropriate destruction of study records</li> <li>○ Failure to report a serious adverse event to the IRB and/or sponsor</li> <li>○ Enrollment of a participant after IRB-approval of study has expired</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Missing original signed and dated consent form (only a photocopy available)</li> <li>• Outdated/expired consent form, as long as there has been no impact on participant safety</li> <li>• Missing pages from executed consent form</li> <li>• Failure to follow the approved study procedure, that in the opinion of the Principal Investigator, does not affect the participant safety or data integrity:               <ul style="list-style-type: none"> <li>○ Study procedures conducted out of sequence</li> <li>○ Omitting an IRB approved research activity on a protocol (e.g. mailing out or collecting QOL surveys, evaluating or documenting performance status), unless the omission could affect safety</li> <li>○ Failure to perform a required lab test that does not affect participant safety.</li> </ul> </li> </ul>



## 10.0 Complaints and Non-compliance

### 10.1 Policy

As part of its commitment to protecting the rights and welfare of human subjects in research, Pennington Biomedical Research Center reviews all complaints and allegations of non-compliance and takes any necessary action to ensure the ethical conduct of research.

All investigators and other study personnel involved in human subject's research are required to comply with all laws and regulations governing their research activities, as well as with requirements and determinations of the IRB.

The following procedures describe how complaints and allegations of non-compliance are handled by the IRB. In cases where serious non-compliance or continuing non-compliance has occurred, the IRB may exercise its authority to monitor, suspend, or terminate the research.

Regulations & Guidance: DHHS 45 CFR §46.103(b)(5)(i); 45 CFR §46.116(b)(5); FDA 21 CFR §50.25(b)(5); 21 CFR §56.108(b)(2); OHRP Guidance on Reporting Incidents to OHRP.

### 10.2 Definitions

**Allegation of non-compliance:** is defined as an unproved assertion of non-compliance.

**Continuing non-compliance:** is defined as a pattern of non-compliance that, in the judgment of the convened IRB, suggests a likelihood that instances of non-compliance will continue without intervention. Continuing non-compliance also includes failure to respond to a request to resolve an episode of non-compliance.

**Finding of non-compliance:** is an allegation of non-compliance that is proven true or a report of non-compliance that is clearly true. (e.g., a finding on an audit of an unsigned consent document, or an admission of an investigator that the protocol was willfully not followed would represent reports of non-compliance that would require no further action to determine their truth and would therefore represent findings of non-compliance.)

**Non-compliance:** is a failure to comply with any of the regulations and policies described in this document and failure to follow the determinations of the IRB. Non-compliance may be minor or sporadic or it may be serious or continuing.



**Non-serious or minor noncompliance:** Noncompliance that does not increase risk to research participants, compromise participants' rights or welfare, or affect the integrity of the research/data or the human research protection program. Examples of minor noncompliance may include, but are not limited to the following: lapses in continuing IRB approval, failure to obtain exempt determination before exempt research involving human subjects is conducted, minor changes in or deviations from an approved protocol, or administrative errors.

**Serious non-compliance:** is the failure to follow any of the regulations and policies described in these SOPs or failure to follow the determinations of the IRB and which, in the judgment of the convened IRB, increases risks to participants, decreases potential benefits, or compromises the integrity of the Human Research Protections Plan. Research being conducted without prior IRB approval is considered serious non-compliance.

Regulations and Guidance: OHRP Guidance on Reporting Incidents to OHRP.

### **10.3 Complaints**

The HRPP Director will promptly handle (or delegate staff to handle), and, if necessary, investigate all complaints, concerns, and appeals received by the IRB. This includes complaints, concerns, and appeals from investigators, research participants and others.

All complaints, written or verbal (including telephone complaints), and regardless of point of origin and funding source are recorded by IRB staff and forwarded to the IRB Chair.

Upon receipt of the complaint, the IRB Chair will make a preliminary assessment whether the complaint warrants immediate suspension of the research project. If a suspension is warranted, the procedures in section 3.11 - Study Suspension, Termination and Investigator Hold will be followed.

If the complaint meets the definition of Non-Compliance, it will be considered an allegation of non-compliance according to section 10.4 – Non-Compliance.

If the complaint meets the definition of an unanticipated problem, it will be handled according to section 8.1- Unanticipated Problems Involving Risks to Subjects or Others.

Within 10 business days of receipt of the complaint, the IRB Chair shall generate a letter to acknowledge that the complaint has been received and is being investigated to the party that reported the incident, if a follow-up contact name is provided.



## **10.4 Non-Compliance**

Investigators and their study staff are required to report instances of possible non-compliance. The investigator is responsible for reporting any possible non-compliance by study personnel to the IRB. Common reports to the IRB that are serious or continuing are typically protocol deviations/violations. However, any individual or employee may report observed or apparent instances of non-compliance to the IRB. In such cases, the reporting party is responsible for making these reports in good faith, maintaining confidentiality and cooperating with any IRB and/or institutional review of these reports. Pennington Biomedical will take reasonable steps to protect persons who file reports in good faith from retaliatory actions based on such filing, in accordance with federal, state and local law.

If an individual, whether investigator, study staff or other, is uncertain whether there is cause to report non-compliance, he or she may contact the IRB Chair (or designee) or IRB Staff directly to discuss the situation informally.

Reports of non-compliance must be submitted to the IRB office within 10 working days of discovery of this non-compliance. The report must include a complete description of the non-compliance and the personnel involved.

Regulations & Guidance: FDA 21 CFR §56.108(b).

### **10.4.1 Review of Allegations of Non-Compliance**

All allegations of non-compliance will be reviewed by the IRB Staff for completeness. The IHRPP Director will assign a primary reviewer, who will review:

1. All documents relevant to the allegation
2. The last approval letter from the IRB
3. The last approved IRB application and protocol;
4. The last approved consent document
5. The grant, if applicable; and
6. Any other pertinent information (e.g., questionnaires, DSMB reports, etc.).

The primary reviewer will review the allegation within 10 working days and make a recommendation following the review as to the truthfulness of the allegation (unless additional time is granted to conduct the review by the IRB Chair or HRPP Director).

When a recommendation of non-compliance is made because the incident was within the limits of an approved protocol for the research involved, the determination is reported by the IRB in writing to the investigator following the review and, if applicable, the reporting party.



If in the judgment of the reviewer, any allegation or findings of non-compliance is considered true, the non-compliance will be processed according to section 10.4.2 – Review of Findings of Non-Compliance.

If in the judgment of the IRB, any allegation or findings of non-compliance warrants suspension of the research before completion of any review or investigation to ensure protection of the rights and welfare of participants, the IRB Chair (or designee) may suspend the research as described in section 3.11- Study Suspension, Termination and Investigator Hold with subsequent review by the IRB.

The HRPP Director, IRB Chair (or designee) may determine that additional expertise or assistance is required to make these determinations and may form a sub-committee to assist with the review and fact gathering process. See 10.4.3 – Subcommittee Procedures.

## **10.4.2 Review of Findings of Non-Compliance**

### ***10.4.2.1 Non-compliance is Not Serious or Continuing***

When the IRB determines that non-compliance occurred, but the non-compliance does not meet definition of serious non-compliance or continuing non-compliance, the determination is reported in writing to the investigator and if applicable the reporting party. The investigator will develop a corrective action plan to prevent future non-compliance, which will be reviewed by the IRB to confirm it's adequate. The report of non-compliance and corrective action is reported to the IRB and reflected in the IRB minutes. If however, the investigator refuses to cooperate with the corrective action plan, the matter is referred to a convened meeting of the IRB with notification to the Institutional Official.

### ***10.4.2.2 Serious Non-Compliance or Continuing Non-Compliance***

When the IRB Chair (or designee) determines that non-compliance has occurred and that the non-compliance meets the definition of serious non-compliance or continuing non-compliance, the report of non-compliance is referred for review by the IRB at the next convened available meeting. However, the HRPP Director with the support of the IRB Chair (or designee) may use discretion and call an emergency IRB meeting should the circumstances warrant such an urgent meeting or determine the non-compliance needs further review by the sub-committee.

Examples of serious non-compliance may include the following, but are not limited to: falsifying IRB documents; conducting human subject's research



without IRB approval; deviating from the IRB approved protocol or consent process; modifying the protocol or consent process without prior IRB approval.

All findings of serious or continuing non-compliance referred to the IRB will be reviewed at a convened meeting. All IRB members will receive:

- All documents relevant to the allegation,
- The last approval letter from the IRB.
- The last approved IRB protocol; and
- The last approved consent document.

At this stage, the IRB may:

- Find that there is non-compliance that is neither serious non-compliance nor continuing non-compliance and an adequate corrective action plan is in place
- Find that there is serious or continuing non-compliance and approve any recommended determinations proposed by the IRB Chair and/or sub-committee
- Request additional information.

#### **10.4.3 Sub-Committee Procedures**

The HRPP Director can appoint a subcommittee consisting of IRB members, and non-members if appropriate, to ensure fairness and expertise. The subcommittee is given a charge by the IRB, which can include any or all of the following:

1. Review of protocol(s) in question;
2. Review of sponsor audit report of the investigator, if appropriate;
3. Review of any relevant documentation, including consent documents, case report forms, subject's investigational and/or medical files etc., as they relate to the investigator's execution of her/his study involving human subjects;
4. Interview of appropriate personnel if necessary;
5. Preparation of either a written or oral report of the findings, which is presented to the convened IRB at its next meeting;
6. Recommend actions if appropriate.

The sub-committee will substantiate the findings of serious or non-serious non-compliance in writing to the convened IRB for review. The HRPP Director (or designee) is responsible for assuring that minutes of the meeting are generated and kept to help support any determinations or findings made by the sub-committee.



The report will include any recommended actions. These recommended actions are described in 10.4.4 – Final Review.

#### **10.4.4 Final Review**

The convened IRB and/or the results from the subcommittee will be reviewed at a convened IRB meeting. When a finding of non-compliance, the IRB's possible actions could include, but are not limited to:

1. Request a correction action plan from the investigator
2. Verification that participant selection is appropriate and observation of the actual informed consent
3. An increase in data and safety monitoring of the research activity
4. Request a directed audit of targeted areas of concern
5. Request a status report after each participant receives intervention
6. Modify the continuing review cycle
7. Request additional investigator and staff education
8. Notify current subjects, if the information about the non-compliance might affect their willingness to continue participation
9. Require modification of the protocol
10. Require modification of the information disclosed during the consent process
11. Require current participants to re-consent to participation
12. Require additional information given to past participants
13. Suspend the study (see below)
14. Terminate the study (see below)
15. Defer to the Research Integrity Officer and the Institutional Official

In cases where the IRB determines that the event of non-compliance also meets the definition of unanticipated problem, the policy and procedure for review of such events will also be followed.

The investigator is informed of the IRB determination and the basis for the determination in writing and is given a chance to respond. If the IRB determines that the non-compliance was serious or continuing, the results of the final review will be reported as described below in section 11.0 - Reporting to Regulatory Agencies and Institutional Officials.

#### **10.4.5 Reinstatement of a Suspended Study**

The corrective action(s) and stipulations necessary for the IRB to consider reinstatement of the research must be decided by the convened IRB. The approval will be described in written correspondence to the Principal Investigator.



## 11.0 Reporting to Regulatory Agencies and Institutional Officials

### 11.1 Policy

Federal regulations require prompt reporting to appropriate institutional officials and the department or agency head of any unanticipated problem, any serious non-compliance or continuing non-compliance with this policy or the requirements or determinations of the IRB; and any suspension or termination of IRB approval. The IRB will comply with this requirement and the following procedures describe how these reports are handled.

### 11.2 Procedures

- IRB staff will initiate these procedures as soon as the IRB takes any of the following actions:
  - Determines that an event may be considered an unanticipated problem
  - Determines that non-compliance was serious or continuing
  - Suspends or terminates approval of research
- The IRB staff is responsible for preparing reports or letters which includes the following information:
  - The nature of the event (unanticipated problem involving risks to subjects or others, serious or continuing non-compliance, suspension or termination of approval of research)
  - Name of the institution conducting the research
  - Title of the research project and/or grant proposal in which the problem occurred
  - Name of the principal investigator on the protocol
  - Number of the research project assigned by the IRB and the number of any applicable federal award(s) (grant, contract, or cooperative agreement)
  - A detailed description of the problem including the findings of the organization and the reasons for the IRB's decision
  - Actions the institution is taking or plans to take to address the problem (e.g., revise the protocol, suspend subject enrollment, terminate the research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.)
  - Plans, if any, to send a follow-up or final report:
    - With a specific date defined
    - When an investigation has been completed or a corrective action plan has been implemented



- The IRB Chair and the institutional official will review the letter and modify the letter/report as needed.
- The institutional official is the signatory for all correspondence from the facility to the regulatory agencies.
- The IRB staff sends a copy of the report to:
  - The IRB by including the letter in the next agenda packet as an informational item
  - The Institutional Official
  - Report to the Research Integrity Officer, if a finding of non-compliance was serious or continuing
  - The following federal agencies:
    - OHRP, if the study is subject to DHHS regulations or subject to a DHHS Federal-wide Assurance
    - FDA, if the study is subject to FDA regulations.
    - DOD, if the study is subject to Department of Defense regulations
    - If the study is conducted or funded by any federal agency other than DHHS that is subject to *The Common Rule*, the report is sent to OHRP or the head of the agency as required by the agency

Note: Reporting to a regulatory agency is not required if the event occurred at a site that was not subject to the direct oversight of the organization, and the agency has been notified of the event by the investigator, sponsor, another organization, or other mechanisms.
  - Principal investigator
  - Sponsor, if the study is sponsored
  - Contract research organization (CRO), if the study is overseen by a contract research organization
  - Others as deemed appropriate by the institutional official

The IRB Chair ensures that all steps of this policy are completed within 10 working days of the initiating action. For more serious actions, the IRB Chair will expedite reporting.



## 12.0 Investigator Responsibilities

### 12.1 Policy

Investigators are ultimately responsible for the conduct of research. Research must be conducted according to the signed Investigator statement, the investigational plan and applicable regulations for protecting the rights, safety, and welfare of subjects under the Investigators care. Investigators may delegate research responsibility. However, Investigators must maintain oversight and retain ultimate responsibility for the conduct of those to whom they delegate responsibility.

The following procedures describe the Investigator responsibilities in the conduct of research involving human participants.

### 12.2 Definitions

**Principal Investigator (“PI”, “Co-I” or “Investigator”):** is an individual who conducts research or under whose immediate direction research is conducted; or, in the event of an investigation conducted by a team of individuals, is the responsible leader of that team. NIH PHS 398

Investigator means an individual who actually conducts a clinical investigation, i.e., under whose immediate direction the test article is administered or dispensed to, or used involving, a subject, or, in the event of an investigation conducted by a team of individuals, is the responsible leader of that team. FDA 21 CFR 50.3.25(d)

**Researcher:** is the PI and/or Investigator.

**Research Team:** is defined as the Investigator and other individuals, also known as key personnel, who contribute to the scientific development or execution of a project in a substantive, measurable way, whether or not they receive salaries or compensation under the protocol.

### 12.3 Investigators

#### 12.3.1 Principal Investigators

For the purposes of this institution Principal Investigators must be on staff (paid employee), adjunct faculty, or a member of the faculty of one of the institutions affiliated with the Pennington Biomedical Research Center. Professionals in training (graduate students, post-doctoral researchers, interns, and residents) are permitted to be Principal Investigators as long as permitted by their home institution policies. Fellows may be Principal Investigators if they have attending privileges at the



Institution. In order to serve as a Principal Investigator, any person who is not a member of the regular faculty must have at least one regular faculty member as a Co-Investigator on the project.

### **12.3.2 Change in Principal Investigator**

If there is a change in the PI, the outgoing Investigator must submit a modification to previously approved research to notify the IRB that he or she has relinquished the responsibilities of the Investigator to the person named, or will do so on a specific date. The newly named Investigator notifies the IRB that he or she has read the protocol and agrees to accept the responsibilities of the Investigator.

### **12.3.3 Student Investigators**

Students may not serve as Investigators. They must have a Pennington Biomedical Research Center employee who fulfills the Investigator eligibility criteria and who will serve as Investigator on the study. (see 1.3.3 – Human Research Protections Program Policy for definition of Principal Investigator)

## **12.4 Responsibilities**

In order to satisfy the requirements of this policy, Investigators who conduct research involving human subjects must:

1. Develop and conduct research that is in accordance with the ethical principles in the Belmont Report
2. Develop a research plan that is scientifically sound and minimizes risk to the subjects
3. Have sufficient resources necessary to protect human subjects, including:
  - Access to a population that would allow recruitment of the required number of subjects
  - Sufficient time to conduct and complete the research
  - Adequate numbers of qualified staff
  - Adequate facilities
  - A process to ensure that all persons assisting with the research are adequately informed about the protocol and their research-related duties and functions
  - Availability of medical or psychological resources that subjects might require as a consequence of the research
4. Assure that all procedures in a study are performed with the appropriate level of supervision and only by individuals who are licensed or otherwise qualified to



perform such under the laws of Louisiana and the policies of Pennington Biomedical Research Center

5. The investigator must maintain a list of appropriately qualified persons to whom they have delegated significant clinical trial-related duties.
6. Assure that all key personnel are educated in the regulatory requirements regarding the conduct of research and the ethical principles upon which they are based
7. Protect the rights and welfare of prospective subjects
8. Ensure that risks to subjects are minimized:
  - By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and
  - Whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes
9. Recruit subjects in a fair and equitable manner
10. Obtain and document informed consent as required by the IRB and ensuring that no human subject is involved in the research prior to obtaining their consent
11. Have plans to monitor the data collected for the safety of research subjects
12. When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, include additional safeguards in the study to protect the rights and welfare of these subjects
13. Have a procedure to receive complaints or requests for additional information from subjects and respond appropriately
14. Ensure that pertinent laws, regulations, and Institution procedures and guidelines are observed by participating Investigators and research staff
15. Ensure that all research that qualifies as human subjects receives IRB review and approval in writing before commencement of the research
16. Comply with all IRB decisions, conditions, and requirements
17. Ensure that protocols receive timely continuing IRB review and approval
18. Report unanticipated problems involving risk to subjects or other or any other reportable events to the IRB (see Section 9.0)
19. Obtain IRB review and approval in writing before changes are made to approved protocols or consent forms



20. Seek IRB assistance when in doubt about whether proposed research requires IRB review.
21. The researcher follows the clinical trial's randomization procedures, if any, and ensures that the code is broken only in accordance with the protocol. If the clinical trial is blinded, the researcher promptly documents and explains to the Sponsor any premature unblinding.
22. A qualified physician (or dentist, when appropriate), who is a researcher or a co-researcher for the clinical trial, is responsible for all clinical trial-related medical (or dental) decisions (not applicable to independent IRB's).
23. Researchers inform participants when medical care is needed for other illnesses of which the researchers become aware.
24. The researcher informs the participant's primary physician about the participant's participation in the clinical trial if the participant has a primary physician and if the participant agrees to the primary physician being informed.
25. Although a participant is not obliged to give his or her reasons for withdrawing prematurely from a clinical trial, the researcher makes a reasonable effort to ascertain the reason, while fully respecting the participant's rights.
26. The researcher provides evidence of his or her qualifications through up-to-date curriculum vitae or other relevant documentation requested by the sponsor, the IRB, or the regulatory authority.
27. The researcher is familiar with the appropriate use of the investigational product, as described in the protocol, in the current investigator brochure, in the product information, and in other information sources provided by the sponsor.
28. During and following a participant's participation in a clinical trial, the researcher ensures that adequate medical care is provided to a participant for any adverse events, including clinically significant laboratory values, related to the clinical trial (not applicable to independent IRBs).
29. The researcher ensures the accuracy, completeness, legibility, and timeliness of the data reported to the sponsor.
30. The researcher permits monitoring and auditing by the sponsor and inspection by the appropriate regulatory authority.
31. The researcher reports all serious adverse events (SAEs) to the sponsor except for those SAEs that the protocol or other document (e.g., investigator's brochure) identifies as not needing immediate reporting. The researcher follows regulatory requirements related to the reporting of unexpected serious adverse drug reactions to the regulatory authority and the IRB.



32. The researcher reports adverse events or laboratory abnormalities identified in the protocol as critical to safety evaluations to the sponsor according to the reporting requirements and within the time periods specified by the sponsor in the protocol.
33. For reported deaths, the researcher supplies the sponsor and the IRB with any additional requested information (e.g., autopsy reports and terminal medical reports)
34. The researcher provides written reports to the sponsor, the IRB, and, where applicable, the organization on any changes significantly affecting the conduct of the clinical trial or increasing the risk to participants.
35. If the researcher terminates or suspends a clinical trial without prior agreement of the sponsor, the researcher informs the organization, sponsor, and the IRB.
36. If the IRB terminates or suspends approval of the clinical trial, the researcher promptly notifies the sponsor.
37. Upon completion of the clinical trial, the researcher informs the organization; the IRB with a summary of the trial's outcome; and the regulatory authority with any reports required.

Regulations & Guidelines: FDA 21 CFR §312.53(c)(1); 21 CFR §312.60; 21 CFR §312.61; 21 CFR §312.62; 21 CFR §812.43(c)(4); 21 CFR §812.100; 21 CFR §812.140

## ***12.5 Training / Ongoing Education of Investigators and Research Team***

As stated above, one component of a comprehensive HRPP is an education program for all individuals involved with research subjects. Pennington Biomedical Research Center is committed to providing training and an on-going educational process for Investigators and members of their research team related to ethical concerns, Federal and State regulatory requirements and Pennington Biomedical Research Center policies for the protection of human subjects. Research teams consist of anyone working directly with human subjects or with identifiable data or biological specimens for research under the purview of the Institution. This includes Investigators, research nurses, coordinators, students, faculty and technicians working with identifiable data. It is the responsibility of the Investigator to ensure that the research team is compliant with all initial and ongoing education as required by Pennington Biomedical Research Center policies and regulatory requirements.

This requirement is mandatory regardless of funding sources. The requirements also apply to research that is considered exempt from IRB review.



Regulations & Guidelines: DHHS 45 CFR §46.102(d); 45 CFR §46.102(f); FDA 21 CFR§50.3(c); 21 CFR §50.3(g); 21 CFR §50.3(j); 21 CFR §56.102(c); 21 CFR §56.102(l)

### **12.5.2 Initial Education**

All Investigators, research team and key personnel are required to complete annual GCP training as per Pennington Biomedical Research Center policy 106.00. This policy is managed and tracked by the Director of Legal and Regulatory Compliance.

New research protocols and applications for continuing review will not be accepted or receive final approval until all sub-Investigators and members of the research team have completed the education requirements.

### **12.5.3 Waiver of Initial Education**

If Investigators or members of their research team have successfully completed human subject research training equivalent to that required by the Institution within the last year, they may request a waiver of the requirement for initial education. Please contact the Director of Legal and Regulatory Compliance for more information about obtaining a waiver of education.

### **12.5.4 Continuing Education and Recertification**

All Investigators and members of their research teams must meet Institution continuing education requirement annually after certification of initial education for as long as they are involved in human subject research. There is no exception to this requirement. Acceptable refresher modules at the CITI web-based training site must be completed. See Institutional Policy 106.00 for more information.

Investigators must submit evidence of continuing education prior to the expiration of their training certification. New research protocols and applications for continuing review will not be accepted from Investigators who have not submitted satisfactory evidence of continuing education.

Investigators who are also IRB Chair, IRB members, or IRB staff will satisfy the training requirements for IRB members and staff described in this policy under Institutional policy 106.00.

### **12.5.5 Investigator Notification of Responsibilities**

All policies and procedures including investigator responsibilities, training and education, guidances and contact information for the HRPP are listed on the HRPP



website found at [www.pbrc.edu/HRPP](http://www.pbrc.edu/HRPP). Investigators are notified via email of changes to the HRPP and are directed to the HRPP website which details the changes.

#### **12.5.6 Investigator Concerns**

Investigators who have concerns or suggestions regarding Pennington Biomedical Research Center HRPP should convey them to the HRPP Manager, Institutional Official or other responsible parties regarding the issue, when appropriate. The Institutional Official or HRPP Manager will research the issue, and when deemed necessary, convene the parties involved to form a response for the Investigator or make necessary procedural or policy modifications, as warranted. In addition, the IRB Chair and/or the HRPP Manager will be available to address Investigators' questions, concerns and suggestions.



## **13.0 Quality Improvement in the HRPP Program**

### **13.1 Definitions**

Quality Improvement: A process initiated to develop/enhance a practice or procedure and to institutionalize the practice or procedure.

Audit: A systematic review, inspection, or verification, typically conducted by an independent individual or group.

Routine (Not-for-Cause) Review: An assessment or examination of something (e.g., a practice or procedure) with the possibility or intention of instituting change if necessary.

Directed (For-Cause) Audit/Review: An audit of research and/or investigators initiated at the request of the Institutional Review Board (IRB) or Institutional Official to obtain or verify information necessary to ensure compliance with regulations and Institutional requirements and to inform Institutional Officials and the IRB about decisions on the conduct of human subjects' research and/or human subjects' protection.

### **13.2 Scope of QI Program**

The QI program focuses primarily on reviewing and monitoring of the activities, policies, procedures, and records for the following groups:

- Investigators and research staff participating in human subjects research
- IRB
- Individuals involved in HRPP education and outreach

### **13.4 QI Program Goals**

The purpose of the HRPP QI program is to verify and promote the following:

- Protection of the rights, welfare, and safety of human subjects participating in research at the Pennington Biomedical Research Center
- Compliance with federal, state, and institutional requirements governing human subjects research
- Integrity of university research and HRPP activities
- Education and training of researchers, including administrators, investigators, research staff, IRB members and faculty involved in human research
- Evaluation and follow-up of QI initiatives and corrective actions and implementation of new quality improvement activities.
- Implement a QI plan that periodically assesses the compliance of the HRPP.



### ***13.5 Development and Review of QI Activities***

The HRPP Manager or designee is responsible for drafting proposals for HRPP QI initiatives after review of the regulations, guidance, and findings from previous HRPP QI projects, in consultation with the IRB Chair. The IRB Chair will review and approve HRPP QI initiatives, as applicable, based on the scope of the activity (e.g., review of HRPP policies).

### ***13.6 Implementation of QI Activities***

The HRPP Manager or designee is responsible for the implementation and communication of HRPP QI activities. Information and accompanying materials will be posted and made available on the HRPP website, as applicable. The IRB Chair and/or Institutional Official will set an effective date for implementation of new projects. When a HRPP QI initiative represents a significant change to existing processes or practices, the effective date will be set to allow for communication, including education and planning for operational changes.

### ***13.7 QI Program Maintenance***

The HRPP Manager or designee is responsible for maintaining the HRPP QI program. The IRB Chair will review program findings and ongoing HRPP QI initiatives as needed, at least annually. Specific findings from directed reviews will be forwarded to the IRB Chair, Pennington Biomedical Research Center QI Committee and/or to the Institutional Official. Program initiatives will be developed (as described above) and/or updated as HRPP needs are recognized or changed.

### ***13.8 QI Plan***

#### ***13.8.1 Compliance Monitoring***

The HRPP Staff conduct periodic and for-cause compliance audits to evaluate adherence to applicable federal regulations, state and local laws and Pennington Biomedical policies and procedures.

#### ***13.8.2 For-Cause Compliance Audits***

Maybe conducted by the HRPP, IRB or other Institutional designees. These designees may be directed to conduct an assessment in response to a particular concern.

Concerns that may prompt a for-cause audit include but are not limited to:

- Failure of routine audits



- Complaints or concerns initiated by a research participant, family member or research staff
- Reports of serious or repeated non-compliance
- Results of audits or monitoring conducted by the following sources: internal and external monitoring, NIH, and FDA audits.

### ***13.8.3 Periodic Compliance Audit of Protocols***

Periodic Compliance Audits are conducted using systematic methods to assess investigator and IRB compliance with federal regulations, local laws and audits and Pennington Biomedical policies and procedures. A random selection of investigator's human subject research records and consent forms are reviewed during these audits for compliance. The following information is reviewed and reported to the IRB:

- IRB file review – documentation of consent form modifications, adverse events, deviations, protocol modifications, monitor letters and continuing review documents
- Subject case file review – subject files contain proper documentation of adverse events, inclusion/exclusion criteria, concomitant medications, enrollment/termination, subject history, lab results, progress notes, physical assessments, drug/device information records, case report forms, source documents
- Consent/Assent/HIPAA for subjects – consent form in subject file, consent form signed and dated, IRB approved consent used, informed consent obtained prior to start of procedures, correct signatures obtained.
- Protocol Adherence – inclusion/exclusion, study procedures performed as designated in protocol, approved concomitant therapy followed, protocol adherence requirements met
- Safety Monitoring – adverse events recorded appropriately, serious adverse events reported to the IRB
- Drug/Device Accountability – adequate record of receipt, dispensing/return records, drug used as per protocol, all authorized personnel appropriately signed for release of drug, IND drug record, administration of drug records present and appropriate

### ***13.8.4 Reporting of Compliance Monitoring Results***

Results of for-cause and periodic monitoring activities are documented and reported to the IRB, the PI and any other units within Pennington Biomedical as appropriate. The Institutional Official or Institutional Official Designee are notified, if the results include non-compliance or other findings pertinent to Institutional Officials. The IRB will review these activities and decide the following:



- The periodic or for-cause audit shows only minor concerns, possible action(s) the IRB may consider:
  - The IRB may do nothing other than notify the PI of the findings
  - Ask the PI to formulate an action plan
  - The IRB may ask for re-education of the PI and staff
  - The IRB may mandate the study continued to be monitored to ensure process improvements were made.
- If the for-cause audit shows major concerns and the convened IRB will evaluate the concern to see if it meets the definition of non-compliance (see policy 10.0 – Complaints and Compliance) and act according to the policy. Other actions the IRB may consider:
  - Ask the PI to formulate an action plan
  - The IRB may ask for re-education of the PI and staff
  - The IRB may mandate the study continued to be monitored to ensure process improvements were made.
  - Ask for modifications to the protocol/consent

### ***13.8.5 Periodic Compliance Audit of IRB Minutes***

Quarterly the IRB completes an internal audit of the meeting minutes to ensure the all items listed in Policy 4.0- Documentation and Records are included in the IRB minutes. A quarterly report will be submitted to the convened IRB for discussion. Process improvements based on these audit results will be considered. Actions the IRB may consider:

- Change policies and procedures to address problems not documented in the minutes.
- Re-educate IRB Members and Staff on policies and procedures

### ***13.8.6 Research Community Feedback Tracking***

The HRPP office tracks comments, questions and issues received from participants to identify areas for potential improvement in the effectiveness of HRPP policies and procedures and for ensuring the protection of human subject research participants. The IRB staff will bring any serious and continuing complaints to the convened IRB for discussion. The IRB will rely on the policy and procedures defined in HRPP Policy 10.0 Complaints and Non-Compliance.

### ***13.8.7 IRB Performance Metrics***

The HRPP Manager or designee produces periodic metrics and analysis of the IRB operations and functions, including measurements of processing times and activity volumes for the IRB and for each protocol event.



### ***13.8.8 Continuous Quality Improvement***

Based on the results of the assessments and feedback received from communities served by the IRB, the HRPP office works in partnership with the IRB and other components of the HRPP to identify root causes of problems, develop, implement or recommend action plans to correct issues and provide education and outreach to promote effectiveness of improvements.

Based on the results of the assessments and feedback received from communities served by the IRB, the HRPP office will work in partnership with the IRB and other components of the HRPP to:

- identify root causes of problems
- foster the development of solutions
- implement or recommend appropriate courses of action
- provide education and outreach programs
- evaluate effectiveness of solutions/outcomes



## **14.0 Participant Outreach Activities**

### **14.1 Responsibility**

It is the responsibility of the HRPP Manager to implement the procedures outlined below.

### **14.2 Outreach Resources and Educational Materials**

In order to involve and inform current and future research participants in accordance with the Belmont principle of Respect for Persons, Pennington Biomedical Research Center HRPP maintains a “Research Participants” page on the HRPP website. This page provides resources for research participants. In addition, research participants are invited via the website to contact HRPP/IRB staff to provide feedback and/or obtain information about human subjects research and HRPP activities.

The following resources are provided to participants:

- Opportunity to submit concerns, trial information and receive feedback.
- Participant Brochure
- Links to government websites (e.g., OHRP, FDA, NIH)

### **14.3 Questions, Concerns and Complaints**

All complaints, concerns and questions received by the IRB from any individual through the Concerns and Complaints Form or any form of communication will be acknowledged and forwarded to the appropriate individual within the Institution for handling and follow-up. While the IRB expects a prompt resolution, the time frame is dependent on the complexity of the complaint or concern.

Contact information for reporting complaints or concerns is provided in the informed consent, participant brochure and the HRPP website.

### **14.4 Periodic Evaluation**

Pennington Biomedical Research Center periodically evaluates its outreach activities and makes changes when appropriate. These evaluations take place in an informal, ongoing manner. All IRB members, IRB Chair, IRB Staff and HRPP Staff will report both positive and negative feedback regarding outreach activities to the HRPP Manager who will track the input and suggest changes made to improve outreach activities. The HRPP Manager will summarize the material annually In order to formally evaluate its outreach activities and determine:



1. The specific community outreach activities being used; and
2. Whether or not these community outreach activities have an evaluative component, and if so what, if any, changes in the outreach activities have resulted from these.



## 15.0 Research Funded by the Department of Defense

### 15.1 Definitions as Defined by DOD

**DOD subjects:** This includes any person captured, detained, held, or otherwise under the control of DOD personnel (military, civilian, or contractor employee). Such persons include: Enemy Combatant, Lawful Enemy Combatant, Unlawful Enemy Combatant, Enemy Prisoner of War, Retained Person., and Civilian Internee. Such persons do not include personnel of the DOD being held for law enforcement purposes. It does not include persons being held primarily for law enforcement purposes, except where the United States is the occupying power. This prohibition does not apply to activities covered by investigational new drug or investigational device provisions the purpose of diagnosis or treatment of a medical condition in a patient. Such treatment (e.g., an investigational new drug) may be offered to detainees with the detainees' informed consent when the medical products are subject to FDA regulations investigational new drugs or investigational medical devices, and only when the same product would be offered to members of the U.S. Military Services in the same location for the same medical condition and only when consistent with established medical practice involving investigational drugs and devices.

**DOD Research Involving Interventions or Interactions with Subjects:**

Research involving a human being as an research subject is an activity, for research purposes, where there is an intervention or interaction with a living individual for the primary purpose of obtaining data regarding the effect of the intervention or interaction. Research involving a human being as an research subject is a subset of research involving human subjects. This definition does not include exempt research involving human subjects.

**DOD Research Monitor:** The research monitor may be identified by an investigator or appointed by an IRB or IO for research involving human subjects determined to involve minimal risk. There may be more than one research monitor (e.g., if different skills or experiences are necessary). The monitor may be an ombudsman or a member of the data safety monitoring board. The Heads of the OSD and DOD Components may waive the requirement to have a research monitor on a case-by-case basis when the inclusion of a research monitor is not necessary to provide additional protections for human subjects. This waiver authority may be delegated to a DOD official, as described in the Component's HRPP management plan, but not at or below the position of the institution's DOD IO.



**DOD Ombudsman:** independent, impartial resource that provides DoD employees worldwide with a safe harbor for informal and confidential dispute resolution.

**DOD Minimal Risk:** Minimal risk is based on the phrase “ordinarily encountered in daily life or during the performance of routine physical or physiological examination or tests”; minimal risk shall not be interpreted to include the inherent risks certain categories of human subjects face in their everyday life. For example the risks imposed in research involving human subjects focused on a special population should not be evaluated against the inherent risks encountered in their work environment (e.g., emergency responder, pilot, soldier in a combat zone) or having a medical condition (e.g., frequent medical tests or constant pain.)

## 15.2 Policy

### 15.2.1 Criteria for Approval Specific to DOD

- When appropriate, research protocols must be reviewed and approved by the IRB prior to the Department of Defense approval. Consult with the Department of Defense funding component to see whether this is a requirement.
- Service members must follow their command policies regarding the requirement to obtain command permission to participate in research involving human subjects while on-duty or off-duty.
- There may be specific educational requirements or certification required by DOD above the educational requirements required by the institution. The IRB staff will assure all additional requirements as noted by the protocol are completed prior to approval of the study. The Department of Defense component may evaluate the education policies to ensure the personnel are qualified to perform the research, based on the complexity and risk of the research.
- The disclosure regarding provisions for research-related injury follows the requirements of the DOD component.
- When conducting multisite research a formal agreement is required to specify the roles and responsibilities of each party including a Statement of Work (SOW) and specific assignment of responsibilities.
- Surveys performed on Department of Defense personnel must be submitted, reviewed, and approved by the Department of Defense after the research protocol is reviewed and approved by the IRB.
- If consent is to be obtained from the research subjects' legal representative, the research must intend to benefit the individual participant.
- The determination that research is intended to be beneficial to the individual research subject must be made by an IRB.



- When investigators are following ICH-GCP (E6) guidelines, investigators and research staff must provide all the disclosures and follow the requirements pertaining to consent covered by ICH-GCP(E6).
- The investigator and research staff are aware of the specific DOD requirements and have been educated about these requirements.
- The research does NOT involve prisoners of war or detainees as subjects.

### **15.2.1 DOD Criteria for Waiver of Consent**

- If the research involves interventions or interactions with subjects, the research does not involve a waiver of consent or permission. The requirement for consent may be waived by the Assistant Secretary of Defense for Research and Engineering ASD(R&E) if the following three conditions are met:
  - The research is necessary to advance the development of a medical product for the Military Services.
  - The research may directly benefit the individual research subject.
  - The research is conducted in compliance with all other applicable laws and regulations. The ASD(R&E) may delegate the waiver authority.

### **15.2.2 DOD Policy Regarding Payment for Research**

- Employees of the Department of Defense (including temporary, part-time, and intermittent appointments) may not be able to legally accept payments to participate in research and should check with their supervisor before accepting such payments. Employees of the Department of Defense cannot be paid for conducting research while on active duty.
- Military personnel will not be paid for research conducted while on duty; however, the personnel can be compensated if involved in the research while not on duty.
- Although federal personnel participating as human subjects in DOD-conducted research while on duty may be compensated up to \$50 for each blood draw for scientific and research purposes in connection with the care of any person entitled to treatment at government expense, this IRB allows no such compensation when compensation is otherwise prohibited.
- Military personnel can participate in research off-duty; however, they cannot be paid from federal funds for research conducted while off duty.
- Non-Federal persons may be compensated for research participation other than blood draws in a reasonable amount as approved by the IRB according to local prevailing rates and the nature of the research.



### **15.2.3 DOD Policy Regarding Recruitment**

- Superiors will not influence the decisions of their subordinates regarding participation in research.
- Superiors will not be present at the time of recruitment and consent. When applicable, the superiors so excluded shall be afforded the opportunity to participate as human subjects in a separate recruitment session.
- When recruitment involves a percentage of a unit, an independent ombudsman is present.
- Research involves minimal risk: The IRB has discussed and determined whether to appoint an ombudsman based in part on the subject population, the consent process, and the recruitment strategy.
- Research involves greater than minimal risk: The IRB has appointed an ombudsman who is unassociated to the research and will be present during the recruitment to monitor that voluntary participation is clearly and adequately stressed and that information provided about the research is clear, adequate, and accurate. The ombudsman may also be the research monitor.

### **15.2.4 DOD Research Cognitively Impaired**

- If the research involves interventions or interactions with cognitively impaired subjects, there is anticipated direct benefit to the subject.

### **15.2.5 DOD Research Involving Pregnant Women, Prisoners and Children**

- Research involving pregnant women, prisoners, and children are subject to the DHHS Subparts B, C. and D.

#### ***15.2.5.1 DOD Research – Subpart B – Research with Pregnant Women and Fetuses***

- For purposes of applying Subpart B, the phrase “biomedical knowledge” shall be replaced with “generalizable knowledge.”
- The applicability of Subpart B is limited to research involving pregnant women as participants in research that is more than minimal risk and included interventions or invasive procedures to the woman or the fetus or involving fetuses or neonates as participants.
- Fetal research must comply with the US Code Title 42, Chapter 6A, Subchapter III, Part H, 289g.

#### ***15.2.5.2 DOD Research – Subpart C – Research with Prisoners***



- Research involving prisoners cannot be reviewed by the expedited procedure.
- When the IRB reviews research involving prisoners, at least one prisoner representative must be present for quorum.
- In addition to allowable categories of research on prisoners in Subpart C, epidemiological research is also allowable when:
  - The research describes the prevalence or incidence of a disease by identifying all cases or studies potential risk factor association for a disease.
  - The research presents no more than minimal risk.
  - The research presents no more than an inconvenience to the participant.
- When a participant becomes a prisoner, if the researcher asserts to the IRB that it is in the best interest of the prisoner-participant to continue to participate in the research while a prisoner, the IRB chair may determine that the prisoner-participant may continue to participate until the convened IRB can review this request to approve a change in the research protocol and until the organizational official and DoD Component office review the IRB's approval to change the research protocol. Otherwise, the IRB chair shall require that all research interactions and interventions with the prisoner-subject (including obtaining identifiable private information) cease until the convened IRB can review this request to approve a change in the research protocol. The convened IRB, upon receipt of notification that a previously enrolled human participant has become a prisoner, shall promptly re-review the research protocol to ensure that the rights and wellbeing of the human subject, now a prisoner, are not in jeopardy. The IRB should consult with a subject matter expert having the expertise of a prisoner representative if the IRB reviewing the research protocol does not have a prisoner representative. If the prisoner-participant can continue to consent to participate and is capable of meeting the research protocol requirements, the terms of the prisoner-participant's confinement does not inhibit the ethical conduct of the research, and there are no other significant issues preventing the research involving human participants from continuing as approved, the convened IRB may approve a change in the study to allow this prisoner-participant to continue to participate in the research. This approval is limited to the individual prisoner-participant and does not allow recruitment of prisoners as participants.
  - Research involving a detainee as a human participants is prohibited.
  - This prohibition does not apply to research involving investigational drugs and devises when the same products would



be offered to US military personnel in the same location for the same condition.

#### **15.2.5.3 DOD Research – Subpart D – Research with Children**

- Research involving children cannot be exempt.

### **15.2.6 DOD Research Involving More Than A Minimal Risk**

#### **15.2.6.1 DOD Research – Research Monitor**

- For research involving more than minimal risk an independent research monitor has been appointed by name who:
  - Has expertise consonant with the nature of risk(s) identified within the research protocol.
  - Is independent of the team conducting the research involving human subjects.
  - Has authority to stop a research in progress, remove individual subjects from research, and take necessary steps to protect the safety and well-being of subjects until the IRB can assess the monitor's report.
- Will promptly report his/her observations and findings to the IRB or other designated official.
- Has an IRB approved written summary of duties, authorities, and responsibilities based on specific risks or concerns about the research. The duties of the research monitor shall be determined on the basis of specific risks or concerns about the research. The research monitor may perform oversight functions (e.g., observe recruitment, enrollment procedures, and the consent process for individuals, groups or units; oversee study interventions and interactions; review monitoring plans and UPIRTSO reports; and oversee data matching, data collection, and analysis) and report their observations and findings to the IRB or a designated official. The research monitor may discuss the research protocol with the investigators, interview human subjects, and consult with others outside of the study about the research. The research monitor shall have authority to stop a research protocol in progress, remove individual human subjects from a research protocol, and take whatever steps are necessary to protect the safety and well-being of human subjects until the IRB can assess the monitor's report. Research monitors shall have the responsibility to promptly report their observations and findings to the IRB or other designated official.



### 15.2.8 DOD Research – Non U.S. Citizens

- If the research involves human subjects who are not U.S. citizens or personnel of the DOD, and is conducted outside the United States, its territories, and its possessions, the IRB will verify:
  - The permission of the host country has been obtained.
  - The laws, customs, and practices of the host country and the United States will be followed.
  - An ethics review by the host country, or local IRB with host country representation, will take place.

### 15.2.9 DOD Research – Classified Research

- See the following additional criteria for Department of Defense (DOD) research involving classified information:
  - Non-exempt classified research must be conducted following the requirements of [3216.02.13](#).
  - The convened IRB approved the research. (Use of an expedited review procedure is prohibited.)
  - The IRB has determined that potential subjects need access to classified information to make a valid, informed consent decision.
  - The IRB has consulted with an expert on classified information.
  - The research does not involve a waiver of informed consent.
- The informed consent process identifies DOD as the supporting institution of the research, unless the research involves no more than minimal risk or the Secretary of Defense has granted an exception.
- The informed consent process includes a statement that the research is classified and an explanation of the impact of the classification.
- Disclosure or use of classified information complies with the federal requirements for access to and protection of classified information.
- Any IRB member who disagrees with a majority decision approving a project will be allowed to appeal the decision to the Secretary of Defense.
- Secretary of Defense approval will be obtained.
- The IRB needs classified information for approval and oversight, subjects must be provided classified information as part of the consent process; or subjects will provide classified information during the course of the research.

### 15.2.10 DOD Research – Non-Compliance

See the following regarding non-compliance for Department of Defense research:



- Records maintained that document compliance or non-compliance with Department of Defense requirements shall be made accessible for inspection and copying by representatives of the Department of Defense at reasonable times and in a reasonable manner as determined by the supporting DoD component.

#### **15.2.11 DOD Research – Additional Reporting Requirements by Investigator to DOD**

- The following shall be promptly reported (no longer than 30 days) to the Department of Defense Human Research Protections Officer by the investigator:
  - When significant changes to the research protocol are approved by the IRB.
  - The results of the IRB continuing review.
  - Change of reviewing IRB.
  - When the organization is notified by any Federal department, agency or national organization that any part of the HRPP is under investigation for cause involving a DOD-supported research protocol.



## 16.0 Research Conducted by the Department of Education

Additional regulatory considerations are required for human research that is funded by the U.S. Department of Education (ED), and/or is conducted in institutions that receive ED funding.

For research funded by the National Institute on Disability and Rehabilitation Research, when an IRB reviews research that purposefully requires inclusion of children with disabilities or individuals with mental disabilities as research participants, the IRB must include at least one person primarily concerned with the welfare of these research participants.

### 16.1 FERPA

The Family Educational Rights and Privacy Act (FERPA) of 1974 (as amended) is a federal law that sets forth requirements for the protection of privacy of students' educational records. This policy addresses the applicability of FERPA to human subject research reviewed by the Pennington Biomedical Research Center Institutional Review Board (IRB).

### 16.2 FERPA Definitions

**Directory information** means information contained in an education record of a student that would not generally be considered harmful or an invasion of privacy if disclosed.

- (a) Directory information includes, but is not limited to, the student's name; address; telephone listing; electronic mail address; photograph; date and place of birth; major field of study; grade level; enrollment status (e.g., undergraduate or graduate, full-time or part-time); dates of attendance; participation in officially recognized activities and sports; weight and height of members of athletic teams; degrees, honors and awards received; and the most recent educational agency or institution attended.
- (b) Directory information does not include a student's
  - (1) Social security number; or
  - (2) Student identification (ID) number, except as provided in paragraph (c) of this section.



- (c) Directory information includes a student ID number, user ID, or other unique personal identifier used by the student for purposes of accessing or communicating in electronic systems, but only if the identifier cannot be used to gain access to education records except when used in conjunction with one or more factors that authenticate the user's identity, such as a personal identification number (PIN), password, or other factor known or possessed only by the authorized user.

**Disclosure** means to permit access to or the release, transfer, or other communication of personally identifiable information contained in education records by any means, including oral, written, or electronic means, to any party except the party identified as the party that provided or created the record.

**Education records.**

- (a) The term means those records that are:
  - (1) Directly related to a student; and
  - (2) Maintained by an educational agency or institution or by a party acting for the agency or institution.
- (b) The term does not include:
  - (1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.
  - (2) Records of the law enforcement unit of an educational agency or institution, subject to the provisions of § 99.8.
  - (3)(i) Records relating to an individual who is employed by an educational agency or institution, that:
    - (A) Are made and maintained in the normal course of business;
    - (B) Relate exclusively to the individual in that individual's capacity as an employee; and
    - (C) Are not available for use for any other purpose.
  - (ii) Records relating to an individual in attendance at the agency or institution who is employed as a result of his or her status as a student are education records and not excepted under paragraph (b)(3)(i) of this definition.



(4) Records on a student who is 18 years of age or older, or is attending an institution of postsecondary education, that are:

- (i) Made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in his or her professional capacity or assisting in a paraprofessional capacity;
- (ii) Made, maintained, or used only in connection with treatment of the student; and
- (iii) Disclosed only to individuals providing the treatment. For the purpose of this definition, “treatment” does not include remedial educational activities or activities that are part of the program of instruction at the agency or institution; and

(5) Records created or received by an educational agency or institution after an individual is no longer a student in attendance and that are not directly related to the individual’s attendance as a student.

(6) Grades on peer-graded papers before they are collected and recorded by a teacher.

**Educational agency or institution** means any public or private agency or institution to which this part applies under § 99.1(a).

**Eligible student** means a student who has reached 18 years of age or is attending an institution of postsecondary education.

**Parent** means a parent of a student and includes a natural parent, a guardian, or an individual acting as a parent in the absence of a parent or a guardian.

**Personally Identifiable Information.** The term includes, but is not limited to:

- (a) The student’s name;
- (b) The name of the student’s parent or other family members;
- (c) The address of the student or student’s family;
- (d) A personal identifier, such as the student’s social security number, student number, or biometric record



### 16.3 FERPA Policy

FERPA applies to educational agencies or institutions to which funds have been made available under any program administered by the Secretary of the U.S. Department of Education if the institution provides educational services or instruction to students and is authorized to direct and control public elementary, secondary, or post-secondary educational institutions. 34 CFR 99.1(a). Funds include those provided to the institution by grant, cooperative agreement, contract, subgrant, or subcontract or if funds are provided to the students attending the institution. If there is a question about the applicability of FERPA to an educational institution, 34 CFR 99.1 should be reviewed.

The education records protected by FERPA are those records that directly related to a student and are maintained by an educational agency or institution or by a party acting for the agency or institution. 34 CFR 99.3. When FERPA is applicable, consent from the parent or student is required in order for the educational institution to disclose the education record or the disclosure must meet an exception criteria found in 34 CFR 99.31. Such disclosures may be requested to obtain student records as part of a human subject research study.

The disclosure must be to an institution (Pennington Biomedical Research Center) conducting studies for, or on behalf of, educational agencies or institutions to:

- a. Develop, validate, or administer predictive tests;
- b. Administer student aid programs; or
- c. Improve instruction

Unless the request meets an exception in 34 CFR 99.31, signed and dated written consent must be obtained from the parent or eligible student before the educational institution discloses the personally identifiable information. 34 CFR 99.30(a). Written consent must include the following elements (34 CFR 99.30(b)):

- a. Specify the records that may be disclosed
- b. State the purpose of the disclosure; and
- c. Identify the party or class of parties to whom the disclosure may be made

If the request involves an exception to parental permission or student consent, the request must meet an exception provided in 34 CFR 99.31(a). The exceptions relevant to research include 34 CFR 99.31(a)(6) or 34 CFR 99.31(11).

- a. The following requirements apply to this exception:
  - i. The exception under 34 CFR 99.31(6) allows release of confidential student records for use in research without consent under specified conditions. These requirements include restrictions placed on the



researchers, including limitations on personal identification of parents and students, destruction of data, and a written agreement between the educational agency or institution and Pennington Biomedical Research Center or the researcher.

- ii. In order for the student records to be disclosed, the researcher on behalf of Pennington Biomedical Research Center, must enter into a written agreement with the educational agency or institution. The written agreement must contain the following elements (34 CFR 99.31(6)(ii)(C)):
  - a. Specifies the purpose, scope, and duration of the study or studies and the information to be disclosed
  - b. Requires the organization to use personally identifiable information from education records only to meet the purpose or purposes of the study as stated in the written agreement
  - c. Requires the organization to conduct the study in a manner that does not permit personal identification of parents and students by anyone other than representatives of the organization with legitimate interests
  - d. Requires the organization to destroy or return to the educational agency or institution all personally identifiable information when the information is no longer needed for the purposes for which the study was conducted and specifies the time period in which the information must be returned or destroyed
- iii. Once the information is disclosed to the researchers, the limitations outlined in the written agreement on use of the student data must be followed. 34 CFR 99.31(6)(ii).

These include:

- a. The data can only be used to meet the purposes or purposes of the study as stated in the written agreement.
- b. The study is conducted in a manner that does not permit personal identification of parents and students by individuals other than representatives of Pennington Biomedical Research Center that have legitimate interests in the information.
- c. The information must be destroyed when no longer needed for the purposes for which the study was conducted.
  - i. The exception under 34 CFR 99.31(11) permits educational institutions or agencies to release “directory information” from students without consent so long as the conditions under 34 CFR 99.37 are met. A researcher may receive directory information from an educational institution without



student or parental consent as required by FERPA. If a student's social security number or other non-directory information is used alone or combined with other data elements to identify or help identify the student or the student's records, informed consent must be obtained. 34 CFR 99.37(d)

## 16.4 PPRA Regulations

The Protection of Pupil Rights Amendment (PPRA) (20 U.S.C. § 1232h; 34 CFR Part 98) applies to programs and institutions that receive funding from the U.S. Department of Education (ED). PPRA is intended to protect the rights of parents and students.

PPRA requires that schools and contractors make instructional materials available for inspection by parents if those materials will be used in connection with an ED-funded survey, analysis, or evaluation in which their children participate. The following instructional materials used in a research or experimentation program must be accessible:

- a. All instructional material--including teachers' manuals, films, tapes, or other supplementary instructional material--which will be used in connection with any research or experimentation program or project must be available for inspection by the parents or guardians of the children engaged in such research.
- b. Research or experimentation program or project means any program or project in any research that is designed to explore or develop new or unproven teaching methods or techniques.
- c. Children are persons enrolled in research not above the elementary or secondary education level, who have not reached the age or majority as determined under state law.

The Protection of Pupil Rights Amendment (PPRA), 20 U.S.C. § 1232h, requires schools to notify parents and obtain consent or allow the parent to opt his/her child out of participating in certain school activities. These activities include a student survey, analysis, or evaluation that concerns one or more of the following eight areas ("protected information surveys"):

- a. Political affiliations or beliefs of the student or student's parent;
- b. Mental or psychological problems of the student or student's family;
- c. Sex behavior or attitudes;
- d. Illegal, anti-social, self-incriminating, or demeaning behavior;



- e. Critical appraisals of others with whom respondents have close family relationships;
- f. Legally recognized privileged relationships, such as with lawyers, doctors, or ministers;
- g. Religious practices, affiliations, or beliefs of the student or parents; or
- h. Income, other than as required by law to determine program eligibility. This requirement also applies to the collection, disclosure or use of student information for marketing purposes (“marketing surveys”), and certain physical exams and screenings.

#### **16.4.1 Investigator Responsibilities**

Investigators must provide an assurance letter from each school in which the research will be conducted the school complies with the Family Educational Rights and Privacy Act (FERPA) and the Protections of Pupil Rights Amendment (PPRA).

Investigators must provide a copy of all surveys and instructional material used in the research. Parents of children involved in the research must be able to inspect these materials upon request within a reasonable amount of time.

Investigators must ensure the school in which the research is being conducted must have policies regarding the administration of physical examinations or screenings that the school may administer to students.

#### **16.4.2 PPRA Policy**

For research funded by the U.S. Department of Education: No student shall be required, as part of any research project, to submit without prior consent to surveys, psychiatric examination, testing, or treatment, or psychological examination, testing, or treatment, in which the primary purpose is to reveal information concerning one or more of the following:

- a. Mental and psychological problems potentially embarrassing to the student or his or her family.
- b. Legally recognized privileged and analogous relationships, such as those of lawyers, physicians, and ministers.
- c. Income, other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under a program.

Prior consent means:



- a. Prior consent of the student, if the student is an adult or emancipated minor; or
- b. Prior written consent of the parent or guardian, if the student is an un-emancipated minor. Schools and contractors obtain prior written parental consent before minor students are required to participate in any ED-funded survey, analysis, or evaluation.

For research not funded by the U.S. Department of Education: The IRB must verify compliance with U.S. Department of Education regulations that schools are required to develop and adopt policies in conjunction with parents regarding the following:

- a. The right of a parent of a student to inspect, upon the request of the parent, a survey created by a third party before the survey is administered or distributed by a school to a student.
- b. Any applicable procedures for granting a request by a parent for reasonable access to such survey within a reasonable period of time after the request is received.
- c. Arrangements to protect student privacy that are provided by the agency in the event of the administration or distribution of a survey to a student containing one or more of the following items (including the right of a parent of a student to inspect, upon the request of the parent, any survey containing one or more of such items):
  - i. Political affiliations or beliefs of the student or the student's parent.
  - ii. Mental or psychological problems of the student or the student's family.
  - iii. Sex behavior or attitudes.
  - iv. Illegal, anti-social, self-incriminating, or demeaning behavior.
  - v. Critical appraisals of other individuals with whom respondents have close family relationships.
  - vi. Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers.
  - vii. Religious practices, affiliations, or beliefs of the student or the student's parent.
  - viii. Income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program).
  - ix. The right of a parent of a student to inspect, upon the request of the parent, any instructional material used as part of the educational curriculum for the student.
  - x. Any applicable procedures for granting a request by a parent for reasonable access to instructional material received.



- xi. The administration of physical examinations or screenings that the school or agency may administer to a student.
- xii. The collection, disclosure, or use of personal information collected from students for the purpose of marketing or for selling that information (or otherwise providing that information to others for that purpose), including arrangements to protect student privacy that are provided by the agency in the event of such collection, disclosure, or use.
- xiii. The right of a parent of a student to inspect, upon the request of the parent, any instrument used in the collection of personal information before the instrument is administered or distributed to a student.
- xiv. Any applicable procedures for granting a request by a parent for reasonable access to such instrument within a reasonable period of time after the request is received.

### **16.5 IRB Review of Department of Education Research**

Requests for use in research must be submitted to the IRB. The IRB will evaluate such requests, including any exceptions to parental permission and student consent, for compliance with FERPA and PPRA requirements.

- a. An educational agency or institution may disclose education records or information from education records without consent if the disclosure is after the removal of all PII, provided that the educational agency/institution (or other party that received the information or education records) has made a reasonable determination that a student's identity is not personally identifiable, whether through single or multiple releases, and taking into account other reasonably available information.



## **17.0 Community Based Participatory Research**

In some instances, the design and implementation of research can be enhanced when individuals from the community in which the research will be conducted are involved in the design, conduct, and analysis of data from the research. This can occur for an individual study or group of studies. Pennington Biomedical Research Center facilitates the involvement of community members by supporting researchers who wish to conduct community-based participatory research or other types of research that involve community members.

### **17.1 Considerations for Investigators Involved in Community Based Research**

- Does the community partner have an IRB and/or approval process?
- If community partners are involved in research activities, are the partners considered “engaged” under federal law. If the community partners are considered engaged they must complete all mandatory education criteria outlined in Pennington Biomedical Research Center Institutional Policy 106.00.
- Consent forms should be reviewed to ensure the reading level is appropriate for the planned participants. An 8<sup>th</sup> grade reading level is suggested.
- The IRB will need to know how the data will be shared with the community partners.

### **17.2 IRB Review of Community Based Research**

The IRB office follows the federal regulations and established policies and procedures when reviewing Community Based Research protocols.

The following detail the IRB review of community based research:

- The IRB will include members with experience conducting community research.
- Under Pennington Biomedical policies and procedures, the IRB may contact a consultant to review any research study where additional expertise is required, including community based research.
- The IRB will review the research with the same policies and procedures outlined in the HRPP policies and procedures manual section 3.0 – IRB Review.



### **17.3 Additional Consideration in the IRB Review of Community Based Research**

- Does the community partner have an IRB and/or approval process?
- If community partners are involved in research activities, are the partners considered “engaged” under federal law. If the community partners are considered engaged they must complete all mandatory education criteria outlined in Pennington Biomedical Research Center Institutional Policy 106.00.
- Consent forms should be reviewed to ensure the reading level is appropriate for the planned participants. An 8<sup>th</sup> grade reading level is suggested.
- If any of the research will take place in participant’s homes, the investigator must address issues of mandated reporting under state laws, if sensitive questions are being asked.
- Privacy, Confidentiality and Coercion in the research



## 18.0 Electronic Signatures and Electronic Records in IRBManager Software

### 18.1 Summary Policy

21 CFR Part 11 has been in effect since August 1997 and establishes certain requirements of the Food and Drug Administration (FDA). 21 CFR11 covers two issues: electronic records and electronic signatures.

### 18.2 Electronic Records and Signatures

#### 18.2.1 Identification controls and limiting of system access to authorized individuals

The access to the system used for electronic IRB submissions and reviews (IRBManager) will be limited to authorized users. Each IRBManager user must have a registered account with a unique name and password and a specified level of system access/authority. Only an IRB Staff is authorized to enable log-in of authorized users. Before access is granted, the user must sign an attestation agreeing that the individual user is accountable and responsible for actions initiated under their electronic signature, and that the user will not disclose their username and password to anyone else. Before enabling access, the IRB Coordinator or Director will ensure that the attestation has been signed by the user. In addition, the IRB Staff will assign the appropriate access level (IRB member, investigator, etc.) based on the user status and document that assignment on the attestation form.

#### 18.2.2 Determination that persons who develop, maintain or use the electronic record/electronic signature systems have the education, training, and experience to perform their assigned tasks

In addition, the attestation requires a certification that a potential system user has completed training on IRBManager, either by attending an IRB provided training session or reviewing the on-line IRB training modules.

#### 18.2.3 Establishment of written policies that hold individuals responsible and accountable for actions initiated under their electronic signatures

The HRPP Office notes that “Only the individual owner of an account is authorized to use that account. Providing passwords or in any way permitting or making it possible for anyone other than the authorized owner of the account to use computer resources is not authorized and may be a violation of Pennington Biomedical Policy 603.00.”

In addition, this policy (see item 4) addresses this requirement with regard to electronic signatures.

#### 18.2.4. Electronic Signatures within IRBManager

The first sign-in to the system requires a three- part identifier, consisting of username, password and ClientID. Subsequent signings are executed by entering the password.

Each individual user is accountable and responsible for actions initiated under their electronic signature. Each user is accountable and responsible for maintaining confidentiality of their username and password and must not disclose their username and password to anyone else. Each user must contact the ETSU Office for the Protection of Human Subjects to report any potential compromise of their password.

An audit trail of all actions, including signing, that occur within the system is maintained by IRBManager.



## **19.0 Deception or Incomplete Disclosure in Research Policy**

### **19.1 Overview**

Some research, particularly psychology and behavioral, deliberately withholds information about the purpose of the research and /or the procedures employed or purposely misleads participants by providing false information about some aspects of the research. This policy describes the special responsibilities imposed on the investigator and the considerations required of the IRB when research involves deception or incomplete disclosure.

### **19.2 Definition(s)**

#### **19.2.1 Deception**

Deception occurs when an investigator gives false information to subjects and intentionally misleads them about some key aspect of the research. A key aspect includes but is not limited to a primary endpoint.

#### **19.2.2 Incomplete Disclosure**

Incomplete disclosure occurs when an investigator withholds information about the specific purpose, nature, or other aspect of the research.

See Section 19.8 for Examples

### **19.3 When Deception May be Used**

The following guidelines from The American Psychological Association (APA) explain when deception is appropriate in research:

- Researchers do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational or applied value and that effective non-deceptive alternative procedures are not feasible.
- Researchers do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.
- Researchers explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data.



## 19.4 Elements of Waiver of Informed Consent

In studies involving deception or incomplete disclosure as determined by the IRB, fully informed consent is not obtained from participants prior to participation. When the consent process will not fully inform participants about the research, the IRB must consider whether the research meets all of the criteria for a waiver of one or more elements of informed consent as set forth in federal regulations at 45 CFR 46.116(d).

The criteria for a waiver of one or more elements of informed consent are:

- **The research involves no more than minimal risk to participants;**
- The waiver or alteration will not adversely affect the rights and welfare of participants;
- The research could not practicably be carried out without the waiver or alteration;
- Whenever appropriate, the participants will be provided with additional pertinent information after participation.

A waiver or alteration of informed consent request must be included in the application to the IRB if deception or incomplete disclosure in research is used in a study.

## 19.5 Goals of Debriefing

When a researcher uses deception, a debriefing at the end of the study is required, when appropriate. Debriefing may be inappropriate if debriefing regarding the deception may cause more harm than the deception itself.

Debriefing after deception has several goals: (1) to repair the breach of informed consent entailed by the deception, (2) to remove any confusions or defuse any tensions that might have been generated by the deception, (3) to make it clear especially to younger participants that deception is permissible only in exceptional circumstances, and (4) to repair (as much as possible) the breach of trust that has occurred not only between the investigator and the participant, but (potentially) between all researchers and all participants.

### 19.5.1 Debriefing Guidelines

Ethical Principles of Psychologists and Code of Conduct guidelines discuss debriefing participants of the deception used in research.

- Researchers provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.



- If scientific or humane values justify delaying or withholding this information, researchers take reasonable measures to reduce the risk of harm.
- When researchers become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

## 19.6 Investigator Responsibilities

The application and protocol submitted to the IRB must include the following:

- Justify the reason for deceiving or withholding information from the participants. This includes an explanation of the research's benefits and why the deception or incomplete disclosure is necessary.
- Explain why the deception or incomplete disclosure is necessary
- Outline the process of debriefing, if applicable; including when, how and by whom the information will be provided to participants
- Provide a copy of your debriefing script, if available/applicable.

## 19.7 IRB Considerations

The IRB must consider the following when reviewing research with deception or incomplete disclosure:

- The IRB must determine that the research qualifies for a waiver or alteration of the required elements of informed consent, in accordance with criteria provided in federal regulations at 45CFR46.116(d)
- The scientific value and validity of the research
- The efficacy of alternative procedures
- The certainty that deception or incomplete disclosure does not extend to influence participant's willingness to participate
- The possibility of experimentally induced harm and the ability of the proposed procedures to remove such harm through debriefing
- The potential of the deception or incomplete disclosure to facilitate unwanted and inappropriate invasions of privacy
- Whether the researcher has the skill and resources to address participants' who become upset
- If the study does not involve a de-briefing, the IRB must consider and document the reasoning of why the risks do not outweigh the benefits in not de-briefing participants.



## **19.8 Examples of Deception and Incomplete Disclosure in Research**

### **19.8.1 Deception Examples:**

- Participants complete a quiz, and are falsely told that they did very poorly, regardless of their performance.
- Participants (who don't know they are in a research study) are observed to see how they behave when they find a large amount of cash in a public location.
- In a study of anxiety, participants are told to expect mild pain during the course of the study, but no painful procedures are administered.

### **19.8.2 Incomplete Disclosure Examples**

- Participants are asked to complete a quiz for research, but not told that the research question involves how background noise affects their performance.
- Subjects are told they are completing study questionnaires to evaluate their satisfaction, when the true purpose of the study is to correlate psychiatric symptoms with subject satisfaction.