

Policy Number: 50

Title: UCI HRP Quality Improvement Program

Date of Last Revision: 08/10/2005, 01/29/09, 12/08/10, 08/08/11, 05/01/16, 03/07/17, 09/20/18, 06/17/20

Policy:

University of California, Irvine (UCI) Institutional Review Board (IRB) is responsible for ensuring that all human subjects research conducted by faculty, staff, and students at UCI approved sites or using UCI's name is conducted in compliance with federal regulations, state and local law as well as UCI HRP policies, procedures, and UCI's Federalwide Assurance with OHRP, in order to preserve the rights and safety of research subjects, the quality of scholarly work and the integrity of the institution.

- I. In an effort to promote accountability and excellence, UCI HRP has developed the Education and Quality Improvement Program (EQUIP). EQUIP monitors and measures the effectiveness, efficiency and quality of UCI's human research protection program.
- II. The primary purpose of the EQUIP is to provide education, training and post-approval monitoring, to assure that all human research protection operations support UCI's mandate to protect the rights and welfare of research participants. This includes compliance with institutional policies and procedures, and applicable federal, state and local laws pertaining to the protection of human subjects in research.
- III. **Components of the Education and Quality Improvement Program (EQUIP)**
 - A. Education (see HRP Policies 48 and 49)
 - B. Post-Approval Monitoring – Periodic Quality Improvement Reviews and directed (for cause) investigations of human subjects research.
 - C. Indirect monitoring of research activities through monitoring unanticipated problems involving risk to research participants or others
 - D. Verification from Other Sources
 - E. Ongoing HRP Internal QI Activities
 1. Minutes QI Review
 2. Informed Consent QI Review
 3. Review of IRB Protocols
 4. HRP Benchmarks and Metrics
 5. IRB/HRP Survey
 - F. Participant Outreach and management of participant complaint and concerns
 - G. IRB Member Self-Evaluation
 - H. HRP Staff Performance Evaluation
 - I. Post-Approval Investigator Responsibilities (PAIR) Program
- IV. **Education:** UCI requires that investigator receive human research training prior to engaging in human subjects research to ensure that investigators have appropriate knowledge of human subject regulations and procedures, and that they understand the

ethical considerations underlying human research protections (See HRP Policies 48 and 49 for detailed information regarding education of researchers and IRB members).

V. Post-Approval Monitoring

- A. Periodic Quality Improvement Reviews - Periodic compliance audits are conducted using systematic methods to assess investigator and IRB compliance with federal regulations, state and local laws, and UCI HRP policies and procedures. Periodic compliance audits include but are not limited to:
 - 1. Examinations of executed informed consent forms and HIPAA authorizations;
 - 2. Reviews of IRB meeting minutes;
 - 3. Detailed examinations of protocol files;
 - 4. In-person observations of the informed consent process.
- B. Directed (for cause) reviews/investigations - The IRB or the Director of Human Research Protections may direct the EQUIP Team or other designees to conduct an assessment in response to a particular concern. Concerns that may prompt a for-cause assessment include but are not limited to:
 - 1. Failure of routine audits;
 - 2. Complaints or concerns initiated by a research participant, family member, or research team/workforce member;
 - 3. Reports of serious or continuing non-compliance;
 - 4. Results of audits or monitoring conducted by other UCI components (e.g., ORO, Internal Audit) reported to the EQUIP Team or other HRP staff.
- C. EQUIP or a designee may initiate the periodic compliance reviews and/or conduct the direct audits. Designees include:
 - 1. UCI School of Medicine ORO conducts directed and random periodic compliance reviews of IRB-approved studies when the Lead Researcher is School of Medicine personnel (i.e., faculty, staff, or student) and/or the research is conducted at UCI Medical Center (UCIMC).
 - 2. Internal Audit Services (IAS) is charged with the task of assisting University management and the Board of Regents in the discharge of their oversight, management, and operating responsibilities.
 - 3. The Chao Cancer Center Quality Assurance (QA) Unit conducts post-approval monitoring and faculty and staff education to ensure the Cancer Center maintains compliance with Federal and University regulations for research.
- D. External Sites - Directed audits and periodic compliance reviews may also be conducted by the IRB Education and Quality Improvement Team at non-UCI sites where the UCI IRB serves as their IRB of Record.
- E. External Consultant - The UCI IRB may engage an external consultant with a specific area of expertise to perform or assist with any of the above-defined auditing and reviewing activities.
- F. Reporting of Monitoring Results
 - 1. The results of any monitoring activity or audit activity by the HRP EQUIP team and/or a designee are reported in writing to the Director of Human Research Protections or designee.
 - 2. The Director of Human Research Protections or designee follows the campus policy for resolving allegations of non-compliance in cooperation with the IRB Chair(s) responsible for the review of the

research when allegations of or incident(s) of non-compliance are reported.

3. If the monitoring or auditing activity finds that a human subject participating in a research project has been exposed to unexpected serious harm, the HRP EQUIP team or designee will promptly report such findings to the Director of Human Research Protections or designee.
 4. The Lead Researcher will be required to submit an "Unanticipated Problems" (UP) report and the IRB Chairperson will determine the need for full IRB Committee review.
- G. Suspend or Terminate Research: If the information gained during the monitoring, auditing, or review process indicates that human subjects of a research project were exposed to unexpected serious risk or harm, or that the policies of the IRB were not met, the IRB may suspend or terminate the research (See HRP Policies 51 and 52)

VI. **Indirect monitoring of unanticipated problems involving risk to research participants or others (UPs):** The EQUIP team monitors when potential UPs are reported to the IRB. The HRP staff works closely with the IRB Chair and IRB to manage potential UPs. When an UP may involve noncompliance (See HRP Policy 52), the EQUIP team works closely with the IRB Chair and IRB to manage the potential UP.

VII. **Internal HRP QI Activities**

- A. Minutes QI Review – EQUIP conducts a quarterly review of three random sets of IRB approved minutes using the IRB Minutes QI Review Form to assure compliance with federal regulations and UCI HRP policies.
- B. Informed Consent QI Review – Six IRB approved informed consent documents are reviewed monthly to verify compliance with federal regulations and UC/UCI HRP policies.
- C. Review of IRB Protocols – EQUIP reviews the last three years of an IRB approved protocol in preparation for a Periodic Quality Improvement reviews. In addition, two additional random active studies are reviewed by EQUIP monthly.
- D. HRP Benchmark targets and Metrics Reports– the HRP has established benchmarks to measure efficiency in all phases of IRB review process. A monthly metric report is generated to evaluate consistency with benchmark targets.
- E. IRB Survey - The EQUIP team monitors comments, questions and issues received from the UCI investigators and from the IRB survey to identify areas for potential improvement in the effectiveness of HRP policies and procedures and for ensuring the protection of human research participants.

VIII. **Verification from Other Sources**

- A. The IRB can require verification that no unapproved changes in an IRB-approved study have occurred since the previous IRB review. The scope and extent of such an independent assessment is determined on a case-by-case basis.
- B. Sources for such outside information could include:
 1. Compliance review from the HRP EQUIP team or designee;
 2. Corroboration from School Deans, Department Chairs, Sponsors, other

- Clinical Research Organizations and other IRBs at collaborating institutions;
 - 3. Copies of FDA audits;
 - 4. Literature searches conducted by clinical librarians;
 - 5. Reports from subjects or study staff; or
 - 6. Directed audit at the request of the IRB Committee or the Director of Human Research Protections or designee.
- C. Examples of when verification from other sources may be requested include, but are not limited to:
 - 1. When the study is complex in design and the project involves unusual types of risk to subjects (e.g., multiple groups, rapid titration schedule to obtain maximum tolerated dose, novel and unique medical device investigations);
 - 2. When the study is conducted by researchers who previously have failed to comply with the requirements of the DHHS regulations or the requirements or determinations of the IRB; or
 - 3. When concerns are raised, based upon information provided in continuing review reports or from other sources, about possible material changes occurring without IRB approval.

IX. Participant Outreach and Management of Complaints and Concerns Regarding Human Subjects Research or the HRP

- A. To enhance the public's understanding of research, UCI HRP has developed the "Especially for Research Participants" web page which includes frequently asked questions about research participation, quick links to external web based resources, and the HRP staff contact information. The HRP staff and the IRB Working Group periodically reviews the web page to determine whether additional information can be provided and to verify that the information provided is accurate and up-to-date and the hyperlinks are active.
- B. The HRP staff is responsible for the processing, review and inquiry into all complaints and concerns that are brought to the attention of the IRB/HRP regarding human subjects research conducted at UCI and/or by UCI personnel. Complainants may include, but are not limited to subjects (past, present or potential), subject family members, investigators, other research staff, or any person with concerns (See HRP Policy 54). When a subject complain may involve noncompliance (See HRP Policy 52), the EQUIP team works closely with the IRB Chair and IRB to manage the complaint.

X. Assessment of IRB Members, IRB Chairs and HRP Staff

- A. IRB Members are assessed on an annual basis based upon meeting participation, preparedness, quality of review, and knowledge of UCI HRP policies and federal regulations. IRB Members complete the "IRB Member Evaluation" form each July. IRB members receive written or verbal feedback from the IRB Chairs. Individual educational needs are identified and forwarded to the EQUIP.
- B. IRB Chairs and Vice Chairs must complete the "IRB Chair Evaluation" form each July. IRB Chairs receive written or verbal feedback from the Institutional Official. Individual educational needs are identified and forwarded to the EQUIP.
- C. HRP Staff receive annual evaluations, constructive feedback, and individual

educational needs are identified with their supervisor.

XI. **Post-Approval Investigator Responsibilities (PAIR) Program**

- A. The purpose of the PAIR program is to facilitate regulatory compliance by educating randomly selected investigator-initiated protocols on post-approval responsibilities, either at the beginning of a new study or at the time of continuing submission. Researchers will receive training on record-keeping requirements and regulatory submissions such as modification submissions, adverse event/unanticipated problems submissions, and continuing protocol submissions.

References:

21 CFR 50

21 CFR 56

45 CFR 46

DOE o 443. 1A

CA Protection of Human Subjects in Experimentation Act 24173

HRP Policies, 44, 48, 49, 51, 52, 54

Procedure Number: 50.A**Title: Procedure for IRB Compliance Activities****Procedure:**

The purpose of this procedure is to outline the processes for conducting compliance reviews and audits by the UCI IRB Education and Quality Improvement Team.

I. Lead Researcher Responsibilities

- A. The Lead Researcher will comply with UCI HRP polices and procedures including:
 - 1. Education requirements
 - 2. Reporting Unanticipated Problems Involving Risk to Participants or Others
 - 3. Managing and reporting participant complaints including resolution of the complaint, if applicable.
- B. Periodic Quality Improvement Reviews
 - 1. Lead Researchers will cooperate with the IRB by being available for questions, having documents accessible, and responding to any written requests within the time frame designated by the IRB in association with a compliance review. The preliminary findings will be communicated to the LR to facilitate understanding of the process and collaboration in resolving any outstanding issues/concerns. The LR or designee will be present for a brief exit interview that will occur following each compliance review conducted by the HRP EQUIP team or designee.
 - 2. Lead Researchers will address the recommendations suggested by the UCI HRP EQUIP team or designee and submit responses within a timely manner.
- C. Directed (for cause) Reviews/Investigations
 - 1. Lead Researchers will cooperate with the IRB by making him/herself available for questions, having documents accessible, and responding to any written requests within the time frame designated by the IRB in association with a directed audit. Written preliminary audit results will be provided to the LR to facilitate understanding of the process and collaboration in resolving any outstanding issues/concerns. The LR or designee will be present for a brief exit interview that will occur following each directed audit.
 - 2. Lead Researchers will abide by all IRB Chairperson or his/her designee and/or full IRB Committee determinations. These determinations may include developing and following a corrective action plan and/or an educational plan and completing it in the time specified by the Committee.
 - 3. The Lead Researcher may be requested to attend a full IRB Committee meeting to present information addressing any concerns resulting from a directed audit, as well as any determination rendered by the full IRB Committee.
- D. Post-Approval Investigator Responsibilities (PAIR) Program
 - 1. Greater than minimal risk New Studies from a New Investigator or an Investigator-Initiated study:
 - a) Voluntarily meet with an HRP EQUIP Team Member to review post-approval responsibilities such as record-keeping requirements, regulatory submissions such as modification applications, adverse

events, unanticipated problems reports, and continuing applications.

2. Continuing Applications for Investigator-Initiated minimal risk protocols:
 - a) Voluntarily complete the PAIR self-assessment form, which evaluates compliance with post-approval responsibilities such as record-keeping requirements, regulatory submissions such as modification applications, adverse events, and unanticipated problems reports.

II. **IRB Committee Responsibilities**

- A. IRB members should comply with UCI HRP policies and procedures including:
 1. Education requirements
 2. Annual IRB Member Evaluations
- B. Periodic Quality Improvement Reviews
 1. The IRB Committee Chair will review a copy of the Compliance Review Report of Findings and may:
 - a) Accept and sign the compliance review report with or without revisions to the currently approved study;
 - b) Impose additional measures for participant safety;
 - c) Mandate education by the HRP EQUIP; and/or
 - d) Refer to full Committee for review and discussion.
- C. Directed (for cause) Reviews/Investigations
 1. Directed audits may be requested to assess compliance with local, State, and Federal laws, participant safety, and HRP policies and procedures.
 2. Determining the need for such additional supervision or participation by the IRB is made by the IRB on a case-by-case basis during the initial and continuing review, or as new information is presented. Factors to be considered by the IRB in determining whether to undertake such additional supervision or participation may include, but are not limited to:
 - a) Involvement of vulnerable populations;
 - b) Research conducted internationally;
 - c) The involvement of recombinant DNA or other types of gene transfer protocols;
 - d) The use of waiver or alteration of informed consent procedures, (e.g. surrogate consent);
 - e) Research for which subjects would be exposed to additional risks, e.g. breach of confidentiality, Phase 1 studies, disproportionate number or severity of SAEs;
 - f) Previous suspension of the research due to compliance issues, poor record-keeping or other concerns;
 - g) Recommendations from other institutional committees (e.g., ICTS, IBC, CRFA, etc.)
 3. Upon receipt and review of the directed audit report, the IRB Committee may:
 - a) Accept the audit report with or without revisions to the currently approved study;
 - b) Impose additional measures for participant safety, these may include, but are not limited to:
 - (1) Request status reports after each participant receives intervention;

- (2) Decrease the continuing review cycle (e.g. 3 months, 6 months, after a specific number of participants are enrolled);
- (3) Require an independent safety monitor or formation of a DSMB to monitor activities locally, or nationally if UCI is a coordinating center;
- (4) Request an off-cycle DSMB review and written report;
- (5) Conduct a follow-up audit by the IRB Education and Quality Improvement Team;
- (6) Require oversight/signatures by superior on all research;
- (7) Replace the Lead Researcher by a qualified LR who is not subordinate to the LR being replaced;
- (8) Limit LR's ability to submit new research studies to the IRB; and/or
- (9) Require a subject advocate to participate in or monitor the informed consent process;
- c) Create an education plan recommended by the IRB Education and Quality Improvement Team, these may include, but are not limited to:
 - (1) One-on-one instruction with the IRB Education and Quality Improvement Team or an IRB Administrator familiar with study;
 - (2) Participation of LR and/or research team in RAMP courses;
 - (3) Attendance of LR and/or research team at IRB Education Sessions or Brown Bags;
 - (4) Attendance of LR and/or research team at local, regional or national conferences on human subjects protections;
 - (5) Review of additional regulatory documents or materials (e.g. Belmont Report, 45 CFR 46, HRP policies and procedures, OHRP determination letters);
 - (6) Additional web-based human subjects protection training (e.g. OHRP, NIH, NCI); and/or
 - (7) Completion of pertinent [Collaborative Institutional Training Initiative](#) (CITI) human research protections modules.
- d) Accept the audit report and:
 - (1) Request that the LR place the study on voluntary "Administrative Hold", pending further investigation;
 - (2) Place a "Suspension" on the study, if applicable (See HRP Policies 51 and 52).
- 4. The Committee will outline any recommendations in a letter to the LR.
- 5. At the direction of the Director of Human Research Protections or designee, the IRB Chair(s) or the IRB Committee, the IRB may engage an expert consultant to perform or assist with any of the auditing and reviewing activities.
- D. Post-Approval Investigator Responsibilities (PAIR) Program
 - 1. Continuing Applications for Investigator-Initiated minimal risk protocols:
 - a) Completed self-assessments that demonstrate noncompliance with post-approval responsibilities will be reviewed by an IRB subcommittee, for determination of noncompliance, serious or continuing noncompliance, and if applicable, determination of corrective plans or referral to IRB-E.

III. IRB Education and Quality Improvement Team Responsibilities

- A. The EQUIP teams works with HRP staff and the IRB to monitor unanticipated

problems involving risk to research participants or others.

- B. Periodic Quality Improvement (QI) Reviews
 - 1. Periodic QI reviews conducted by the HRP EQUIP team or designee may include, but are not limited to the following:
 - a) Repositories or DNA/Genotyping;
 - b) Research meeting exempt criteria;
 - c) Research meeting expedited criteria;
 - d) Research meeting full IRB Committee reviews;
 - e) Auditing advertisements and other recruiting material as deemed appropriate by the IRB;
 - f) Contact research subjects;
 - g) Observation of the consent process and/or documentation;
 - h) Observation of research interactions or interventions with research participants;
 - i) Non-human research or non-research;
 - j) Monitoring of the storage and use of investigational devices;
 - k) Review projects to verify from sources other than the LR that no unapproved changes have occurred since previous IRB review; and/or
 - l) Other monitoring activities as deemed appropriate by the IRB.
 - 2. Each month, the HRP EQUIP team and/or designee will perform one periodic QI reviews.
 - a) At least six of the twelve periodic QI reviews conducted annually will be conducted on social/behavioral research studies and at least one periodic compliance reviews will be conducted at non-UCI sites. Periodic QI reviews conducted on social/behavioral research studies will focus on research that involves greater than minimal risk, research that includes special and/or vulnerable populations, and/or research that involves collection of sensitive personal information.
 - b) The Lead Researcher will be contacted via e-mail using the compliance e-mail template to schedule the on-site visit.
 - c) An exit interview with the study personnel and/or the LR will be conducted at the conclusion of the compliance review to discuss the preliminary findings.
 - d) The HRP EQUIP team or designee will draft a review summary, which will include a summary of the findings, as well as specific recommendations.
 - e) A memo and a summary of findings will be distributed to the Director of Human Research Protections or designee, and the Chairperson of the IRB Committee responsible for the study.
 - f) All EQUIP periodic QI reviews will be placed on an agenda either as requiring a full committee review or for notification as determined by the IRB Committee Chair.
 - g) The original signed report will be placed in the "Periodic Compliance" Binder.
 - h) A copy will also be maintained electronically in a secure file.
- C. Directed (for cause) Reviews/Investigations
 - 1. The HRP EQUIP team or designee will contact the LR to schedule the on-site visit via e-mail.

2. The HRP EQUIP team or designee will conduct a focused or comprehensive review contingent upon consideration of the request and preliminary evaluation which may include, but is not limited to the following:
 - a) A review of the inclusion/exclusion criteria, participant selection and recruitment methods to verify that subject selection is appropriate;
 - b) A review of the consent process and/or documentation. This may include an observation of the consent process and/or review of the documentation of consent;
 - c) A review of progress reports requested from the LR;
 - d) A review of all study documentation, regulatory documents, presentations, and monitoring reports;
 - e) Monitoring the progress of the activity and intervening as necessary through such steps as visits to the activity site and continuing evaluation to determine if any unanticipated risks to participants or others have arisen; and/or
 - f) Any other related documents as deemed appropriate by the UCI IRB.
 3. Conclusion of review activities
 - a) HRP EQUIP team or designee will document the preliminary findings in writing as well as specific recommendations.
 - b) At the conclusion of the directed audit, an exit interview with the LR or his/her designee will be conducted to discuss the preliminary findings to facilitate the LR's understanding of the process and collaborate in resolving any outstanding issues or concerns.
 4. Reporting Activities
 - a) A memorandum and a summary of findings will be distributed to the Director of Human Research Protections or designee, the IRB Chairperson of the IRB Committee responsible for the study.
 - b) All audit summary reports will be placed on an agenda for full Committee review and a determination.
 5. Documentation
 - a) A compliance review hard-copy file will be created upon initiation of the review activities.
 - b) The summary report will be maintained electronically in a secure file as well as hard copy in a locked file cabinet.
- D. Off-site Reviews
1. External reviews are conducted by the HRP EQUIP team or designee at non-UCI sites where the UCI IRB serves as the IRB of Record. These reviews will be conducted in accordance with the procedures detailed above. Additionally, assuring proper recruitment, space, facilities, qualified staff, enrollment, and execution of the consenting process may be reviewed.
 2. The on-site visits will also entail review of documentation required when applying for a Memorandum of Understanding including but not limited to:
 - a) Verification of up-to-date comprehensive general liability and professional liability for all Investigators and research staff;
 - b) Correct titles and degrees for all research staff;
 - c) Verification of the researcher personnel's qualifications;
 - d) CVs for all research personnel;
 - e) Certificates for all researcher personnel verifying their successful completion of the UCI Human Subjects Training requirements or a comparable Human Research Protections training (e.g., CITI training);

- f) Documentation of the local research context; and
 - g) Names and phone numbers of the local contacts for each non-UCI site.
- E. Management of participant complaint and concerns
 1. To enhance the public's understanding of research, UCI HRP has developed the "Especially for Research Participants" web page which includes frequently asked questions about research participation, quick links to external web based resources, and the HRP staff contact information. The HRP staff and the IRB Working Group periodically reviews the web page to determine whether additional information can be provided and to verify that the information provided is accurate and up-to-date and the hyperlinks are active.
 2. The HRP staff is responsible for the processing, review and inquiry into all complaints and concerns that are brought to the attention of the IRB/HRP regarding human subjects research conducted at UCI and/or by UCI personnel. Complainants may include, but are not limited to subjects (past, present or potential), subject family members, investigators, other research staff, or any person with concerns. (See HRP Policy 54). When a subject complain may involve noncompliance (See HRP Policy 52), the EQUIP team works closely with the IRB Chair and IRB to manage the complaint.
- F. HRP Internal Quality Improvement (QI) Activities
 1. Minutes QI Review – EQUIP conducts a quarterly review of three random sets of IRB approved minutes using the IRB Minutes QI Review Form to assure compliance with federal regulations and UCI HRP policies.
 2. Informed Consent QI Review – Six IRB approved informed consent documents are reviewed monthly using the IRB Informed Consent QI Review Form to verify compliance with federal regulations and UC/UCI HRP policies.
 3. Review of IRB Protocols – EQUIP reviews the last three years of an IRB approved protocol in preparation for a Periodic Quality Improvement reviews. In addition, two additional random active studies will be reviewed by EQUIP.
 4. HRP Benchmark targets and Metrics Reports– the HRP has established benchmarks to measure efficiency in all phases of IRB review process. A monthly metric report is generated to evaluate compliance with the benchmark target.
 5. IRB Survey - The EQUIP team monitors comments, questions and issues received from the UCI investigators and from the IRB survey to identify areas for potential improvement in the effectiveness of HRP policies and procedures and for ensuring the protection of human research participants.
 6. A summary of findings will be distributed to the Director of Human Research Protections or designee. The information will be discussed at an IRB staff meeting, as applicable. As internal HRP problems are identified, the HRP EQUIP team will develop a solution and action plan to address the problem, implement the action plan, and evaluate the outcome to assure resolution.
 7. The QI forms will be filed electronically.
- G. Post-Approval Investigator Responsibilities
 1. Greater than minimal risk New Studies from a New Investigator or an Investigator-Initiated study:

- a) EQUIP team will randomly select qualified protocols and send an email memo to the LR/AC, with a notification to schedule an appointment with EQUIP staff to review Post-Approval Investigator Responsibilities.
 - (1) EQUIP staff will review the PAIR Form (General Requirements, and if applicable Addendum for Clinical Research Investigations) with the LR/AC.
 - (2) EQUIP staff will include a note in the HPS that a PAIR meeting has been completed, and update the metrics/tracking log.
- 2. Continuing Applications for Investigator-Initiated minimal risk protocols:
 - a) EQUIP team will randomly select qualified protocols and send an email memo to LR/AC, with a notification to complete a Post-Approval Investigator Responsibilities self-assessment form.
 - b) EQUIP staff will review the PAIR Self-Assessment Form
 - c) Completed self-assessments that demonstrate compliance with post-approval responsibilities:
 - (1) The signed self-assessment will be uploaded to HPS (docs tab) and File Net.
 - (2) Include an HPS notes tab that the PAIR self-assessment has been completed, and update the metrics/tracking log.
 - d) Completed self-assessments that demonstrate non-compliance with post-approval responsibilities:
 - (1) EQUIP staff will follow-up with a preliminary fact-finding memo, and include an note in the HPS notes-tab regarding noncompliance associated with a PAIR self-assessment form.
 - (2) LR response will be reviewed at subcommittee, with the following determinations:
 - (a) The matter is Noncompliance, but not serious nor continuing: Corrective actions required, and reviewed/resolved at the subcommittee level.
 - (b) The matter is Serious and/or Continuing Noncompliance, refer to EQUIP for-cause audit and IRB-E
 - (c) Resolve through the EQUIP and IRB-E process
 - (d) Upon resolution, update internal tracking system

IV. **General Responsibilities**

- A. If while conducting a directed audit or compliance review the auditor finds an issue that potentially places participants at risk, they will report the findings immediately to the Director of Human Research Protections or designee and the IRB Chairperson of the Committee responsible for the study.
- B. In addition, the auditor will clearly document the reasons for this determination.