SOP Table of Contents

STANDARD OPERATING PROCEDURES

HRP-001 - SOP - Definitions
HRP-012 - SOP - Observation of Consent Process
HRP-013 - SOP - LARs, Children, and Guardians
HRP-020 - SOP - Incoming Items
HRP-021 - SOP - Pre-Review
HRP-023 - SOP - Emerg and Device Comp Use Review
HRP-024 - SOP - New Information
HRP-025 - SOP - Investigations
HRP-026 - SOP- Susp or Term Issued Outside of Conv IRB
HRP-027 - SOP - Emerg Use Comp Use Indiv Pt Access Post Rev
HRP-030 - SOP - Designated Reviewers
HRP-031 - SOP - Non-Committee Review Preparation
HRP-032 - SOP - Non-Committee Review Conduct
HRP-040 - SOP - IRB Meeting Preparation
HRP-041 - SOP - IRB Meeting Conduct
HRP-042 - SOP - IRB Meeting Attendance Monitoring
HRP-043 - SOP - IRB Meeting Minutes
HRP-044 - SOP - Not Otherwise Approvable Research
HRP-050 - SOP - Conflicting Interests of IRB Members
HRP-051 - SOP - Consultation
HRP-052 - SOP - Post-Review
HRP-054 - SOP - Institutional Conflicts of Interests
HRP-055 - SOP - Financial Conflicts of Interests
HRP-060 - SOP - Annual Evaluations of the HRPP
HRP-061 - SOP - Quarterly Evaluations of the HRPP
HRP-063 - SOP - Expiration of IRB Approval

HRP-064 - SOP - NIH GDS Institutional Certification

HRP-065 - SOP - Response Plan for Emergencies-Disasters Impacting the HRPP

HRP-070 - SOP - IRB Records

HRP-071 - SOP - Toolkit Management

HRP-072 - SOP - IRB Records Retention

HRP-080 - SOP - IRB Formation and Registration

HRP-081 - SOP - IRB Removal

HRP-082 - SOP - IRB Membership Addition

HRP-083 - SOP - IRB Membership Removal

HRP-084 - SOP - IRB Meeting Scheduling and Notification

HRP-090 - SOP - Informed Consent Process for Research

HRP-091 - SOP - Written Documentation of Consent

HRP-099 - SOP - VA Research

HRP-801 - SOP - Establishing Authorization Agreements

HRP-802 - SOP - Institutional Profile Management

HRP-804 - SOP - External IRB Post-Review

HRP-805 - SOP - External IRB Updates

HRP-806 - SOP - Review Request to Cede Review

SOP: Definitions

1 PURPOSE

1.1 This policy establishes the definitions followed by the human research protection program. This is a non-exhaustive list and regulatory agencies should be referenced for complete definitions where applicable.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 Adverse Event (AE): For Veterans Administration (VA) human subjects research any untoward physical or psychological occurrence in a human subject participating in research, whether or not considered related to the subject's participation in research.

3.1.1 Adverse events are untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers.

3.2 Allegation of Non-Compliance: An unproved assertion of Non-Compliance.

3.3 Assurance of Compliance (Human Subjects) or Federalwide Assurance: An assurance is a written commitment to protect human research subjects and comply with the requirements of the Common Rule.

3.4 Authorization Agreement: Also called a Reliance Agreement, is the agreement that documents respective authorities, roles, responsibilities, and communication between an institution/organization providing the ethical review and a participating institution relying on the ethical review.

3.5 Certificate of Confidentiality: A Certificate of Confidentiality is a document issued by a component of HHS pursuant to The Public Health Service Act Section 301(d), 42 U.S.C. 241(d) amended by Section 2012 of the 21st Century Cures Act, Public Law 114-255, to protect the privacy of individuals who are subjects of certain specified research activities by authorizing investigators to withhold from all persons not connected with the conduct of such research the names or other identifying characteristics of such subjects. Persons so authorized to protect the privacy of such individuals may not disclose information in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals.

3.6 Certification: The official notification by the institution to the supporting Federal department or agency component that a research project or activity involving human subjects has been reviewed and approved by an IRB in accordance with an approved assurance.

3.7 Children: 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.

3.7.1 See HRP-013 - SOP - LARs, Children, and Guardians for applicable law at this institution.

3.8 Clinical Investigation: 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(i) or 520(g) of the Federal Food, Drug, and Cosmetic Act, or is not subject to requirements for prior submission to the FDA under these sections of the act, but the results of which are intended to be submitted later to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit.

3.9 Clinical Trial: A research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of the interventions on biomedical or behavioral health-related outcomes.

3.10 Coded Information/Data: For the purposes of this policy, identifying information that would enable the Investigator to readily ascertain the identity of the individual to whom the private information or specimens pertain has been replaced with a number, letter, symbol, or combination thereof and a key to decipher the code exists, enabling linkage of the identifying information to the private information or specimens.

3.11 Collaborating Individual Investigator: The Office for Human Research Protections notes that some human subjects research conducted by an assured institution may involve the following two types of collaborating individual investigators:

3.11.1 Collaborating independent investigator: not otherwise an employee or agent of the assured institution; conducting collaborative research activities outside the facilities of the assured institution; and not acting as an employee of any institution with respect to his or her involvement in the research being conducted by the assured institution.

3.11.2 Collaborating institutional investigator: not otherwise an employee or agent of the assured institution; conducting collaborative research activities outside the facilities of the assured institution; acting as an employee or agent of a non-assured institution with respect to his or her involvement in the research being conducted by the assured institution; and employed by, or acting as an agent of, a non-assured institution that does not routinely conduct human subjects research.

3.12 Collaborative Study: A study in which two or more institutions coordinate, with each institution completing a portion of the research activities outlined in a specific protocol.

3.12.1 For Veterans Administration (VA) research, Collaborative (Study) Research involves human subjects research activities involving investigators from VA and at least one non-VA institution. Collaborative Research includes VA and non-VA institutions.

3.13 Conflicting Interest: An individual involved in research review is automatically considered to have a conflicting interest when the individual or the individual's spouse, domestic partner, children, and/or dependents have any of the following interests in the sponsor, product or service being tested, or competitor of the sponsor held by the individual or the individual's immediate family:

3.13.1 Involvement in the design, conduct, or reporting of the research.

3.13.2 Ownership interest, stock options, or other ownership interest of any value exclusive of interests in publicly-traded, diversified mutual funds.

3.13.3 Compensation of any amount in the past year or of any amount expected in the next year, excluding compensation for costs directly related to conducting research.

3.13.4 Proprietary interest including, but not limited to, a patent, trademark, copyright or licensing agreement.

3.13.5 Board or executive relationship, regardless of compensation.

3.13.6 Reimbursed or sponsored travel by an entity other than a federal, state, or local government agency, higher education institution or affiliated research institute, academic teaching hospital, or medical center.

3.13.7 Any other reason for which the individual believes that he or she cannot be independent.

3.14 Continuing Non-Compliance: A pattern of Non-Compliance that indicates an inability or unwillingness to comply with applicable laws, regulations, or institutional policies pertaining to the protection of human subjects and / or with the requirements or determinations of an IRB.

3.14.1 For Veterans Administration (VA) research Continuing Non-Compliance means repeated instances of same or similar noncompliance with applicable laws, regulations, policies, agreements, or determinations of a research review committee or the prolonged persistence of noncompliance occurring after its identification, awareness, or implementation of a corrective action intended to effectively resolve the noncompliance.

3.15 Continuing Review**:** Periodic review of research activities necessary to determine whether the risk/benefit ratio has changed, whether there are unanticipated findings involving risks to participants

or others, whether any new information regarding the risks and benefits should be provided to participants, and to ensure that the protocol remains in compliance with all federal regulations, state laws and UC/UCI policies and procedures.

3.16 Cooperative Research: Cooperative research projects are non-exempt/clinical investigations that involve more than one institution. See Collaborative Study and Multi-Site Study.

3.17 De-Identified Health Information: Health information that has been stripped of all 18 identifiers as defined by HIPAA (*See* Appendix A), so that the information could not be traced back to an individual. De-identified data also pertains to health information that has been assigned and retains a code or other means of identification provided that:

3.17.1 The code is not derived from or related to the information about the individual;

3.17.2 The code could not be translated to identify the individual; and

3.17.3 The covered entity (as described above) does not use or disclose the code for other purposes or disclose the mechanism for re-identification.

3.18 Designated Reviewer: The IRB chair, an Experienced IRB Member (including an IRB Staff Reviewer) as designated by the IRB chair to conduct Non-Committee Reviews.

3.19 Deviation: Accidental or unintentional change to the research protocol that does not increase risk or decrease benefit or have a significant effect on the participant's rights, safety or welfare, or on the integrity of the data. Deviations may result from the action of the participant, researcher, or staff. *This definition may not match the Principal Investigator's or Sponsor's definition.* Examples: a rescheduled study visit, an omitted routine safety lab for a participant with previously normal values; or failure to collect an ancillary self-report questionnaire data (e.g., quality of life).

3.20 Experienced IRB Member: An IRB member is considered experienced if the IRB chair considers the IRB member to have sufficient experience in and knowledge of conducting IRB reviews.

3.21 Experimental Subject: For Department of Defense (DOD) research, research involving an "experimental 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 "experimental subjects" is a subset of research involving human participants.

3.22 Expiration Date: The first date that the protocol is no longer approved. The date after the end date of the approval period.

3.23 Finding of Non-Compliance: Non-Compliance in fact.

3.24 Guardian: an individual who is authorized under applicable state or local law to consent on behalf of a child to general medical care.

3.24.1 See HRP-013 - SOP - LARs, Children, and Guardians for applicable law at this institution.

3.25 HIPAA Authorization: A customized document, usually as a part of the informed consent document, that gives UCI permission to use specified protected health information (PHI) for a specific purpose, or to disclose PHI to a third party specified by the individual other than for treatment, payment or healthcare operations.

3.26 Human Research: Any activity that either:[i]

3.26.1 Is Research as Defined by DHHS and involves Human Subjects as Defined by DHHS; or

3.26.2 Is Research as Defined by FDA and involves Human Subjects as Defined by FDA.

3.27 Human Subject as Defined by DHHS: A living individual about whom an investigator (whether professional or student) conducting research (1) obtains information or biospecimens through Intervention or Interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or (2) obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens. For the purpose of this definition:

3.27.1 Intervention: Physical procedures by which information or biospecimens are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes.

3.27.2 Interaction: Communication or interpersonal contact between investigator and subject.

3.27.3 Private Information: 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 that the individual can reasonably expect will not be made public (for example, a medical record).

3.27.4 Identifiable Private Information[ii]: Private Information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information.

3.27.5 Identifiable Biospecimen[iiiiii]: A biospecimen for which the identity of the subject is or may be readily ascertained by the investigator or associated with the biospecimen.

3.28 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 a medical device is used.

3.29 Immediate Family: Spouse, domestic partner; and dependent children.

3.30 Individual Investigator Agreement: a permissible mechanism under which an institution holding an Office for Human Research Protections (OHRP)-approved Federalwide Assurance (FWA) may extend – for one or more research protocols – the applicability of its FWA to cover two types of collaborating individual investigators: collaborating independent investigators and collaborating institutional investigators employed by a non-assured institution.

3.31 Institutional Review Board (IRB): A specifically constituted review body established or designated by an entity to protect the rights and welfare of human subjects recruited to participate in biomedical or social science/behavioral research.

3.32 Institutional Official/ Organizational Official (IO/OO):

3.32.1 Institutional Official (IO): Term utilized by DHHS. The Institutional Official (IO) is the individual who is legally authorized to act for the institution and, on behalf of the institution, obligates the institution to the Terms of the Assurance. The IO is responsible for ensuring that the Human Research Protection Program (HRPP) functions effectively and that the institution provides the resources and support necessary to comply with all requirements applicable to research involving human subjects. The IO represents the institution named in the Federalwide Assurance (FWA)[iii]. The IO is the Title.

3.32.2 For Veteran's Administration (VA) research, the Institutional Official (IO) is the individual legally authorized as Signatory Official to commit an institution to an FWA. The Signatory Official assures that human subjects research to which the FWA applies is conducted in accordance with the terms of the assurance (see VHA Handbook 1058). The Principal Deputy Under Secretary for Health or designee is the IO for VHA Central Office, and VA facility Directors are the IOs for local VA facilities.

3.33 Institutional Profile: A record of information an institution keeps about another collaborating institution/organization for one or more Collaborative Studies or Multi-Site Studies.

3.34 Investigation: A searching inquiry for facts; detailed or careful examination.

3.35 Legally Authorized Representative (LAR): An individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedures(s) involved in the research.

3.35.1 If there is no applicable law addressing this issue, then this individual is recognized by institutional policy as acceptable for providing consent in the non-research context on behalf of the prospective subject to the subject's participation in the procedure(s) involved in the research.

3.35.2 See HRP-013 - SOP - LARs, Children, and Guardians for who may serve as a Legally Authorized Representative at this institution.

3.36 Limited Data Set: Protected health information that excludes direct identifiers of the individual or of relatives, employers, or household members of the individual, with the exception of city, state, ZIP Code, elements of dates, and other numbers, characteristics, or codes not listed as direct identifiers.

3.37 Minimal Risk: The probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.[iv]

3.37.1 For research involving prisoners Minimal Risk is the probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons.

3.37.2 When following Department of Defense regulations, the definition of minimal risk in 32 CFR 219 does not include the inherent occupational risks that certain participants face in their everyday life, such as those:

3.37.2.1 Encountered by Service members, law enforcement, or first responders while on duty.

3.37.2.2 Resulting from or associated with high-risk behaviors or pursuits.

3.37.2.3 Experienced by individuals whose medical conditions involve frequent tests or constant pain.

3.38 Multi-Site Study: A study in which two or more institutions coordinate, with each institution completing all research activities outlined in a specific protocol.

3.39 Non-Committee Review: Any of the following:

3.39.1 Determination of whether an activity is Human Research.

3.39.2 Determination of whether Human Research is exempt from regulation.

3.39.3 Reviews of non-exempt research using the expedited procedure.

3.39.4 Determinations of which subjects can continue in expired research.

3.39.5 Concurrence of IRB Chair or designee for non-emergency individual patient/small group expanded access for an unapproved medical device (commonly known as Compassionate Use) or non-emergency individual patient expanded access IND with request for authorization to use alternative IRB review procedures.

3.40 Non-Compliance: Failure to comply with applicable laws, regulations, or institutional policies pertaining to the protection of human subjects, and/or with the requirements or determinations of an IRB.

3.40.1 In the case of research funded or conducted by the Department of Defense (DOD), Non-Compliance includes failure of a person, group, or institution to act in accordance with Department of Defense (DOD) instruction 3216.02, its references, or applicable requirements

3.40.2 In the case of Veterans Administration (VA) research, Non-Compliance is any failure to adhere to the requirements for overseeing, reviewing, approving, or conducting VA research set forth in law, regulation, policy, or study agreements (such as reliance agreements, memoranda of understanding, data use agreements), including any failure to conduct research in accordance with a VA study protocol approved by a research review committee.

3.41 Nonviable: An expelled or delivered fetus which, although it is living, cannot possibly survive to the point of sustaining life independently, even with the support of available medical therapy [45 CFR 46.203 (d) and (e)]. Although it may be presumed that an expelled or delivered fetus is nonviable at a gestational age less than 20 weeks and weight less than 500 grams [Federal Register 40 (August 8, 1975): 33552], a specific determination as to viability must be made by a physician in each instance.

3.42 Participating Site (pSite): An institution that participates in a Single IRB (sIRB) Study.

3.43 Prisoner: 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.

3.43.1 For Department of Defense (DOD) research the term includes military personnel in either civilian or military custody.

3.44 Protected Health Information (PHI): Individually identifiable health information that is or has been collected or maintained by the covered entity in the course of providing healthcare that can be linked back to the individual participant.

3.45 Protocol Exception: a one-time, intentional action or process that departs from the approved protocol. Protocol Exceptions are generally for a single subject (e.g., the subject does not meet eligibility criteria or is allergic to one of the medications provided as supportive care). IRB approval of the Protocol Exception is required prior to implementation by the study team.

3.46 Related to the Research: A financial interest is Related to the Research when the interest is in:

3.46.1 Related financial interests occur when the Researcher, their spouse/registered domestic partner and/or dependent children have a disclosable financial interest that would reasonably appear to be affected by the research or when the entity in which the financial interests are held would reasonably appear to be affected by the research.

3.46.2 The following are examples (which are not all inclusive) of related financial interests:

3.46.2.1 The project results could be relevant to the development, manufacturing, or improvement of products or services of the entity in which the Researcher has a financial interest.

3.46.2.2 The Researcher has a financial interest in an entity that might license (for commercial purposes) an invention, technology, drug, device, procedure or any other product used in the project or that will predictably result from the project.

3.46.2.3 The Researcher received compensation from activities in his/her professional field during the prior twelve months, where the financial interest of the entity or the investigator would reasonably appear to be affected by the project.

3.46.2.4 The Researcher has a financial interest in an entity, and the project proposes to subcontract a portion of the work, or lease property, or refer participants to, or make purchases from the entity.

3.46.2.5 The Researcher has a financial interest in an entity that will participate in the project, including as part of a consortium.

3.47 Research as Defined by DHHS: A systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

3.47.1 The following activities are not considered Research as Defined by DHHS:

3.47.1.1 Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.

3.47.1.2 Public health surveillance activities conducted by a public health authority, limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance.

3.47.1.2.1 Including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority.

3.47.1.2.2 Including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products.

3.47.1.2.3 Including those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters).

3.47.1.3 Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes.

3.47.1.4 Authorized operational activities (as determined by the relevant federal agency) in support of intelligence, homeland security, defense, or other national security missions.

3.47.1.5 Secondary research involving non-identifiable newborn screening blood spots.

3.48 Research as Defined by FDA: Any experiment that involves a test article and one or more Human Subjects, and that meets any one of the following:

3.48.1 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;

3.48.2 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

3.48.3 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.

3.49 Restricted: Applies to investigators who are delinquent in meeting IRB requirements.

3.50 Research (Scientific) Misconduct: Fabrication, falsification, plagiarism or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, performing, or reviewing research, or reporting research results. Misconduct does not include honest error or honest differences in interpretations or judgments of data

3.51 Right to Try: In May 2018, the Federal Right to Try (RTT) Act was signed into law, creating a federal framework for patients to access investigational new drugs and biologics outside of clinical trials and outside of the U.S. Food and Drug Administration's (FDA) expanded access program. The federal law enables manufacturers and physicians to provide investigational drugs to eligible patients without risk of liability. It follows California's passage of the State's Right to Try Act, signed into law in 2016. Similar to the federal law, the California law enables manufacturers and physicians to provide investigational products to eligible patients without risk of liability under state law.

3.52 Serious Adverse Event (SAE): An untoward occurrence, whether or not considered related to a subject's participation in Human Research, that results in death, a life-threatening experience, inpatient hospitalization, prolongation of hospitalization, persistent or significant disability or incapacity, congenital anomaly or birth defect, or that requires medical, surgical, behavioral, social or other intervention to prevent such an outcome.

3.53 Serious Non-Compliance: Non-Compliance such that the failure to comply could adversely affect the rights, safety, or welfare of a human subject; place a human subject at increased risk of harm; cause harm to a human subject; affect a human subject's willingness to participate in research; or damage or compromise the scientific integrity of research data.

3.53.1 For Department of Defense (DOD) research Serious Non-Compliance includes failure of a person, group, or institution to act in accordance with Department of Defense (DOD) Instruction 3216.02 and its references such that the failure could adversely affect the rights, safety, or welfare of a human subject; place a human subject at increased risk of harm; cause harm to a human subject; affect a human subject's willingness to participate in research; or damage or compromise the scientific integrity of research data.

3.53.2 For Veterans Administration (VA) research Serious Non-Compliance is any failure to adhere to requirements for conducting Human Research that may reasonably be regarded as:

3.53.2.1 Presenting a genuine risk of substantive harm, to the safety, rights, or welfare of human research subjects, or others, including their rights to privacy and confidentiality of identifiable private information;

3.53.2.2 Presenting a genuine risk of substantive harm to the safety, rights, or welfare of research personnel who conduct research;

3.53.2.3 Presenting a genuine risk of substantive reputational harm to the Veterans Administration (VA); or

3.53.2.4 Substantively compromising a VA medical facility's human research protection programs (HRPP).

3.54 Single IRB (sIRB) Study: A study in which two or more institutions (participating sites, or pSites) coordinate to complete the research activities, but all institutions rely on a single

institution's/organization's IRB for ethical review. The reviewing IRB may or may not be affiliated with any of the pSites.

3.55 Suspension of IRB Approval: An action of the IRB, IRB designee, Institutional Official/Organizational Official, or designee of the Institutional Official/Organizational Official to temporarily or permanently withdraw IRB approval of some or all research procedures short of a Termination of IRB Approval. Suspended studies remain open and are subject to continuing review.

3.56 Systematic: Having or involving a system, method, or plan.

3.57 Termination of IRB Approval: An action of the IRB, IRB designee, Institutional Official/Organizational Official, or designee of the Institutional Official/Organizational Official to permanently withdraw IRB approval of all research procedures. Terminated studies are permanently closed and no longer require continuing review.

3.58 UCI Facilities: Facilities owned, operated, or leased by UCI including UCI campus, UCIMC, and any space rented to the University.

3.59 UCI Personnel: UCI students, staff, and faculty (including part-time, emeritus, and volunteer faculty), or any other agents of UCI.

3.60 UCI Resources: Funds, facilities, employee time, equipment, supplies, services, and non-public information.

3.61 Unanticipated: An event is "unanticipated" when it was unforeseeable at the time of its occurrence. Unanticipated and unexpected are not synonymous. A research protocol can monitor for an unexpected event but cannot monitor for an unforeseen event. All unanticipated events are unexpected, but not vice versa.

3.62 Unanticipated Problem Involving Risks to Participants or Others: Any event, experience, or problem that is: (1) unexpected (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the IRB-approved documents, such as the protocol and informed consent document, and (b) the characteristics of the subject population being studied; (2) related or possibly related to participation in the research (possibly related means there is a reasonable possibility that the incident, experience, or problem may have been caused by the procedures involved in the research); and (3) suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.[v]

3.62.1 For Department of Defense (DOD) research the term Unanticipated Problem Involving Risks to Subjects or Others includes any incident, experience, or outcome that meets ALL three of the following conditions:

3.62.1.1 Is unexpected (in terms of nature, severity, or frequency) given the procedures described in the research protocol documents (e.g., the IRB-approved research protocol and informed consent document) and the characteristics of the human subject population being studied.

3.62.1.2 Is related or possibly related to participation in the research (in this Instruction, possibly related means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research).

3.62.1.3 Suggests that the research places human subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized, even if no harm has actually occurred.

3.62.2 For Veterans Administration (VA) research:

3.62.2.1 Unanticipated Problem Involving Risks to Subjects or Others (UPIRTSO) is an incident, experience or outcome that is: unexpected; related or possibly related to participation in the research; and indicative of the research placing subjects or others at substantively greater risk of harm (including physical, psychological, economic or social harm) than was previously known or recognized.

3.62.2.2 The term "unexpected" refers to an incident, experience, or outcome that is new or greater than previously known in terms of nature, severity, or frequency, given the

procedures described in protocol-related documents and the characteristics of the study population.

3.62.2.3 The phrase "related to participation in the research" means a logical sequence of cause and effect shows that the study procedures were the reason for the incident, experience, or outcome. The phrase "possibly related to participation in the research" implies a lesser degree of certainty about causality and refers to an incident, experience, or outcome for which there is some evidence to reasonably suggest a causal relationship between study procedures and the incident, experience, or outcome.

3.62.2.4 An unexpected SAE that is related or possibly related to participation in human subjects research constitutes a UPIRTSO.

4 RESPONSIBILITIES

4.1 Individuals writing policies and procedures are to indicate terms defined in this policy with a double underline.

4.2 Individuals using policies and procedures are to consult this policy for the definitions of double underlined terms.

5 PROCEDURE

5.1 None

6 MATERIALS

6.1 HRP-013 - SOP - LARs, Children, and Guardians

7 REFERENCES

7.1 UCI Administrative Policies and Procedures Section 481-3: Conflicts of Interest in Human Subjects Research

7.2 45 CFR §46.102

7.3 21 CFR §50.3, 21 CFR §56.102, 21 CFR §312.3, 21 CFR §812.2(a), 21 CFR §812.3(p)

7.4 VHA Directive 1058 dated November 8, 2024; VHA Directive 1004.08 dated October 31, 2018; VHA Directive 1200.05(3) dated January 7, 2019, amended July 13, 2023

---

[i] The terms "Human Subject Research," "Research Involving Human Subjects," "Clinical Research," "Clinical Investigation," "Clinical Study" and similar phrases are considered to be synonyms for the term Human Research.

[ii] Definitions of "identifiable private information" and "identifiable biospecimen" are included in FDA's proposed rule to amend part 50, Protection of Human Subjects, and part 56, Institutional Review Boards (87 FR 58733, September 28, 2022). In that rule, the proposed definitions of "identifiable private information" and "identifiable biospecimen" harmonize with the revised Common Rule's definitions of these terms (45 CFR 46.102(e)(5) and (6)).

[iii] https://www.hhs.gov/ohrp/sachrp-committee/recommendations/2008-september-18-letter-attachment/index.html

[iv] The phrase "ordinarily encountered in daily life or during the performance of routine physical or physiological examinations or tests" should not be interpreted to include the inherent risks certain categories of 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 environment (e.g., emergency responder, pilot, soldier in a combat zone) or having a medical condition (e.g., frequent medical tests or constant pain).

[v] See OHRP guidance "Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events: OHRP Guidance (2007)" at https://www.hhs.gov/ohrp/regulations-and-policy/guidance/reviewing-unanticipated-problems/index.html

SOP: Observation of Consent Process

1 PURPOSE

1.1 This procedure establishes the process to observe the consent process.

1.2 The process begins when the IRB determines that the consent process should be observed.

1.3 The process ends when the IRB determines that the consent process no longer should be observed.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The IRB may consider observation of the consent process when:

3.1.1 The IRB wants verification from sources other than the investigator that no material changes have taken place since prior IRB review.

3.1.2 There are Allegations or Findings of Non-Compliance.

3.1.3 The nature of the research indicates that the consent process can be improved through observation.

3.2 The IRB, Institutional Official/ Organizational Official (IO/OO), or designee designates who conducts the observation. The IRB may have the observation conducted by:

3.2.1 IRB staff.

3.2.2 IRB members.

3.2.3 A person recommended by the investigator.

3.2.4 An independent person hired by the IRB, paid for by the investigator's funds.

4 RESPONSIBILITIES

4.1 The person designated to conduct the observation of the consent process carries out these procedures.

5 PROCEDURE

5.1 Observe the consent process and determine whether the information in the consent document and any other written information was accurately explained to, and apparently understood by, the subject or the subject's Legally Authorized Representative (LAR), and that informed consent was freely given by the subject or the LAR.

5.1.1 If not, indicate that consent is not legally effective, and the prospective subject may not be entered into the research.

5.1.2 If yes, document in writing that the consent process was observed, and that informed consent was freely given by the subject or LAR.

6 MATERIALS

6.1 None

7 REFERENCES

7.1 None

SOP: LARs, Children, and Guardians

1. PURPOSE

1.1. This policy establishes how to determine which individuals meet the following DHHS and FDA definitions:

1.1.1. Legally Authorized Representative (LAR)

1.1.2. Children

1.1.3. Guardian

2. REVISIONS FROM PREVIOUS VERSION

2.1. None

3. POLICY

3.1. Unless the IRB has waived the requirement to obtain consent, when research involves adults unable to consent, permission must be obtained from a LAR.

3.1.1. When research is conducted in California the following individuals meet this definition:

3.1.1.1. A “legally authorized representative” means "an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject’s participation in the procedure(s) involved in the research."

3.1.1.2. In California, individuals under the age of 18 years old are considered minors. Because in California some people under 18 years of age can consent for themselves to some research procedures, not all “minors” meet the federal criteria for being “children.”

3.1.1.3. California Health & Safety Code § 24178 identifies the individuals who are legally authorized in California to provide surrogate consent for research.

3.1.1.4. For purposes of obtaining informed consent required for medical experiments i*n a non-emergency room environment,* if a person is unable to consent and does not express dissent or resistance to participation, surrogate informed consent may be obtained from a SDM with reasonable knowledge of the subject, who shall include any of the following persons, in the following descending order of priority:

3.1.1.4.1. The agent named in the potential research participant’s advance health care directive. The conservator or guardian of the potential research participant, with authority to make healthcare decisions for the potential participant.

3.1.1.4.2. The spouse of the potential research participant.

3.1.1.4.3. The registered domestic partner of the potential research participant as defined in Section 297 of the Family Code.

3.1.1.4.4. An adult child of the potential research participant.

3.1.1.4.5. A custodial parent of the potential research participant.

3.1.1.4.6. An adult sibling of the potential research participant.

3.1.1.4.7. An adult grandchild of the potential research participant.

3.1.1.4.8. An available adult relative with the closest degree of kinship to the potential research participant, whose relationship to the potential participant does not fall within one of the above listed categories (e.g., aunt; uncle; cousin; etc.).

3.1.1.4.9. The investigator is responsible for making a reasonable effort to determine if that individual is available to serve as surrogate. Potential surrogates must be advised that if a higher-ranking surrogate is identified at any time, the investigator will defer to the higher-ranking surrogate's decision regarding the subject's participation in the research. When there are two or more available persons who may provide surrogate consent and who are in the same order of priority (e.g., an adult son and daughter of the potential participant), if any of those persons in the same order of priority expresses dissent as to the participation of the person in the medical experiment, consent shall not be considered as having been given.

3.1.1.5. For purposes of obtaining informed consent required for medical experiments *in an emergency room environment,* if a person is unable to consent and does not express dissent or resistance to participation, surrogate informed consent may be obtained from a SDM who is any of the following persons:

3.1.1.5.1. The agent named in the potential research participant's advance health care directive.

3.1.1.5.2. The conservator or guardian of the potential research participant, with authority to make health care decisions for the potential participant.

3.1.1.5.3. The spouse of the potential research participant.

3.1.1.5.4. The registered domestic partner of the potential research participant as defined in Section 297 of the Family Code.

3.1.1.5.5. The adult child of the potential research participant.

3.1.1.5.6. A custodial parent of the potential research participant.

3.1.1.5.7. An adult sibling of the potential research participant.

3.1.1.5.8. In emergency room research settings, no surrogate consent may be utilized if there is a disagreement whether to consent among any available surrogates.

3.1.1.5.9. SDMs described in this section shall exercise substituted judgment, and base decisions about participation in accordance with the person's individual health care instructions, if any, and other wishes, to the extent known to the SDM. Otherwise, the SDMs shall make the decision in accordance with the person's best interests. In determining the person's best interests, the SDM shall consider the person's personal values and his or her best estimation of what the person would have chosen if he or she were capable of making a decision per Cal. Health & Safety Code § 24178(g).

3.1.1.5.10. A surrogate decision-maker is prohibited from receiving financial compensation for providing consent per Cal. Health & Safety Code § 24178(i).

3.1.1.5.11. Section 3.1.1.4. and 3.1.1.5. above do not apply to any of the following persons, except as otherwise provided by law:

3.1.1.5.11.1. Persons who lack the capacity to give informed consent and who are involuntarily committed pursuant the California Welfare and Institutions Code § 5000 *et seq*; or

3.1.1.5.11.2. Persons who lack the capacity to give informed consent and who have been voluntarily admitted or have been admitted upon the request of a conservator pursuant to Chapter 1 (commencing with Section 6000) of Part 1 of Division 6 of the California Welfare and Institutions Code.

3.1.1.6. Required Documentation. In all cases involving adult patients who are incompetent or lacks decision-making capacity for healthcare decisions and consent of a

Surrogate Decision-Maker is utilized, the Principal Investigator, shall document in the medical record:

3.1.1.6.1. The basis for their determination that the individual lacks decision-making capacity;

3.1.1.6.2. The investigator must detail a decision-making capacity assessment which the IRB reviews and approves.

3.1.1.6.3. If the determination that the prospective participant lacks decision making capacity is based on a diagnosis of mental illness, the researcher obtains consultation with a psychiatrist or licensed psychologist.

3.1.1.6.4. The identity of the SDM and the rationale for the selection of the individual as SDM, which shall be documented on the Investigator Certification of Surrogate Decision Makers for Potential Subject's Participation in University of California Research form. A copy of the form should be provided to the SDM. In addition, the researcher must keep the original, signed form in the research records with the signed informed consent document.

3.2. For research outside California, a determination of who is a LAR is to be made with consultation from legal counsel.

3.3. DHHS and FDA's Subpart D applies to all research involving children.

3.3.1. When research is conducted in California all individuals under the age of 18 years are children. Exceptions exist for minors as follows.

3.3.2. Minors may consent for themselves to medical care related to the prevention or treatment of pregnancy, but not necessarily to sterilization or abortion [California Family Code Section 6925; Health and Safety Code Section 123450 for abortion].[1]

3.3.2.1. Minors 12 years of age or older have the legal right to consent on their own behalf, for:

3.3.2.1.1. Mental health treatment or counseling on an outpatient basis or residential shelter services (in limited circumstances) [California Family Code Section 6924].

3.3.2.1.2. Medical care related to the diagnosis or treatment of infectious, contagious, or communicable diseases that are required to be reported to the local health officer or a related sexually transmitted disease [California Family Code Section 6926].

3.3.2.1.3. Medical care related to the diagnosis or treatment of the condition and collection of medical evidence about alleged rape or sexual assault [California Family Code Section 6927].

3.3.2.1.4. Medical care and counseling related to the diagnosis and treatment of an alcohol or drug-related problem [California Family Code Section 6929].

3.3.2.2. Self-sufficient minors who are:

3.3.2.2.1. 15 years of age or older;

3.3.2.2.2. living separately from their parents/guardians; and

3.3.2.2.3. managing their own financial affairs have the legal right to consent on their own behalf to medical or dental care [California Family Code 6922].

[1] American Academy of Pediatrics v. Lungren (1997) 16 Cal.4th 307. **A minor may consent to an abortion without parental consent and without court permission.** California Health and Safety Code remains unchanged.

3.3.2.3. Emancipated minors, those who are:
3.3.2.3.1. married or divorced
3.3.2.3.2. on active duty in the U.S. armed forces *or* emancipated by the court; and
3.3.2.3.3. have the legal right to consent on their own behalf to medical, dental, or mental health treatment. They also have extensive other rights to enter into legal and business arrangements, and so can consent to be included in other research (e.g., interviews, surveys) [California Family Code 7000-7143].
3.3.2.4. Capacity to consent depends upon:
3.3.2.4.1. The age, ability, experience, education, training, and degree of maturity and judgment of the minor. A minor between the ages of fourteen (14) and eighteen (18) may have such capacity, but a minor under the age of fourteen (14) would rarely have such capacity;
3.3.2.4.2. The conduct and demeanor at the time consent is to be given;
3.3.2.4.3. The totality of the circumstances;
3.3.2.4.4. The nature of the proposed research procedures and their risks, probable consequences, benefits, and alternatives to the treatment; and
3.3.2.4.5. The minor's ability to appreciate the nature, risks, consequences, benefits, and alternatives of the proposed research procedures.
3.3.3. Contact legal counsel for more information.
3.3.4. For research outside California, a determination of who is a child is to be made with consultation from legal counsel.

3.4. Unless the IRB has waived the requirement to obtain consent, when research involves children consent may only be obtained from biologic or adoptive parents, guardian, an individual legally authorized to consent on behalf of the child to general medical care[i]. Before obtaining permission from an individual who is not a parent, contact legal counsel.

4. RESPONSIBILITIES

4.1. Investigators are to follow this policy when obtaining permission for adults unable to consent or children to take part in research.

5. PROCEDURE

5.1. None

6. MATERIALS

6.1. None

7. REFERENCES

7.1. 45 CFR §46.102, 45 CFR §46.402
7.2. 21 CFR §50.3

[i] DHHS and FDA definition of “guardian.”

SOP: Incoming Items

1 PURPOSE

1.1 This procedure establishes the process to triage information submitted to the IRB.
1.2 The process begins when any communication is received by the IRB.
1.3 The process ends when an IRB staff member determines the appropriate action for the received information.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 None

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

5 PROCEDURE

5.1 If the item is a request either for this IRB to review for another Participating Site (pSite) or for this institution to rely on an external IRB, follow HRP-021 - SOP - Pre-Review.
5.2 If the item is a request for an approval or determination[i] by this institution's IRB that does not include other pSites, follow HRP-021 - SOP - Pre-Review.
5.3 If the item is an update to a study for which an external IRB is the IRB of record, follow HRP-805 - SOP - External IRB Updates.
5.3.1 If there are financial disclosures, follow HRP-055 - SOP - Financial Conflicts of Interests.
5.4 If the item is a notification of an emergency use of a test article in a life-threatening situation have a Designated Reviewer follow HRP-023 - SOP - Emergency Use, Compassionate Use, Indiv Patient Expanded Access.
5.5 If the item is an investigator's request to continue subjects in expired research have a Designated Reviewer follow HRP-063 - SOP - Expiration of IRB Approval.
5.6 If the item does not fit into the above categories:
5.6.1 If the item is a question, concern, or complaint involving research or human subjects:
5.6.1.1 Document the nature of the question, concern, or complaint and the contact information of the person contacting the IRB.
5.6.1.2 Respond to any questions or concerns. When appropriate, tell the person that you will call/email him/her once you have been able to find additional information. If necessary, consult with your supervisor.
5.6.2 Follow HRP-024 - SOP - New Information.
5.7 Self-determination of either non-human subject research or exemption will remain in pre-review status. They are not to be submitted for IRB review.
5.8 Assign items to IRB staff for pre-review no later than 2 business days.

6 MATERIALS

6.1 HRP-021 - SOP - Pre-Review
6.2 HRP-023 - SOP - Emergency Use, Compassionate Use, Indiv Patient Expanded Access
6.3 HRP-055 - SOP - Financial Conflicts of Interests
6.4 HRP-063 - SOP - Expiration of IRB Approval

[i] A “request for an approval or determination” includes approval of new research, response to modifications required to secure approval, continuing review of research, modification to previously approved research, request for study closure, or a determination whether an activity is exempt Human Research or is not Human Research.

SOP: Pre-Review

1 PURPOSE

This procedure establishes the process to pre-review a request for approval (approval of new research, approval to rely on an external IRB, humanitarian use device (HUD), continuing review of research, or modification to previously approved research) or a determination whether an activity is exempt Human Research, self-exempt Human Research or is not Human Research.

1.1 The process begins when the IRB receives a request for local IRB approval, including requests from other institutions when this institution is the IRB of record, e.g., for a Collaborative Study or Multi-Site Study, or a request to rely on an external IRB.

1.2 The process ends when the information has been placed on the agenda for an IRB meeting or will be handled by Non-Committee Review, or the information is sent to the Reliance Coordinator or IRB staff to review the request to rely on an external IRB.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The addition of a participating site to a previously approved protocol for which the IRB will serve as the IRB of record for that participating site is considered a modification to previously approved research.

3.2 Single subject protocol exceptions are reviewed as modifications to previously approved research. [i]

3.3 A new HUD protocol submission must be reviewed at a convened IRB meeting. Continuing review of a HUD can be handled by Non-Committee Review.

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

5 PROCEDURE

5.1 If the submission is a response to modifications required to secure approval received within 30 days of the IRB review date:

5.1.1 Evaluate whether the investigator made the required modifications.

5.1.2 If the investigator made the required modifications, follow HRP-052 - SOP - Post-Review to issue an approval.

5.1.3 If the investigator did not make the required modifications or made unrequested modifications, execute the “Request Pre-Review Clarification” activity from the investigator. Offer the investigator the opportunity to correct the submission.

5.1.3.1 If the investigator corrects the submission, have the investigator make changes then execute the “Submit Response” activity and stop processing the current submission until changes are received.

5.1.3.2 If the investigator will not correct the submission, have the investigator execute the “Submit Response” activity to resubmit and continue processing.

5.2 If the request is for this institution to rely on an external IRB:

5.2.1 Refer to HRP-806 - SOP - Review Request to Rely on External IRB

5.3 If the request includes review of a pSite submission:

5.3.1 Determine if the pSite is engaged in the non-exempt human subjects research using HRP-311- WORKSHEET - Engagement Determination.

5.3.1.1 If the pSite is not engaged in the non-exempt human subjects research, execute the "Submit Invitation Decision" activity to notify the lead investigator using HRP-850 - LETTER - Decline to Serve that this IRB will not serve as the IRB of Record for the pSite.

5.3.2 If the pSite is engaged, click on the Institutional Profile area in the IRB system and:

5.3.2.1 Confirm that the pSite has an active profile. If not, see 5.3.2.2.1.

5.3.2.2 Determine whether an existing Authorization Agreement covers the study activities for the pSite.

5.3.2.2.1 If not, follow HRP-801 - SOP - Establishing Authorization Agreements to collect the information needed to confirm reliance and create a new or updated Institutional Profile in the IRB system.

5.3.3 Execute the "Submit Invitation Decision" activity to notify the pSite using HRP-851 - LETTER - Invitation Decision or HRP-850 - LETTER - Decline to Serve that this IRB will or will not serve as the IRB of Record for their participation in the study.

5.3.4 If the IRB will serve as the sIRB for the pSite, after all site materials are submitted, proceed to Section 5.7.

5.4 For all other submissions, complete Pre-Review Activity or review the previously completed Pre-Review Activity and revise as needed, considering the items on HRP-308 - WORKSHEET - Pre-Review and note all remaining contingencies in the "Notes" section.

5.5 If the information is not complete, contact the investigator by selecting the "Request Pre-Review Clarifications" Activity. Offer the investigator the opportunity to provide additional information.

5.5.1 Continue processing once the investigator responds to the request for additional information.

5.6 If the request is for an initial approval and principal investigator is Restricted, contact the investigator. Explain that the investigator is Restricted, give the reasons, and indicate that if a new protocol goes to the IRB, the IRB policy is to disapprove the research. Offer the investigator the opportunity to withdraw the submission pending removal of the Restricted status.

5.6.1 If the investigator withdraws the submission, stop processing the current submission.

5.6.2 If the investigator will not withdraw the submission, discuss whether you may continue to process the submission with the IRB Manager.

5.7 Evaluate the most likely level of review using HRP-310 - WORKSHEET - Human Research Determination, HRP-311 - WORKSHEET - Engagement Determination, HRP-312 - WORKSHEET - Exemption Determination, HRP-313 - WORKSHEET - Expedited Review, and/or HRP-323 - PI WORKSHEET - Criteria for Approval HUD as references:

5.7.1 If the request can be handled as a Non-Committee Review and the principal investigator is not Restricted, Follow HRP-031 - SOP - Non-Committee Review Preparation.

5.7.2 If the request cannot be handled as a Non-Committee Review, place the protocol on the agenda for a convened IRB meeting in an IRB with appropriate scope using the "Assign Meeting" activity. Follow HRP-040 - SOP - IRB Meeting Preparation. (Do not assign a Veterans Administration (VA) protocol to a commercial IRB unless it has been specifically designated by the VA Office of Research and Development to serve as an IRB for cooperative research.[ii])If the request is a non-emergency individual patient expanded access use of an investigational drug for which an IRB waiver is requested or device compassionate use, follow HRP-031 - SOP - Non-Committee Review Preparation and HRP-023 - SOP - Emergency Use, Compassionate Use, Indiv Patient Expanded Access.

5.8 Pre-Review is conducted by IRB staff within 5 business days.

6 MATERIALS

6.1 HRP-023 - SOP - Emergency Use, Compassionate Use, Indiv Patient Expanded Access
6.2 HRP-024 - SOP - New Information
6.3 HRP-031 - SOP - Non-Committee Review Preparation
6.4 HRP-040 - SOP - IRB Meeting Preparation
6.5 HRP-052 - SOP - Post-Review
6.6 HRP-308 - WORKSHEET - Pre-Review
6.7 HRP-310 - WORKSHEET - Human Research Determination
6.8 HRP-311 - WORKSHEET - Engagement Determination
6.9 HRP-312 - WORKSHEET - Exemption Determination
6.10 HRP-313 - WORKSHEET - Expedited Review
6.11 HRP-323 - PI WORKSHEET - Criteria for Approval HUD
6.12 HRP-806 - SOP - Review Request to Rely on External IRB
6.13 HRP-850 - LETTER - Decline to Serve
6.14 HRP-851 - LETTER - Invitation Decision

7 REFERENCES

None.

---

[i] Per OHRP correspondence dated 07/22/2011, protocol exceptions are considered changes to previously approved research and eligible for review via expedited procedure.
[ii] Refer to the VA application process for the use of a commercial IRB approved by ORD: https://www.research.va.gov/programs/epros/irb_relationships.cfm

SOP: All Emergency Use, Compassionate Use (Device Only) and IRB Waiver for Individual Patient Expanded Access (Drug Only) Review

1 PURPOSE

1.1 This procedure establishes the process to review notifications of:

1.1.1 Emergency use of a drug, biologic, or device in a life-threatening situation.

1.1.2 Non-emergency individual patient/small group expanded access for an unapproved medical device (commonly known as Compassionate Use).

1.1.3 Non-emergency individual patient expanded access use of an investigational drug for which an IRB waiver is requested.

1.1.4 The use of an investigational drug, agent, or biologic as part of the Right to Try (RTT) Act.

1.2 The process begins when the IRB receives a notification of a proposed or actual use.

1.3 The process ends when a Designated Reviewer has:

1.3.1 Determined whether the proposed or actual use will follow or has followed FDA-regulation and guidance; and

1.3.2 Notified the physician and IRB staff of the determination.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 Whenever possible physicians are to notify the IRB of a proposed emergency use of a drug, biologic, or device in a life-threatening situation in advance of the use.

3.2 Physicians are to notify the IRB of a proposed compassionate use of an unapproved device, for the purpose of obtaining concurrence from an IRB Chair.

3.3 Emergency uses and device compassionate uses cannot be claimed as research.

3.4 Investigators are to notify the IRB of a non-emergency individual patient expanded access use of an investigational drug “Request for Authorization to Use Alternative IRB Review Procedures” identified on FDA Form 3926 (field 10.b.) or a separate waiver request included with FDA Form 1571 for the purpose of obtaining concurrence from an IRB Chair or designee.

3.5 Involving Right to Try, committee review is required.

4 RESPONSIBILITIES

4.1 A Designated Reviewer carries out these procedures.

5 PROCEDURE

5.1 Determine if the notification/request is one of the following:

5.1.1 Emergency use of a drug, biologic, or device in a life-threatening situation. If so, use the HRP-322 - PI WORKSHEET - Emergency Use to determine whether the circumstances will meet, or if the use described in the 5-day report have met, the regulatory and guidance criteria for emergency use, and indicate the results of this determination to the IRB staff (or directly to the physician if time sensitive).

5.1.1.1 If the notice is in advance of the use, inform the IRB staff (or physician if time sensitive) that the physician can proceed with the use or work with the physician to

identify what additional information/procedures the physician needs to follow. **Set a 5-day reminder to request the 5-day report.**

5.1.1.2 If the actual emergency use described in the 5-day report did not follow FDA requirements, manage using the Submit RNI activity.

5.1.2 Compassionate use of a device. If so, use HRP-325 - PI WORKSHEET - Expanded Access. Compassionate Use to determine whether the circumstances will meet the regulatory and guidance criteria and indicate the results of this determination to the physician.

5.1.2.1 Execute the "Submit Designated Review" activity. For the Review Level, choose Expedited Review and choose "Other" for the category. Choose that continuing review is required.

5.1.2.2 In the "Notes" section document that the decision is IRB Chair/designee concurrence (or not to concur) for the compassionate use of an unapproved medical device.

5.1.3 Non-emergency individual patient expanded access use of an investigational drug for which an IRB waiver is requested. If so, use HRP-314 - WORKSHEET - Criteria for Approval to determine whether the proposed use meets the requirements under 21 CFR 50 and 56.111[i] and indicate the results of this determination to the IRB staff.

5.1.3.1 Execute the "Submit Designated Review" activity. For the Review Level, choose Expedited Review and choose "Other" for the category. Choose that continuing review is required.

5.1.3.2 In the "Notes" section document that the decision to concur (or not) is in lieu of review and approval at a convened IRB meeting at which a majority of the members are present per the request for a waiver under 21 CFR § 56.105 of the requirements in § 56.108(c).

5.1.4 The use of an investigational drug, agent, or biologic as part of the Right to Try (RTT) Act.

5.1.4.1 Execute the "Submit Designated Review" activity. For the Review Level, choose Full Committee Review and choose "Other" for the category. Choose that continuing review is required.

5.1.5 If none of the above, stop processing the request and inform the physician or submitter.

5.2 Inform IRB staff of the results of the evaluation.

6 MATERIALS

6.1 HRP-024 - SOP - New Information

6.2 HRP-314 - WORKSHEET - Criteria for Approval

6.3 HRP-322 - PI WORKSHEET - Emergency Use

6.4 HRP-325 - PI WORKSHEET - Expanded Access

7 REFERENCES

7.1 21 CFR § 50.23; 21 CFR § 50.24; 21 CFR § 56.102(d); 21 CFR § 56.104(c).

7.2 21 CFR § 812.36; 21 CFR § 812.47.

7.3 21 CFR § 56.105; 21 CFR § 56.108(c).

7.4 (FDA Information Sheet Guidance for IRBs, Clinical Investigators, and Sponsors) Frequently Asked Questions About Medical Devices: http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM127067.pdf.

7.5 Individual Patient Expanded Access Applications: Form FDA 3926 Guidance for Industry; https://www.fda.gov/ucm/groups/fdagov-public/@fdagov-drugs-gen/documents/document/ucm432717.pdf

7.6 California Right to Try:
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1668

7.6.1 https://research.uci.edu/human-research-protections/clinical-research/drugs-and-biologics-used-in-clinical-research/right-to-try-drugs-biologics/

[i] "The IRB chairperson (or designated IRB member) would consider the same information that the full IRB would consider to determine whether to approve the treatment when reviewing and concurring for individual patient expanded access use." Per FDA correspondence dated 10/10/17

SOP: New Information

1 PURPOSE

1.1 This procedure establishes the process to manage information reported to the IRB to ensure that information that represents Non-Compliance, Unanticipated Problems Involving Risks to Subjects or Others, Suspensions of IRB Approval, and Terminations of IRB Approval are managed to protect the rights and welfare of subjects.

1.2 The process begins when the IRB receives an information item.

1.3 The process ends when the information item is determined not to represent a problem that requires management, is managed administratively, or referred to the convened IRB for review.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 Allegations of Serious or Continuing Non-Compliance on the part of IRB staff or IRB members will be referred to the Institutional Official (IO)/Organizational Official (OO) for further action.

3.2 All incidents of serious and/or continuing noncompliance that occur either at a UCI site, or at a non-UCI site where the UCI IRB is the IRB of record, must be reported to the IRB in ZOT IRB within 5 business days of the occurrence or within 5 business days from the date in which the Principal Investigator (PI) learned of the occurrence.

3.3 Such reports may come from any source including, but not limited to, an IRB Committee Member, an Investigator, a participant or their family members, institutional personnel, other institutional Committees, UC Irvine Whistleblower Office, UCI Health Affairs Compliance Officer, the media, anonymous sources, or the public.

3.4 By investigating and managing issues of potential noncompliance, the IRB seeks to:

3.5 Assure the safety of human research participants;

3.6 Develop action plans to prevent reoccurrence, and promote future compliance;

3.7 Educate research staff to assure their understanding of Food and Drug Administration (FDA) and Office for Human Research Protections (OHRP) guidelines and regulations, and UCI IRB Policy; and

3.7 Fulfill its obligation and responsibility to report Serious Non-Compliance and/or Continuing Non-Compliance to applicable government oversight agencies.

3.8 If the non-compliance appears to meet the definition of research misconduct, forward to the Vice Chancellor for Research.

3.9 The organization will promptly notify the federal department or agency funding the research of any for cause investigation of that research by another federal department or agency.

3.9.1 For Department of Defense (DOD) research the report is sent to the DOD human research protection officer.

3.10 The organization will promptly notify the Department of Defense (DOD) if the IRB of record changes.

3.11 Substantiated allegations related to classified Department of Defense (DOD) Human Subjects Research must be reported immediately.

3.12 For Veterans Administration (VA) research:

3.12.1 The following events involving exempt or nonexempt VA human subjects research must be reported to the local VA medical facility per the facility's required reporting timelines:

3.12.1.1 Deaths of a human subject participating in VA human subjects research that is believed to be both unexpected and related or possibly related to participation in a

VA human subjects research study (applies to the death of a human subject enrolled in the study under the auspices of the VA medical facility).

3.12.1.2 Unanticipated Problems Involving Risks to Subjects or Others (UPIRTSO) in VA human subjects research.

3.12.1.3 Occurrence of serious or continuing noncompliance with applicable laws, regulations, policies, and agreements pertaining to VA human subjects research.

3.12.1.4 The suspension or early termination of a VA human research study by the IRB, R&DC, or IO due to the study not being conducted in accordance with applicable regulations, policies, agreements, or IRB requirements or due to concerns about the safety, rights, or welfare of human subjects or others.

3.12.1.5 A change in the status (e.g., expiration, restriction, suspension, or termination) of the VA medical facility's human subjects research FWA.

3.12.1.6 The termination or non-renewal of the HHS-OHRP registration of any IRB relied upon by the VA medical facility for review and oversight of VA research.

3.12.1.7 A failure of the VA medical facility to achieve or maintain full accreditation of its HRPP if such accreditation is sought by the VA medical facility.

3.12.1.8 The issuance of a research-related citation or determination of noncompliance by a state or Federal entity (including the VA Office of Inspector General) or an accrediting organization, pertaining to the VA medical facility's HRPP and human subjects research portfolio.

3.13 IRB members or staff who believe they are being or have been subject to undue influence must report this to the Associate Vice Chancellor for Research Administration, the Senior Director, Human Research Protections, or utilize the University of California Whistleblower Policy.

3.14 Attempts to unduly influence an IRB committee member or IRB staff will be investigated in accordance with Sec. 480-7, Resolving Regulatory Non-compliance.

3.15 If IRB staff become aware of an information item that has not been submitted in the IRB system, they will enter the new information using the "Report New Information" activity and associate the information item with the appropriate study as applicable.

3.16 A modification is required in order to lift a suspension of IRB approval and must be reviewed by the convened IRB to determine whether all corrective actions are met.

4 RESPONSIBILITIES

4.1 The IRB staff members carry out this procedure.

5 PROCEDURE

5.1 Review each item of information within 1 business day and answer the following questions and complete the Submit RNI Pre-Review Activity: (*See attached flowchart for a diagram of the flow of this procedure*.)

5.1.1 Is this an Allegation of Non-Compliance?

5.1.2 Is this a Finding of Non-Compliance?

5.1.3 Is this an Unanticipated Problem Involving Risks to Subjects or Others?

5.1.4 Is this a Suspension of IRB Approval or Termination of IRB Approval?

5.2 If you are unable to answer a question, consult the IRB chair or IRB Compliance manager.

5.3 The IRB may request that additional information be obtained by the IRB Education and Quality Improvement (EQUIP) team.

5.4 If the IRB chair and IRB Compliance manager are unable to answer a question, follow HRP-025 - SOP - Investigations.

5.5 If the answer is "yes" to one or more questions, then follow the corresponding sections below.

5.5.1 Allegations of Non-Compliance: Determine whether each Allegation of Non-Compliance has any basis in fact.

5.5.1.1 If yes, follow the procedures under Findings of Non-Compliance.

5.5.1.2 If no, follow any other corresponding sections.

5.5.2 Findings of Non-Compliance: Determine whether each Finding of Non-Compliance is Serious Non-Compliance or Continuing Non-Compliance.

5.5.2.1 If no, follow the procedures under Non-Serious/Non-Continuing Non-Compliance.
5.5.2.2 If yes, follow the procedures under Serious or Continuing Non-Compliance.

5.5.3 Non-Serious/Non-Continuing Non-Compliance
5.5.3.1 Determine whether the individual or group responsible for the Non-Compliance has developed and implemented a suitable corrective action plan.
5.5.3.2 If the individual or group responsible for the Non-Compliance is unwilling or unable to develop and implement a suitable corrective action plan, consider the Non-Compliance to be Continuing Non-Compliance and follow the procedures for Serious or Continuing Non-Compliance.

5.5.4 Serious Non-Compliance; Continuing Non-Compliance; Suspension of IRB Approval; Termination of IRB Approval; or Unanticipated Problem Involving Risks to Subjects or Others
5.5.4.1 If the notification involves enrollment of a Prisoner in a study not approved to enroll Prisoners, please see below for additional considerations to aid in decision-making.
5.5.4.2 Confirm your decision with the IRB chair or IRB manager.
5.5.4.3 Place on the agenda for the next available convened IRB meeting in an IRB with appropriate scope as an item of Serious Non-Compliance; Continuing Non-Compliance; Suspension of IRB Approval; Termination of IRB Approval; or Unanticipated Problem Involving Risks to Subjects or Others.

5.6 If in your opinion the rights and welfare of subjects might be adversely affected before the convened IRB can review the information, contact the IRB chair or IRB manager to consider a Suspension of IRB Approval following the HRP-026 - SOP - Suspension or Termination Issued Outside of Convened IRB.

5.7 If the notification involves a subject becoming a Prisoner in a study not approved by the IRB to involve Prisoners:

5.7.1 Confirm that the subject is currently a Prisoner.
5.7.1.1 If the subject is currently not a Prisoner no other action is required.

5.7.2 Consider whether stopping all research interactions and interventions with, and obtaining identifiable private information about, the now-incarcerated subject until the regulatory requirements for research involving Prisoners are met or until the subject is no longer a Prisoner would present risks to the subject.
5.7.2.1 If the subject's involvement in the research cannot be stopped for health or safety reasons, do one of the following:
5.7.2.1.1 Keep the subject enrolled in the study and review the research for involvement of Prisoners. If the research is subject to DHHS oversight, notify OHRP.
5.7.2.1.2 Remove the subject from the study and provide the study intervention as clinical care or compassionate use.
5.7.2.2 If the subject's involvement in the research can be stopped, inform the investigator that all research interactions and interventions with, and obtaining identifiable private information about, the now-incarcerated subject must be stopped immediately until the regulatory requirements for research involving Prisoners are met or until the subject is no longer a Prisoner.

5.7.3 For Department of Defense (DOD) research, have the convened IRB promptly (within 30 days) re-review the research protocol to ensure that the rights and well-being of the human subject, now a prisoner, are not in jeopardy.
5.7.3.1 Promptly report all decisions to the Department of Defense (DOD).
5.7.3.2 The Department of Defense (DOD) must concur with the IRB before the subject can continue to participate while a Prisoner.

5.8 Take any additional actions required to resolve any concerns or complaints associated with the information.

5.9 If the information does not involve a Serious Non-Compliance; Continuing Non-Compliance; Suspension of IRB Approval; Termination of IRB Approval; or Unanticipated Problem Involving Risks

to Subjects or Others and a response is expected, complete review and prepare and send letter per HRP-052 - SOP - Post-Review.

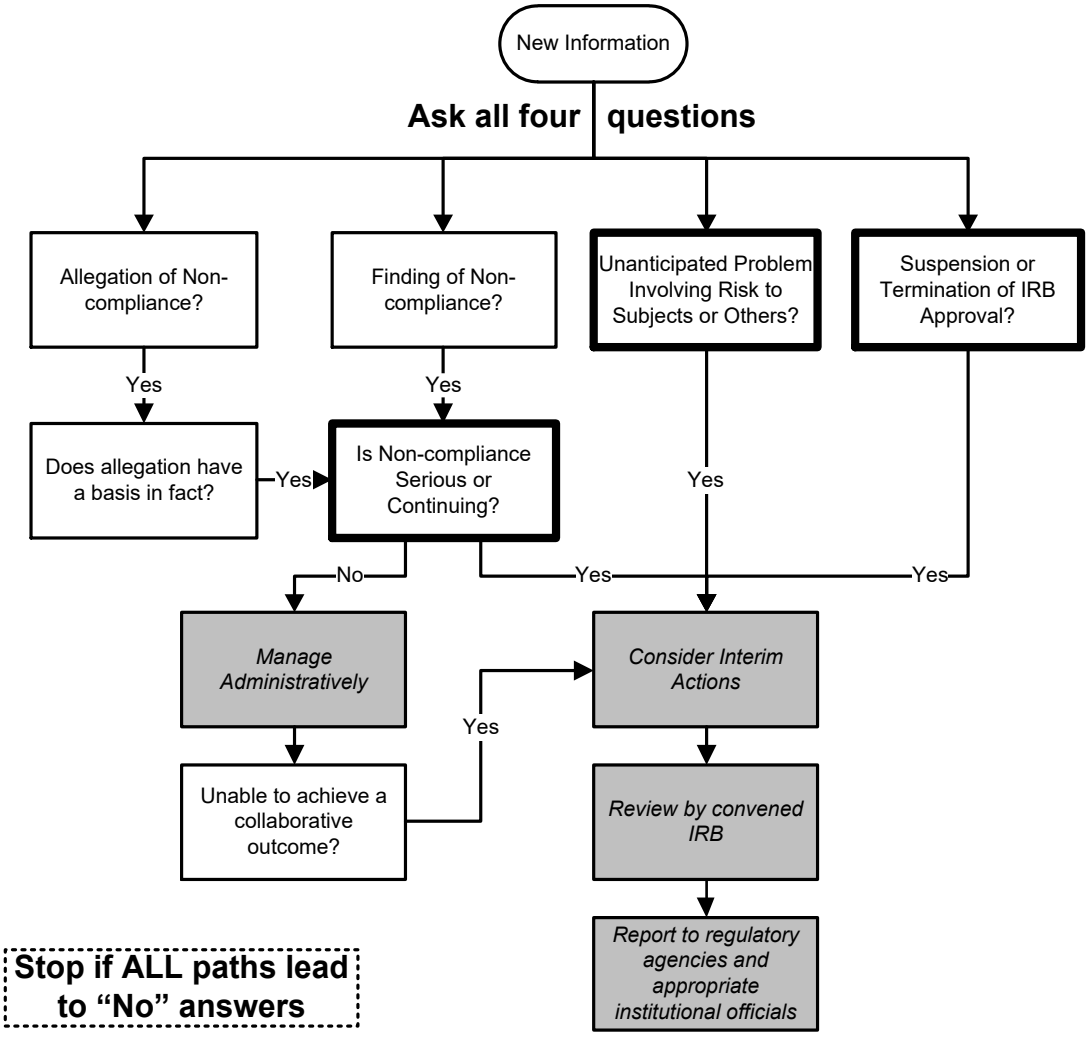
6 MATERIALS

6.1 HRP-025 - SOP - Investigations
6.2 HRP-026 - SOP - Suspension or Termination Issued Outside of Convened IRB
6.3 HRP-052 - SOP - Post-Review

7 REFERENCES

7.1 21 CFR §56.108(b)
7.2 45 CFR §46.103(b)(5), 45 CFR §46.108(a)
7.3 VHA Directive 1200.05(3), Amended July 13, 2023
7.4 VHA Directive 1058, November 8, 2024
7.5 DoDI 3216.02
7.6 University of California Whistleblower Protection Policy
7.7 Sec. 480-7, Resolving Regulatory Non-compliance

7.8 Flowchart



SOP: Investigations

1 PURPOSE

1.1 This procedure establishes the process to conduct investigations.

1.2 The process begins when the IRB staff members and chair cannot answer a question required by HRP-024 - SOP - New Information.

1.3 The process ends when the investigation is complete and the answer has been provided to the Institutional Official/Organizational Official (IO/OO) or designee.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 None

4 RESPONSIBILITIES

4.1 The IO/OO or designee:

4.1.1 Appoints the members of the investigative committee based on the expertise and background needed to answer the question.

4.2 Appoints a chair of the investigative committee.

4.2.1 Charges the investigative committee with the question to be answered.

4.3 The investigative committee carries out these procedures within 60 days.

4.4 Investigative committee members make their decisions based on a preponderance of the evidence.

4.5 Investigative committee decisions are made by majority vote.

4.6 Individuals being interviewed may have counsel present. However, counsel cannot address the investigative committee. The investigative committee by a vote of the majority may exclude counsel when in the opinion of the investigative committee that person's presence is disruptive.

5 PROCEDURE

5.1 Notify the investigator that an investigation is being conducted, the question to be answered, and the time frame for completion.

5.2 Determine what information to gather and what individuals to interview.

5.3 Gather information and interview individuals.

5.4 If the investigative committee believes that a transcription of the interviews will be required to make a proper decision, the investigative committee may record the interviews and obtain a transcript.

5.5 Repeat information gathering and interviews until a decision can be made.

5.6 The investigative committee provides a written report of the investigative committee's decision to the IO/OO or designee.

6 MATERIALS

6.1 HRP-024 - SOP - New Information

7 REFERENCES

SOP: Suspension or Termination Issued Outside of Convened IRB

1 PURPOSE

1.1 This procedure establishes the process for someone other than the convened IRB to institute a Suspension of IRB Approval or a Termination of IRB Approval.

1.2 The process begins when the IRB Chair, Organizational Official / Institutional Official (IO/OO) or designee institutes a Suspension of IRB Approval or a Termination of IRB Approval.

1.3 The process ends when the Suspension of IRB Approval or a Termination of IRB Approval has been placed on the agenda for review by the convened IRB.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The IRB chair may institute a Suspension of IRB Approval when in the opinion of the IRB chair subjects may be at risk of adverse effects on their rights and welfare before action may be considered by the convened IRB.

3.2 The IO/OO or designee may institute a Suspension of IRB Approval or Termination of IRB Approval for any reason.

3.2.1 For Veterans Administration (VA) research, this authority may be delegated by the IO to the Chief of Staff (COS). ORD has authority to suspend or terminate any research activity it is funding.

3.3 Whenever possible the individual following these procedures communicates with investigators orally and in writing.

3.4 Suspension of IRB Approval or Termination of IRB Approval must be reported to the local VA medical facility per the facility's required reporting timelines.

4 RESPONSIBILITIES

4.1 The individual instituting a Suspension of IRB Approval or Termination of IRB Approval follows these procedures.

5 PROCEDURE

5.1 Notify the investigator of the Suspension of IRB Approval or Termination of IRB Approval along with the reasons for the decision.

5.2 Ask the investigator to provide for the status a list of all Human Subjects currently involved in the research (e.g., actively receiving investigational treatment, follow-up only).

5.3 Ask the investigator whether any actions are required to protect those subjects' rights and welfare or to eliminate an apparent immediate hazard.

5.4 Consider whether any of the following additional actions are required to protect those or other subjects' rights and welfare or to eliminate an apparent immediate hazard:

5.4.1 Transferring subjects to another investigator.

5.4.2 Making arrangements for clinical care outside the research.

5.4.3 Allowing continuation of some research activities under the supervision of an independent monitor.

5.4.4 Requiring or permitting follow-up of subjects for safety reasons.

5.4.5 Requiring adverse events or outcomes to be reported to the IRB and the sponsor.

5.4.6 Notification to current Human Subjects.

5.4.7 Notification to former Human Subjects.

5.5 For Veterans Administration (VA) research, the VA medical facility Director must report the Suspension of IRB Approval or Termination of IRB Approval to ORO within 5 business days of becoming aware of the determination(s). The notification must include a statement of the reason for the action.

5.6 Refer to the IRB staff to place on the agenda for a convened IRB meeting in an IRB with appropriate scope as an item of Suspension of IRB Approval or Termination of IRB Approval. Follow HRP-041 - SOP - IRB Meeting Conduct for convened IRB review of the item.

5.7 Complete and send to the investigator HRP-515 - LETTER - Suspension or Termination.

6 MATERIALS

6.1 HRP-041 - SOP - IRB Meeting Conduct

6.2 HRP-515 - LETTER - Suspension or Termination

7 REFERENCES

7.1 21 CFR §56.108(b)(3), 21 CFR §56.113

7.2 45 CFR §46.103(b)(5)(ii), 45 CFR §46.108(a), 45 CFR §46.113

7.3 VHA Directive 1058, November 8, 2024

7.4 VHA Directive 1200.05(3), January 7, 2019, Amended July 13, 2023

SOP: All Emergency Use, Compassionate Use (Device Only) and IRB Waiver for Individual Patient Expanded Access (Drug Only) Post-Review

1 PURPOSE

1.1 This procedure establishes the process to communicate the review of:

1.1.1 Emergency use of a drug, biologic, or device in a life-threatening situation.

1.1.2 Non-emergency individual patient/small group expanded access for an unapproved medical device (commonly known as Compassionate Use).

1.1.3 Non-emergency individual patient expanded access use of an investigational drug for which an IRB waiver is requested.

1.1.4 The use of an investigational drug, agent, or biologic as part of the Right to Try (RTT) Act.

1.2 The process begins when the Designated Reviewer has notified IRB staff of whether an actual or proposed use has followed or will follow FDA regulations and guidance.

1.3 The process ends when the IRB staff has communicated the results to the physician and if necessary initiated the non-compliance process.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 None

4 RESPONSIBILITIES

4.1 IRB staff carry out these procedures.

5 PROCEDURE

5.1 For emergency use of a drug, biologic, or device in a life-threatening situation:

5.1.1 If the Designated Reviewer has indicated that the proposed use will follow FDA regulations:

5.1.1.1 Complete HRP-570 - LETTER - Pre-Rev EU - Crit Met and send to the physician.

5.1.1.2 Set a 5 day deadline for receipt of the 5 day report.

5.1.2 If the Designated Reviewer has indicated that the proposed use will NOT follow FDA regulations, complete HRP-571 - LETTER - Pre-Rev EU - Crit Not Met and send to the physician.

5.1.3 If the Designated Reviewer has indicated that the actual use described in the 5-day report followed FDA regulations, complete HRP-572 - LETTER - Review of EU - Crit Met and send to the physician.

5.1.4 If the Designated Reviewer has indicated that the proposed use did NOT follow FDA regulations:

5.1.4.1 Complete HRP-573 - LETTER - Review of EU - Crit Not Met and send to the physician.

5.1.4.2 Manage under HRP-024 - SOP - New Information as Non-Compliance.

5.2 For compassionate use of a device, complete HRP-574 - LETTER - Device Compassionate Use.

5.3 For non-emergency individual patient expanded access use of an investigational drug for which an IRB waiver is requested, complete HRP-575 - LETTER - Rev of IRB Waiver for Indiv Pt Drug Exp Access.

5.4 For RTT use the HRP-510 - LETTER – Approval. Letter to be customized in accordance with RTT. See prior RTT cases in HRP Shared Folder or WIKI for reference.

5.4.1 Biannually, via email, the HRP will report the following status as required to the State Department of Public Health, the Medical Board of California, and the Osteopathic Medical Board of California:

5.4.1.1 The duration of the treatment.

5.4.1.2 The costs of the treatment paid by eligible patients.

5.4.1.3 The success or failure of the investigational drug, biological product, or device in treating the immediately life-threatening disease or condition from which the patient suffers.

5.4.1.4 Any adverse event for each investigational drug, biological product, or device

6 MATERIALS

6.1 HRP-024 - SOP - New Information

6.2 HRP-570 - LETTER - Pre-Rev EU - Crit Met

6.3 HRP-571 - LETTER - Pre-Rev EU - Crit Not Met

6.4 HRP-572 - LETTER - Review of EU - Crit Met

6.5 HRP-573 - LETTER - Review of EU - Crit Not Met

6.6 HRP-574 - LETTER - Device Compassionate Use

6.7 HRP-575 - LETTER - Rev of IRB Waiver for Indiv Pt Drug Exp Access

7 REFERENCES

7.1 21 CFR §50.23; 21 CFR §50.24; 21 CFR §56.102(d); 21 CFR §56.104(c); 21 CFR §56.105/ FDA Form 3926

7.2 21 CFR §812.36; 21 CFR §812.47.

7.3 (FDA Information Sheet Guidance for IRBs, Clinical Investigators, and Sponsors) Frequently Asked Questions About Medical Devices: http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM127067.pdf.

7.4 UC Office of the General Counsel Health Sciences Research Advisory: *Clinical Use of Investigational Drugs, Devices and Biologics under Federal and California Law*, November 2018

SOP: Designated Reviewers

1 PURPOSE

1.1 This procedure establishes the process to designate IRB members and IRB Staff colleagues who can conduct Non-Committee Reviews.

1.2 The process begins when the IRB chair designates an Experienced IRB Member (including IRB Staff Reviewers) to conduct Non-Committee Reviews.

1.3 The process ends when the IRB member has been noted in the IRB roster to conduct Non-Committee Reviews.

1.4 For IRB Staff delegations of authority, refer to HRP-030a - IRB Delegation of Authority.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 IRB rosters are maintained using HRP-601 - DATABASE - IRB Roster.

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

5 PROCEDURE

5.1 Obtain from the IRB chair the name of the IRB member designated to conduct Non-Committee Reviews.

5.2 Review list of IRB members designated to conduct Non-Committee Reviews in the “Assign Designated Reviewer” activity.

5.3 Verify that the IRB member is an Experienced IRB Member.

5.4 Update HRP-601 - DATABASE - IRB Roster to indicate that the IRB member is a Designated Reviewer.

5.5 Use the “Update Eligible Designated Reviewers” activity to indicate that the IRB member is a Designated Reviewer.

6 MATERIALS

6.1 HRP-601 - DATABASE - IRB Roster

6.2 HRP-030a - IRB Delegation of Authority

7 REFERENCES

7.1 21 CFR §56.110(b).

7.2 45 CFR §46.110(b).

SOP: Non-Committee Review Preparation

1 PURPOSE

1.1 This procedure establishes the process to prepare for a Non-Committee Review.

1.2 The process begins when an IRB staff member identifies an application as being possibly eligible for Non-Committee Review.

1.3 The process ends when the IRB staff member provides the materials to the Designated Reviewer.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 IRB rosters are maintained using HRP-601 - DATABASE - IRB Roster.

3.2 For individuals who access materials through an electronic system or are provided all submitted materials, those individuals are expected to review the materials listed in HRP-301 - WORKSHEET - Review Materials according to their role: “Documents Provided to All IRB Members and Alternate IRB Members,” “Additional Items Provided to Primary Reviewer,” and “Additional Items Provided to Scientific/Scholarly Reviewer.”

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

5 PROCEDURE

5.1 Use the “Assign Designated Reviewer” activity and select a Designated Reviewer.

5.1.1 If no Designated Reviewer is available, or if available Designated Reviewers are unable to perform a Non-Committee Review in a timely manner such that review by the convened IRB would result in a timelier review, schedule the protocol to be reviewed by the convened IRB.

5.1.2 Execute the “Assign Designated Reviewer” activity.

5.2 Execute the “Assign Designated Reviewer” activity to send to the Designated Reviewer within ten business days of receipt of a complete submission.

5.3 Protocols eligible for a self determination of exemption or a self-determination of non-human subject research are not assigned a Designated Reviewer. They remain in “Pre-Review” status as part of the self-determination process.

6 MATERIALS

6.1 HRP-301 - WORKSHEET - Review Materials

6.2 HRP-601 - DATABASE - IRB Roster

7 REFERENCES

7.1 21 CFR §56.110(b)

7.2 45 CFR §46.110(b)

SOP: Non-Committee Review Conduct

1 PURPOSE

1.1 This procedure establishes the process for a Designated Reviewer to conduct a Non-Committee Review or a Limited IRB Review.

1.2 The process begins when the Designated Reviewer has the provided materials.

1.3 The process ends when the Designated Reviewer completes the review and returns the completed materials to an IRB staff member.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The Designated Reviewer may not disapprove research.

3.2 The Designated Reviewer utilizes all applicable worksheets in the review of research.

3.3 All applicable criteria for approval in HRP-314 - WORKSHEET - Criteria for Approval must be satisfied in order for the research to be approved using the expedited procedure.

3.4 All applicable criteria for approval in HRP-312 - WORKSHEET - Exemption Determination must be satisfied for research to be determined to be exempt (including applicable criteria for Limited IRB Review in HRP-319 - WORKSHEET - Limited IRB Review.

4 RESPONSIBILITIES

4.1 The HRP staff and/or a Designated Reviewer carries out these procedures.

5 PROCEDURE

5.1 Review all materials.

5.2 If the information is not complete, contact the investigator by selecting the “Request Designated Review Clarifications” activity. Offer the investigator the opportunity to provide additional information.

5.2.1 Continue processing once the investigator responds to the request for additional information.

5.2.2 If the investigator will not correct the submission, have the investigator execute the “Submit Response” activity to resubmit and continue processing.

5.3 Make the appropriate determination:

5.3.1 Not Human Research,

5.3.2 Human Research not Engaged,

5.3.3 Exempt Research Self-Determination

5.3.4 Exempt Human Research that requires IRB review (including exempt Human Research that requires Limited IRB Review),

5.3.5 Human Research approved using the expedited procedure, or

5.3.6 Human Research that requires review by a convened IRB (Committee Review).

5.4 If consultation is needed follow HRP-051 - SOP - Consultation.

5.5 If the review is complete, execute the “Submit Designated Review” activity.

5.6 Return all materials and the required, completed worksheets (e.g., HIPAA – HRP-441) to the IRB staff within 5 business days of receipt of materials

6 MATERIALS

6.1 HRP-051 - SOP - Consultation

6.2 HRP-312 - WORKSHEET - Exemption Determination
6.3 HRP-314 - WORKSHEET - Criteria for Approval
6.4 HRP-319 - WORKSHEET - Limited IRB Review and Broad Consent

7 REFERENCES

7.1 21 CFR §56.110(b).
7.2 45 CFR §46.110(b).

SOP: IRB Meeting Preparation

1 PURPOSE

1.1 This procedure establishes the process to prepare for a convened IRB meeting.

1.2 The process begins when the agenda is closed, approximately 10 days before a meeting date.

1.3 The process ends when IRB meeting agenda materials have been sent or made available to IRB members.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 At least one IRB member or consultant is responsible for scientific/scholarly review of research.

3.2 Protocols are reviewed by IRB members and consultants with sufficient expertise.

3.3 When IRB members review research that involves vulnerable subjects, at least one individual who is knowledgeable about or experienced in working with such subjects will be present at the meeting.

3.4 IRB members are provided sufficient information so that each member can provide an opinion on whether the regulatory criteria for approval are met.

3.5 Alternate IRB members serve the same function as other IRB members, except that if the alternate IRB member and the regular IRB member for whom the alternate member is substituting are both present only one member may vote.

3.6 In general, review materials are provided to all IRB members 7 days before convened meetings.

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

5 PROCEDURE

5.1 Confirm which IRB members (regular, alternate, and chairs) will be present at the meeting.

5.2 Consult HRP-601 - DATABASE - IRB Roster to be aware of the experience, expertise, and representational capacity of the IRB.

5.3 Review all submissions placed on the agenda for a convened IRB meeting.

5.4 Education. As necessary, education will be placed on the agenda for IRB Committee members, which may include; federal regulations, local policies and procedures, any changes in federal regulations, any changes in local policies and procedures, or other items as requested by the IRB.

5.5 Prepare an agenda for the meeting.

5.5.1 Execute the “Assign Reviewers” activity in the meeting workspace to assign a primary reviewer to each agenda item.

5.5.2 Execute the “Assign Reviewers” activity in the meeting workspace to assign a scientific/scholarly reviewer to each agenda item who has scientific/scholarly expertise in the area of research. The primary reviewer and scientific/scholarly reviewer are typically the same individual.

5.5.3 If the scientific/scholarly reviewer is not an IRB member, determine whether the scientific/scholarly reviewer has a Conflicting Interest as defined in HRP-001 - SOP - Definitions. If so, assign another scientific/scholarly reviewer.

5.5.4 **For social, behavioral, and educational research:** An appropriate scientific statistical review takes place at the school or departmental level. The Department Chair or Institute Director signs the IRB application attesting that the research is appropriate in design (i.e., the research uses procedures consistent with sound research design, the study design can be reasonably expected to answer the proposed question, and the importance of the knowledge expected to result from the research is known). The IRB reserves the right to require statistical review on a study-by study basis.

5.6 Use HRP-305 - WORKSHEET - Quorum and Expertise to ensure that the meeting will be appropriately convened and to ensure the IRB will have the appropriate expertise for each protocol.

5.6.1 If the meeting will not meet the quorum and expertise requirements, take steps to obtain the required attendance of members and consultants or cancel the meeting.

5.6.2 Follow the procedures in HRP-051 - SOP - Consultation to obtain consultants. Note any consultants on the agenda.

5.7 For individuals who are provided materials (IRB members, scientific/scholarly reviewers, consultants):

5.7.1 Execute the “Send Agenda” activity in the meeting workspace to deliver review materials to reviewers.

6 MATERIALS

6.1 HRP-001 - SOP - Definitions

6.2 HRP-051 - SOP - Consultation

6.3 HRP-305 - WORKSHEET - Quorum and Expertise

6.4 HRP-601 - DATABASE - IRB Roster

7 REFERENCES

7.1 45 CFR §46.108(b)

7.2 21 CFR §56.108(b)

SOP: IRB Meeting Conduct

1 PURPOSE

1.1 This procedure establishes the process to conduct convened meetings.

1.2 The process begins when the IRB members gather for a convened meeting.

1.3 The process ends when the meeting is adjourned.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The IRB reviews research in accordance with the applicable regulatory criteria for approval.

3.2 The IRB chair (and vice chair, where applicable), votes as a regular member.

3.3 Meetings are conducted in person or via teleconference.

3.4 IRB attendance is captured by documenting in the IRB meeting minutes the IRB members and alternates in attendance, replacement of a voting member by an alternate, attendance of IRB members who participate through teleconference, and IRB members who are recused due to a conflicting interest. Members are absent when recused and do not count towards quorum while recused.

3.5 If quorum is lost during a meeting, the IRB cannot take votes until the quorum is restored, even if more than half of the members are still present.

3.6 Substantive changes or requirements, requests for more information for IRB consideration, and other issues related to the criteria for approval require review and approval by the convened IRB.

3.7 Minor or prescriptive changes or requirements (modifications required to secure approval) may be reviewed for approval by the IRB chair or a designated individual.

3.8 The worksheets described in HRP-301 - WORKSHEET - Review Materials and listed below in “Section 6: MATERIALS” are provided to IRB members in advance of meetings per HRP-040 - SOP - IRB Meeting Preparation to conduct meetings and meet regulatory requirements.

3.9 For Veterans Administration (VA) Research “Substantive Changes” are defined as those ineligible for “Modifications Required to Secure Approval” as defined in this SOP.

4 RESPONSIBILITIES

4.1 The IRB chair carries out these procedures, unless otherwise noted.

4.2 Primary reviewers lead IRB members through consideration of the regulatory criteria for approval.

5 PROCEDURE

5.1 Call the meeting to order.

5.2 Ask IRB members whether anyone has a Conflicting Interest in any item on the agenda and note the responses.

5.3 Ask IRB members if there are any questions about the report of completed non-committee reviews that was made available to the IRB prior to the meeting.

5.4 For each agenda item:

5.4.1 Table the item when notified by IRB staff that requirements for review of a specific item as defined in HRP-305 - WORKSHEET - Quorum and Expertise are not met.[i]

5.4.2 If there are IRB members with a Conflicting Interest, invite the IRB to ask questions of those members and then ask those members to leave for discussion and voting or if present by teleconference, be placed on hold or disconnect for discussion and voting.

5.4.2.1 For Veterans Administration (VA) research, members with a Conflicting Interest present by teleconference are to disconnect for discussion and voting.

5.5 For each agenda item involving the initial review, modification or continuing review of a protocol:

5.5.1 If there is a consultant present, ask the consultant to present his or her review to the IRB.

5.5.2 If a consultant provided written information to the IRB, ask the primary reviewer to present that information to the IRB.

5.5.3 Ask the scientific or scholarly reviewer or primary reviewer to present the scientific or scholarly review to the IRB.

5.5.4 Ask the primary reviewer to lead the IRB through a discussion of the criteria in HRP-314 - WORKSHEET - Criteria for Approval and all referenced worksheets (listed below) to have the convened IRB determine which regulatory criteria are met (or continue to be met), which are not met (or no longer met), and which would be met if the investigator modified the protocol as requested by the IRB.

5.5.5 Restate the IRB's consensus regarding any protocol specific findings justifying a determination when required by a worksheet and not previously determined and documented.

5.5.6 Make a motion for one of the following actions:

5.5.6.1 Approve (with a specific continuing review interval for initial or continuing review when applicable): Made when all criteria for approval are met. Include in motions for initial and continuing review the period of approval and the level of risk.

5.5.6.2 Modifications Required to Secure Approval (with a specific continuing review interval for initial or continuing review when applicable): Made when IRB members require specific modifications such that an IRB staff member can determine whether an investigator has made the required changes without judging whether a change meets the regulatory criteria for approval. When making this motion, the assigned primary reviewer restates the modifications required by the IRB members and the IRB member's reasons for those changes.

5.5.6.3 Defer: Made when the research does not qualify for Approval or Modifications Required to Secure Approval and the IRB has recommendations that might make the protocol approvable. When making this motion, the assigned primary reviewer describes the IRB member's reasons for the decision and describes recommendation to make the research approvable.

5.5.6.4 Disapprove: Made when the research does not qualify for Approval or Modifications Required to Secure Approval and the IRB has no recommendations that might make the protocol approvable. When making this motion, the assigned primary reviewer describes the IRB member's reasons for the decision.

5.5.6.4.1 PI should be invited to the convened meeting for a discussion of the protocol, prior to issuing a disapproval.

5.5.6.5 Suspension or Termination of IRB Approval: Made when current approved research does not qualify for Approval or Modifications Required to Secure Approval. When making this motion, have the primary reviewer use HRP-321 - WORKSHEET - Review of Information Items to lead the convened IRB through a discussion of what actions are needed, if any, to protect subjects. The assigned primary reviewer describes the IRB member's reasons for the decision.

5.5.7 For modifications in response to a previous Suspension of IRB approval:

5.5.7.1 Have the primary reviewer summarize any corrective actions taken by the Principal Investigator.

5.5.7.2 Based on this new information, determine whether the corrective actions are sufficient to address the issues that prompted the suspension.

5.5.7.2.1 If so, make a motion for the IRB to approve the modification, which will lift the suspension of IRB approval.

5.5.7.2.2 If not, make an appropriate motion and identify the additional action items are required to protect subjects.

5.5.8 Review any modifications required to secure approval to ensure that the IRB staff has recorded them.

5.5.8.1 Ensure that the required modifications include all final contingencies listed in the "Notes" section of the Pre-Review activity.

5.5.8.2 For a pending financial interest review indicate that a determination that the financial interest is not a conflict of interest or has been eliminated can be verified by the IRB staff, but if there is a management plan, it must return to the convened IRB for review.

5.6 For each agenda item that is new information (Unanticipated Problem Involving Risks to Subjects or Others, Serious Non-Compliance, Continuing Non-Compliance, Suspension of IRB Approval, or Terminations of IRB Approval):

5.6.1 Have the primary reviewer use HRP-321 - WORKSHEET - Review of Information Items to lead the convened IRB through a discussion of what actions are needed, if any, to protect subjects.

5.6.2 Restate the IRB's consensus regarding any actions that need to be taken to protect subjects.

5.6.3 Make a motion for the IRB's determination(s) regarding the action items (e.g., the motion is for the Principal Investigator to provide the IRB additional information regarding the status of currently enrolled subjects).

5.7 Open the floor for additional discussion.

5.8 Call for a vote.

5.9 Only IRB members may vote.

5.9.1 If a member and an alternate are both present, only one may vote.

5.9.1.1 Consultants may not vote.

5.9.1.2 For a motion to be approved, it needs the approval of more than half of the members present at the meeting. (If there are 10 or 11 members present at the meeting, 6 votes are required for approval, which is greater than 5 and 5.5, respectively.)

5.10 Re-invite IRB members with a Conflicting Interest back into the meeting.

5.11 Provide any written information provided by a member or consultant to the IRB staff.

5.12 Adjourn the meeting when notified by IRB staff that quorum has been lost or when there is no further business.

6 MATERIALS

6.1 HRP-040 - SOP - IRB Meeting Preparation
6.2 HRP-301 - WORKSHEET - Review Materials
6.3 HRP-305 - WORKSHEET - Quorum and Expertise
6.4 HRP-308 - WORKSHEET - Pre-Review
6.5 HRP-314 - WORKSHEET - Criteria for Approval
6.6 HRP-315 - WORKSHEET - Advertisements
6.7 HRP-316 - WORKSHEET - Payments
6.8 HRP-317 - WORKSHEET - Short Form of Consent Documentation
6.9 HRP-318 - WORKSHEET - Additional Federal Agency Criteria
6.10 HRP-321 - WORKSHEET - Review of Information Items
6.11 HRP-323 - PI WORKSHEET - Criteria for Approval HUD
6.12 HRP-410 - PI WORKSHEET - Waiver or Alteration of Consent Process
6.13 HRP-411 - PI WORKSHEET - Waiver of Written Documentation of Consent
6.14 HRP-412 - PI WORKSHEET - Pregnant Women
6.15 HRP-413 - PI WORKSHEET - Non-Viable Neonates
6.16 HRP-414 - PI WORKSHEET - Neonates of Uncertain Viability
6.17 HRP-415 - PI WORKSHEET - Prisoners
6.18 HRP-416 - PI WORKSHEET - Children
6.19 HRP-417 - PI WORKSHEET - Cognitively Impaired Adults with Impaired Decision-Making Capacity
6.20 HRP-418 - WORKSHEET - Non-Significant Risk Device
6.21 HRP-419 - PI WORKSHEET - Waiver of Consent Process for Emergency Research

7 REFERENCES

7.1 21 CFR §50.20, §50.25, §50.27, §56.109, §56.111.
7.2 45 CFR §46.109, §46.116, §46.117.

[i] "Tabled" is not an action of the IRB, but is a status based on the inability of the IRB to take an action because of reasons of quorum.

SOP: IRB Meeting Attendance Monitoring

1 PURPOSE

1.1 This procedure establishes the process to monitor quorum at convened IRB meetings.

1.2 The process begins when the IRB staff member responsible for monitoring quorum notifies the IRB chair that quorum has been attained.

1.3 The process ends when the meeting is adjourned.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 None

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

5 PROCEDURE

5.1 At meetings consult HRP-305 - WORKSHEET - Quorum and Expertise to determine that the meeting is appropriately convened by meeting the “QUORUM REQUIREMENTS” and notify the IRB chair when the meeting is appropriately convened.

5.2 Before each protocol consult HRP-305 - WORKSHEET - Quorum and Expertise to determine that the meeting is appropriately convened by meeting the “EXPERTISE REQUIREMENTS” and notify the IRB chair when the meeting is not appropriately constituted for the review of that protocol.

5.3 When a member leaves the meeting room for any reason (including a Conflicting Interest) consult HRP-305 - WORKSHEET - Quorum and Expertise to determine that the meeting continues to be appropriately convened by meeting the “QUORUM REQUIREMENTS” and notify the IRB chair when the meeting is not appropriately convened.

6 MATERIALS

6.1 HRP-305 - WORKSHEET - Quorum and Expertise

7 REFERENCES

7.1 45 CFR §46.108(b)

7.2 21 CFR §56.108(c)

SOP: IRB Meeting Minutes

1 PURPOSE

1.1 This procedure establishes the process to record minutes for convened meetings.

1.2 The process begins when the meeting is called to order.

1.3 The process ends when the minutes are approved by the IRB chair or IRB Manager.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None.

3 POLICY

3.1 Minutes are to comply with regulatory and guidance requirements.

3.2 Minutes are to record separate deliberations for each action.

3.3 Minutes are officially approved on behalf of the IRB by the IRB chair or IRB manager.

3.4 IRB members may review and make corrections to minutes.

3.5 The IRB writes minutes and makes them available for review by the committee by the next IRB meeting. Minutes are made available to the Institutional Official/ Organizational Official (IO/OO).

3.6 Minutes may not be altered by anyone including a higher authority once accepted by the convened IRB. Any updates to an already accepted version of the IRB minutes must be re-accepted by the convened IRB.

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

5 PROCEDURE

5.1 Execute the “Convene Meeting” activity

5.2 Record each voting member (regular members and alternates) present at the meeting at any time: (Do not record non-voting members under “Attendance Table”)

5.2.1 Name.

5.2.2 Status: E.g., chair, vice chair, scientific member, non-scientific member, unaffiliated member, representative of vulnerable population (specify), prisoner representative, Veterans Administration (VA) representative, or alternate member.

5.2.3 For alternate members who are substituting for a regular member, indicate the name of the regular member for whom the alternate member is substituting.

5.2.4 Whether the member was present by teleconference.

5.2.5 Identify any member who has a conflicting interest in the research and was recused from participation in the review and deliberation process.

5.3 Record the total number of members in HRP-601 - DATABASE - IRB Roster. Exclude alternate members in this count.

5.4 Record the number of members required for quorum. Divide the number of members by two and select the next whole number. For example, if there are 10 IRB members on the HRP-601 - DATABASE - IRB Roster, then 10/2 = 5 and the next whole number is 6. If there 11 IRB members on the HRP-601 - DATABASE - IRB Roster, then 11/2=5.5 and the next whole number is 6.

5.5 Members who are recused from voting on a specific study because of conflicting interests may not be counted toward the quorum. Their recusal may not be recorded as an abstention.

5.6 Indicate whether members present by teleconference received all pertinent material before the meeting and were able to actively and equally participate in all discussions. Delete if no members were present by teleconference.

5.7 Indicate that a report of protocols reviewed by subcommittee during the period from the last committee meeting to the present committee meeting was provided to the IRB.

5.8 Indicate that the IRB Chair or designee reminded the IRB about any conflicts of interest not already noted in the agenda – and to recuse themselves as necessary.

5.9 Record the meeting start time.

5.10 For each submission reviewed record in the "Submit Committee Review" activity or "Submit RNI Committee Review" activity, as appropriate:

5.10.1. Motion: Approved, Modifications Required to Secure Approval, Deferred, Disapproved, Suspended, or Terminated. For initial or continuing review add the period of approval to the motion.

5.10.2. Risk Level: Minimal Risk or more than Minimal Risk.

5.10.3. Refer to HRP-302 - WORKSHEET - Approval Intervals to calculate approval intervals (if applicable).

5.10.4. Last Day of Approval Period: Record the study expiration date.

5.10.5. Recommended Changes and Reasons: If the motion is Modifications Required to Secure Approval or deferral/disapproval, complete the table with the required changes and corresponding reasons. If no recommended changes, indicate "None."

5.10.6. Controverted Issues and their Resolutions: Summarize the issues where IRB members expressed a difference of opinion. For each issue indicate the resolution or indicate that there was none. If no controverted issues, indicate "None."

5.10.1 Determinations and findings that require documentation: Reference the Tabular Minutes Template to ensure all elements are addressed. It may be necessary to complete, re-complete and further revise these sections after completing step 5.13 below.

5.10.7. RNI Determinations: Record the determination of Unanticipated Problem Involving Risks to Subjects or Others, suspension or termination of IRB approval, serious non-compliance, continuing non-compliance, non-compliance that is neither serious nor continuing, allegation of non-compliance with no basis in fact, or none of the above.

5.10.8. RNI Considerations: Record requirements determined by the IRB, for example modification to the protocol or ask subjects to re-consent.

5.10.2 Additional Information and Notes: Summarize issues useful to understand the agenda item. For example, a brief history of recent IRB actions.

5.10.3 Supporting documents: For any determinations that require documentation, upload the appropriate worksheet(s), or any other appropriate supporting documents, as applicable. (This is uncommon at UCI.)

5.10.9. Vote: Record as the number of members for, against, abstaining, absent, or recused. List the names of IRB members who were absent or recused. Do not count votes of consultants. If both a regular IRB member and the alternate IRB member are present at the meeting record the vote of just one.

5.10.9.1. For: Voting for the motion.

5.10.9.2. Against: Voting against the motion.

5.10.9.3. Abstain: Present for the vote, but not voting "For" or "Against."

5.10.9.4. Absent: Listed under "Members Present" but not present for the discussion and vote on this protocol for reasons other than a Conflicting Interest. List the names of absent members in the vote. For example: "For: 7 Against: 3 Abstain: 2 Absent: 2 (Alice Baker, Charlie Delta) Recused: 0 Substitutions: 0."

5.10.9.5. Recused: Listed under "Members Present" but not present for the discussion and vote on this protocol for because of a Conflicting Interest. List the names of

recused members in the vote. For example: “For: 7 Against: 3 Abstain: 2 Absent: 0 Recused: 2 (Evelyn Foxtrot, George India) Substitutions: 0.”

5.10.9.6. Substitutions: Listed under “Members Present” When regular members and their alternate(s) are listed under “Members Present” and an alternate member substitutes for the regulator member, identify the name of the alternate to indicate which individual is serving as the voting member for this vote. May be deleted if there are no substitutions. For example: “For: 7 Against: 3 Abstain: 2 Absent: 0 Recused: 0 Substitutions: 1 (Evelyn Foxtrot substituted for George India).”

5.11 Ensure the minutes reflect the following language in the applicable sections. Again, reference the Tabular Minutes Template to ensure the current terminology is used:

5.11.1. The Committee reviewed and discussed the following agenda items and determined that they involved greater than minimal risk and met the criteria for approval (45 CFR 46.111 and if applicable, 21 CFR 56.111) unless otherwise noted.

5.11.2. Approvals of amendments to protocols are granted for the remainder of the current approval period.

5.11.3. Approvals of renewals / new submissions are granted for one year unless otherwise noted.

5.11.4. Details of amendments / renewals / new submissions and if applicable the IRB Committee basis for requiring changes previously communicated to the Lead Researcher are documented in the IRB Database and were provided to the Committee ahead of the meeting.

5.11.5. The Committee reviewed the informed consent form(s) and determined that they meet the criteria for approval (45 CFR 46.116 and if applicable, 21 CFR 50, subpart B).

5.11.6. The IRB’s discussion and resolution of any controverted issues are summarized (45 CFR 46.115(a)(2); 21 CFR 56.115(a)(2)).

5.12. Record the meeting end time.

5.13. Execute the “Prepare Minutes” activity and combine the attendee information with the generated submission-specific determinations.

5.12 Within 2 business days revise minutes for accuracy. Re-reference the Tabular Minutes Template to ensure all elements are addressed and provide them to the IRB chair or IRB manager for review and approval.

5.14. The Administrator develops a draft of the IRB Committee meeting minutes and includes the draft in the full Committee materials for the next convened meeting.

5.15. The IRB Committee members review and communicate to the Administrator any necessary revisions. The final version of the meeting minutes is maintained electronically.

5.13 The Institutional Official has access to all final versions of minutes.

5.16. Once approved by the IRB chair or IRB manager, execute the “Close Meeting” activity.

5.17. Email minutes to:

5.17.1. Veterans Administration (VA) Research and Development Committee

5.17.2. When an affiliate IRB is the IRB of Record, the affiliate may either:

5.17.2.1. Provide VA with unredacted copies of meeting minutes, or

5.17.2.2. Provide VA with redacted copies of meeting minutes and permit relevant VA personnel (including, but not limited to, ORO staff, local VA Research Office staff, local RCOs, and R&D Committee members) to review the unredacted meeting minutes within two business days of a written request from VA. Such review may occur at the affiliate site during normal business hours, or as otherwise mutually acceptable to VA and the affiliate.

5.18. The minutes will show on the next agenda for that IRB committee under “Previous meetings with minutes for approval” for the IRB members at the next convened meeting to review and accept.

5.19. Once accepted, execute the “Approve Minutes” activity to finalize the minutes.

6 MATERIALS

6.1 Tabluar Minutes Template on HRP WIKI

5.20. HRP-501 - TEMPLATE MINUTES

6. REFERENCES

6.11. 21 CFR §56.115(a)(2)

6.12. 45 CFR §46.115(a)(2)

6.13. VHA Directive 1200.05(3) Amended July 13, 2023

6.2 https://www.fda.gov/media/94686/download

SOP: Not Otherwise Approvable Research

1 PURPOSE

1.1 This procedure establishes the process for the organization to review research that is not otherwise approvable.

1.2 This process begins when the IRB determines that research involving children, pregnant women, fetuses or neonates as subjects is not otherwise approvable, but presents a reasonable opportunity to understand, prevent, or alleviate a serious problem affecting those subjects' health or welfare.

1.3 The process ends when the federal agency or the Institutional Official/ Organizational Official (IO/OO) or designee communicates a decision to the IRB.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 For HHS-funded or conducted research and FDA-regulated research involving children, the research may proceed only if the HHS Secretary or his or her designee/Commissioner of Food and Drugs, after consulting with a panel of experts in pertinent disciplines (e.g., science, medicine, education, ethics, law) and following an opportunity for public review and comment, makes a determination as indicated in the applicable regulation.

3.2 When research is not otherwise approvable, but because the research is not subject to regulatory approval no government agency will conduct a review of this research to determine whether it can be approved, this organization will conduct its own review that parallels the regulatory process.

3.3 The criteria used to make a determination are:

3.3.1 That the research in fact satisfies the conditions of IRB approvable research in HRP-413 - PI WORKSHEET - Non-Viable Neonates, HRP-414 - PI WORKSHEET - Neonates of Uncertain Viability, or HRP-416 - PI WORKSHEET - Children, or HRP-412 - PI WORKSHEET - Pregnant Women.

3.3.2 All of the following criteria are met:

3.3.2.1 The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children or pregnant women, fetuses or neonates.

3.3.2.2 The research will be conducted in accordance with sound ethical principles;

3.3.2.3 Adequate provisions are made for soliciting the assent of children, the permission of their parents or guardians, and the consent of subjects as required by HRP-314 - WORKSHEET - Criteria for Approval, HRP-413 - PI WORKSHEET - Non-Viable Neonates, HRP-414 - PI WORKSHEET - Neonates of Uncertain Viability, or HRP-416 - PI WORKSHEET – Children.

4 RESPONSIBILITIES

4.1 IRB staff members carry out the procedures in Sections 5.1 and 5.2.

4.2 The IO/OO or designee carries out these procedures in Section 5.3.

5 PROCEDURE

5.1 For research involving children, when using HRP-416 - PI WORKSHEET – Children and the IRB determines the research meets the criteria for category 21 CFR §50.54/45 CFR §46.407 "*Research not otherwise approvable which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children*," proceed as follows:

5.1.1 For DHHS, the research may proceed only after OHRP has reviewed and approved the research. Refer to DRAFT guidance Research Involving Children as Subjects and Not Otherwise Approvable by an IRB: Process for Referrals to FDA and OHRP for appropriate next steps. Contact OHRP OHRP@hhs.gov for additional information and the appropriate next steps.

5.1.2 For FDA-regulated research, the research may proceed only after the FDA has reviewed and approved the research. Refer to Process for Handling Referrals to FDA Under 21 CFR 50.54 - Additional Safeguards for Children in Clinical Investigations for appropriate next steps. Contact the FDA opt@fda.gov for additional information and the appropriate next steps.

5.1.3 For research conducted or funded by the Department of Defense (DOD), the research may proceed when the DoD institutions demonstrate to the Senior Designated Official (SDO) that the IRB has fulfilled its duties in accordance with Part 407 of Subpart D of Part 46 of Title 45, CFR, and Section 50.54 of Title 21, CFR. Work with the study investigator to contact the institution's assigned DOD point of contact (e.g. HRPO/HPA/EDO) for the study to determine next steps.

5.1.4 For all other research, refer to Section 5.3.

5.2 For research involving pregnant women, fetuses, or neonates, when using HRP-412 - PI WORKSHEET - Pregnant Women, HRP-413 - PI WORKSHEET - Non-Viable Neonates, and/or HRP-414 - PI WORKSHEET - Neonates of Uncertain Viability and the IRB determines the research meets the criteria for category §46.207 "*Research not otherwise approvable which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of pregnant women, fetuses, or neonates*," proceed as follows:

5.2.1 For DHHS-regulated research, the research may proceed only after the Secretary, after consultation with a panel of experts in pertinent disciplines (for example: science, medicine, ethics, law) and following opportunity for public review and comment, including a public meeting announced in the FEDERAL REGISTER, has reviewed and approved the research. Contact OHRP OHRP@hhs.gov for additional information and the appropriate next steps.

5.2.2 For research conducted or funded by the Department of Defense (DOD), the research may proceed when the DoD institutions demonstrate to the Senior Designated Official (SDO) that the IRB has fulfilled its duties in accordance with Subpart B of 45 CFR §46 and the SDO must receive explicit written approval from the DoD Office of Human Research Protections (DOHRP). Work with the study investigator to contact the institution's DOD assigned point of contact (e.g. HRPO/HPA/EDO) for the study to determine next steps.

5.2.3 For all other research, refer to Section 5.3.

5.3 For research that is not otherwise approvable and not subject to regulatory approval by a government agency, proceed as follows:

5.3.1 Identify a panel of five or more experts in pertinent disciplines (e.g., science, medicine, education, ethics, and law) and relevant subject advocates to review the protocol.

5.3.2 Screen for Conflicting Interests of panel members and do not use panel members with a Conflicting Interest.

5.3.3 Inform potential experts that they will be asked to provide individual written recommendations and that their reports, as well as their identities, will be publicly available during the public review and comment period.

5.3.4 Publish in a form accessible to the public:

5.3.4.1 A request for written comments, including an Internet link to the protocol, relevant sections of grant applications, parental permission and assent documents, and relevant excerpts from the IRB minutes and correspondence.

5.3.4.2 The date and location of the expert panel meeting (to be held a minimum of 30 days after the notice is posted).

5.3.4.3 Indicate that the panel meeting will be open to the public and that the public will be given an opportunity to comment at the panel meeting.

5.3.4.4 Note that written comments on posted materials must be submitted at least 7 days before the day of the panel meeting to be considered by the panelists (which will allow the public 21 days to comment on posted materials);

5.3.4.5 Indication that the panelists' reports/recommendations (see below) will be posted 14 days after the panel meets.

5.3.4.6 Invite comments for up to 30 days after the meeting of the convened panel for review and consideration by the panel.

5.3.5 Open the meeting to the public.

5.3.6 After the convened panel discussion occurs and public comments are received, have each panel member write an independent recommendation as to whether the protocol should proceed, proceed with modifications, or not proceed.

5.3.7 Post panel reports on the organization's website for informational purposes for 30 days after the panel meeting.

5.3.8 Review the panel deliberations, reports, public comments, and make one of the following recommendations within 90 days of the convened panel meeting:

5.3.8.1 The organization approves support of the research as submitted;

5.3.8.2 The organization approves support of the research, but with required and/or recommended modifications; or

5.3.8.3 The organization disapproves support of the research.

5.3.9 Inform the IRB and the investigator.

5.3.10 Post the decision on the organization's Website.

6 MATERIALS

6.1 HRP-314 - WORKSHEET - Criteria for Approval

6.2 HRP-412 - PI WORKSHEET - Pregnant Women

6.3 HRP-413 - PI WORKSHEET - Non-Viable Neonates

6.4 HRP-414 - PI WORKSHEET - Neonates of Uncertain Viability

6.5 HRP-416 - PI WORKSHEET - Children

7 REFERENCES

7.1 45 CFR §46.207, 45 CFR §46.407

7.2 21 CFR §50.24(e), 21 CFR §50.54(b), 21 CFR §812.6

SOP: Conflicting Interests of IRB Members

1 PURPOSE

1.1 This procedure establishes the process to identify and manage Conflicting Interest of IRB members.

1.2 The process begins when an IRB member is asked to review an IRB submission.

1.3 The process ends when an IRB member has either identified a Conflicting Interest and notified IRB staff, or when an IRB member has determined that he or she does not have a Conflicting Interest.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 IRB members are responsible to know the definition of Conflicting Interest and self-identify when they have a Conflicting Interest.

4 RESPONSIBILITIES

4.1 IRB members (regular and alternate) follow these procedures.

5 PROCEDURE

5.1 Before reviewing research, IRB members are to determine whether they have a Conflicting Interest with research.

5.2 If an IRB member has a Conflicting Interest for review outside a meeting (e.g., the expedited procedure), he or she is to notify the IRB staff and return all materials.

5.3 If an IRB member has a Conflicting Interest for review of a submission for which he or she has been assigned as a primary or scientific reviewer, he or she is to notify the IRB staff so the submission can be re-assigned.

5.4 If an IRB member has a Conflicting Interest for review of research at a meeting, he or she is to notify the meeting chair, stay in the meeting room only to answer questions about the research, and to leave the meeting room for discussion and voting regarding that research.

6 MATERIALS

6.1 None

7 REFERENCES

7.1 21 CFR §56.107(e)

7.2 45 CFR §46.107(e)

SOP: Consultation

1 PURPOSE

1.1 This procedure establishes the process for the IRB to obtain consultants.

1.2 The process begins when the IRB staff or IRB member has identified the need for consultation.

1.3 The process ends when the consultant has provided additional expertise to the IRB.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The IRB invites consultants with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available on the IRB.

3.2 Consultants with a Conflicting Interest may not provide information to the IRB.

4 RESPONSIBILITIES

4.1 For review by a convened IRB, IRB staff members carry out these procedures.

4.2 For Non-Committee Review, the Designated Reviewer carries out these procedures.

5 PROCEDURE

5.1 Identify a consultant with the required expertise who can provide a review. Identify individuals as follows:

5.1.1 IRB members from other committees

5.1.2 Other employees of the organization

5.1.3 External consultants

5.2 Contact the consultant and determine availability for review.

5.3 Determine whether the consultant has a Conflicting Interest as defined in HRP-001 - SOP – Definitions. If so, obtain another consultant.

5.4 Use HRP-301 - WORKSHEET - Review Materials to determine which documents to make available to the consultant so the IRB can obtain the additional expertise needed, and make these documents available to the consultant. If the additional expertise needed does not require review of any materials, no materials need be provided.

5.5 For review by the convened IRB:

5.5.1 Make the consultant's written comments, if any, available to the IRB members attending the meeting.

5.5.2 If the consultant did not provide a written report or if requested by an IRB member, invite the consultant to the IRB meeting.

5.6 For Non-Committee Review:

5.6.1 Directly obtain the information (oral or written) from the consultant.

5.6.2 Document information received with the name of the consultant.

6 MATERIALS

6.1 HRP-001 - SOP - Definitions

6.2 HRP-301 - WORKSHEET - Review Materials

7 REFERENCES

7.1 21 CFR §56.107(f)

7.2 45 CFR §46.107(f)

SOP: Post-Review

1 PURPOSE

1.1 This procedure establishes the process for communications after a protocol is reviewed.

1.2 The process begins when:

1.2.1 A Designated Reviewer has completed a Non-Committee Review and provided completed materials to the IRB staff; OR

1.2.2 An IRB meeting has adjourned, and the IRB chair or IRB manager has finalized the minutes; OR

1.2.3 An IRB staff member has verified that modifications required to secure approval have been made.

1.3 The process ends when all correspondence related to IRB determinations and actions have been sent and additional tasks have been completed.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The IRB reports its findings and actions to the investigator.

3.2 The IRB reports its findings and actions to the institution through IRB minutes, accessible to the Institutional Official.

3.3 When the IRB disapproves research, it provides the investigator with a statement of the reasons for the decision and gives the investigator an opportunity to respond in person or in writing.

3.4 Communication of review results to investigators are to be completed within 10 business days of the IRB meeting or receipt of the completed Non-Committee Review materials.

3.5 When a modification is reviewed to lift a suspension for a previous Suspension of IRB Approval, the state of the study will change from “Suspended” to “Approved” when the modification is approved.

3.6 Reporting of Serious Non-Compliance; Continuing Non-Compliance; Suspension of IRB Approval; Termination of IRB Approval; and Unanticipated Problem Involving Risks to Subjects or Others to outside agencies is to take place within 30 business days from the determination of a reportable problem.

3.6.1 Reporting to OHRP only occurs for non-exempt Human Research that:

3.6.1.1 Is HHS-supported or conducted;

3.6.1.2 Is conducted or supported by a Federal Agency that has adopted the Common Rule and has not approved a separate assurance, other than the FWA, for the research; OR

3.6.1.3 The institution has chosen to apply the Common Rule on its FWA to all its non-exempt Human Research regardless of the source of support.

3.6.2 Reporting to the FDA only occurs for FDA-regulated Human Research.

3.6.3 Reporting to OHRP or the FDA should not occur if any of the above criteria are not met.

3.7 If the report is determined to be an unanticipated problem involving risk to subjects or others for a multi-site study AND did not occur locally (meaning at any site under this IRB’s purview) (e.g. the sponsor submits a protocol modification that includes a newly identified risk), reporting to OHRP and the FDA is not required.

3.8 For Veterans Affairs (VA) research that involves:

3.8.1 An Unanticipated Problem Involving Risks to Subjects or Others that is a local research death, notification to the VA facility Director, the Research Compliance Officer (RCO) and the Associate Chief of Staff/R&D must occur within 5 business days of the convened IRB's determination(s).

3.8.2 Information determined by the IRB to constitute an Unanticipated Problem Involving Risks to Subjects or Others, Serious Non-Compliance or Continuing Non-Compliance, notification to the VA facility Director, the Research Compliance Officer (RCO) and the Associate Chief of Staff/R&D must occur within 5 business days of the convened IRB's determination(s).

3.8.3 If the IRB is unable to make a determination on the apparent Unanticipated Problem Involving Risks to Subjects or Others within 30 calendar days of the convened IRB's initial review due to insufficient information or due to a lack of sufficient time to complete its review, the IRB must notify the VA medical facility Director, the Research Compliance Officer (RCO), and the ACOS/R&D in writing no later than five (5) business days after the determination was due.

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

5 PROCEDURE

5.1 If the Non-Committee Review indicated a Conflicting Interest or a lack of expertise, follow HRP-031 - SOP - Non-Committee Review Preparation.

5.2 For initial reviews, continuing reviews, or modifications:

5.2.1 If the communication is an IRB determination of Approved:

5.2.1.1 For DHHS-regulated research involving prisoners, refer to HRP-303 – WORKSHEET – Communication of Review Results to send applicable letters.

5.2.1.1.1 If HRP-415 - PI WORKSHEET – Prisoners reflects prisoners as a class or prisoners as controls, await OHRP approval before proceeding.

5.2.1.2 Execute the "Finalize Documents" to stamp and accept all changes for attached documents.

5.2.1.3 Execute the "Prepare Letter" activity and modify the letter as needed.

5.2.1.4 Execute the "Send Letter" activity.

5.2.2 If the communication is an IRB determination other than Approved:

5.2.2.1 Execute the "Prepare Letter" activity and modify the letter as needed.

5.2.2.2 Execute the "Send Letter" activity.

5.3 Refer to HRP-303 - WORKSHEET - Communication of Review Results to determine if any paper-based letters need to be sent and send all applicable letters within 30 business days.

5.3.1 Refer to HRP-303 - WORKSHEET - Communication of Review Results and send all applicable letters to the Principal Investigator within 5 business days.

5.3.1.1 Have letter signed by the signatory in the template letter.

5.3.1.2 Send the letter to the inside addresses and cc list as directed by the letter.

5.4 For continuing reviews or modifications to studies where enrollment is suspended and the submission does not change the enrollment suspension status, execute the "Suspend" activity in the study workspace, and document that the enrollment to the study remains suspended.

5.5 For determinations of Serious Non-Compliance; Continuing Non-Compliance; Suspension of IRB Approval; Termination of IRB Approval; or Unanticipated Problem Involving Risks to Subjects or Others:

5.5.1 If the determination was Serious Non-Compliance; Continuing Non-Compliance; or Unanticipated Problem Involving Risks to Subjects or Others:

5.5.1.1 Execute the "Prepare Letter" activity and modify the appropriate letter as needed.

5.5.1.2 Execute the "Send Letter" activity.

5.5.2 If the determination was Suspension of IRB Approval:

5.5.2.1 Execute the “Suspend” activity in the study workspace.

5.5.2.2 Execute the “Prepare Letter” activity in the study workspace and modify the letter as needed.

5.5.2.3 Execute the “Send Letter” activity.

5.5.3 If the determination was Termination of IRB Approval:

5.5.3.1 Execute the “Terminate” activity in the study workspace.

5.5.3.2 Execute the “Prepare Letter” activity in the study workspace and modify the letter as needed.

5.5.3.3 Execute the “Send Letter” activity.

5.5.4 When reporting to OHRP only, complete the *OHRP Incident Report Form*[i] within 30 business days from the determination of a reportable problem.

5.5.5 If reporting to both OHRP and any other outside agency concurrently, utilize the OHRP Incident Report Form email confirmation and HRP-520a – LETTER – External Report – OHRP and Other Agencies and send within 30 business days from the determination of a reportable problem.

5.5.6 If reporting to other outside agencies NOT including OHRP, complete HRP-520 – LETTER – External Report NOT Including OHRP and send within 30 business days from the determination of a reportable problem.

6 MATERIALS

6.1 HRP-031 - SOP - Non-Committee Review Preparation

6.2 HRP-303 - WORKSHEET - Communication of Review Results

6.3 HRP-520 - LETTER - External Report NOT Including OHRP

6.4 HRP-520a - LETTER - External Report OHRP and Other Agencies

7 REFERENCES

7.1 45 CFR §46.103(b)(4)(i), 45 CFR §46.207, 45 CFR §46.305(c), 45 CFR §46.306(a)(1), 45 CFR §46.407, Informed Consent Requirements in Emergency Research (OPRR Letter, 1996)

7.2 21 CFR §56.108(a)(1), 21 CFR §50.24(e), 21 CFR §50.54(b), 21 CFR §812.66

7.3 VHA Directive 1058.01 October 22, 2020

[i] https://oash.force.com/ohrpwebforms/s/incident-web-form

SOP: Institutional Conflicts of Interest

1 PURPOSE

1.1 This procedure establishes the process to identify institutional financial interests that may cause an institutional conflict of interests.

1.2 The process begins when the Organizational Official/ Institutional Official (IO/OO) or designee is informed of a change in the institution's financial holdings outside of standard investments.

1.3 The process ends when the IRB staff are provided an updated list of the institution's financial holdings.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 An institutional financial conflict of interests exists when any of the following might affect the design, conduct, or reporting of research:

- 3.1.1 Licensing, technology transfer, patents
- 3.1.2 Investments of the organization
- 3.1.3 Gifts to the organization when the donor has an interest in the research
- 3.1.4 Financial interests of senior administrative officials
- 3.1.5 Other financial interests

3.2 Senior administrative officials are required to disclose their financial interests to the Conflict of Interests Officer:

- 3.2.1 Upon joining the organization
- 3.2.2 Every year
- 3.2.3 When there are changes to financial interests

3.3 The Technology Transfer Office, Sponsored Projects, legal counsel, and the Conflict of Interests Officer are to notify the IO/OO or designee of any change in the institution's financial holdings not controlled by the institution's investment managers related to:

- 3.3.1 Licensing (e.g., licensing or technology transfer agreements)
- 3.3.2 Investments of the organization
- 3.3.3 Gifts to the organization when the donor has an interest in the research
- 3.3.4 Financial interests of senior administrative officials
- 3.3.5 Other financial interests

3.4 The fiduciary responsibility of the institution's investment managers is to maintain a diversified portfolio of holdings that that meets the institution's goals in terms of capital appreciation, income, and risk. IO/OO may not influence the decisions of the institution's investment managers. This institution considers such investments to be similar to diversified mutual funds and not subject to disclosure under this policy.

3.5 The evaluation and management of an institutional conflict of interest may not vary by funding or regulatory oversight.

3.6 If an institutional financial holding related to prospective or ongoing Human Research is identified, it will be managed according to HRP-055 - SOP - Financial Conflicts of Interests.

4 RESPONSIBILITIES

4.1 The IO/OO or designee carries out these responsibilities.

5 PROCEDURE

5.1 Upon receipt of information of a change in financial interest update the list of investments that are not controlled by the institution's investment managers. Include information about the name of the company, the names of related companies, and affected products or services.

5.2 Provide a copy of the updated list to the IRB staff.

6 MATERIALS

6.1 HRP-055 - SOP - Financial Conflicts of Interests

7 REFERENCES

None.

SOP: Financial Conflicts of Interest

1 PURPOSE

1.1 This procedure establishes the process to evaluate a report of an individual financial interest of an investigator or research staff Related to the Research.

1.2 The process begins when COI Office determines that an investigator or research staff has reported a financial interest Related to the Research.

1.2.1 IRB staff may detect an institutional conflict of interest. This will be handled outside of the COI Office. IRB staff may request a non-UCI COI Office or non-UCI IRB assist in the review of the reported interest and impact on the research.

1.3 The process ends when the UCI Conflict of Interest Oversight Committee (COIOC) has evaluated the reported interest and communicated the results of this evaluation to the IRB.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 Individuals engaged in human subjects research by doing one or more of the following in a human subjects research project:

3.1.1 Intervenes with subjects by performing research procedures, or by manipulating the environment for research purposes;

3.1.2 Participates in the recruitment and/or selection of subjects;

3.1.3 Participates in the informed consent process;

3.1.4 Collects or reports subject identifiable data; and/or

3.1.5 Have access to subject identifiable study data or identifiable specimens.

3.2 Individuals subject to this policy are required to disclosable their financial interests Related to the Research:

3.2.1 On submission of an initial review.

3.2.2 When adding new research personnel, only the new Researchers must disclose.

3.2.3 When a Researcher has acquired or discovered a new disclosable financial interest (e.g., through purchase, marriage, or inheritance) that relates to an active IRB protocol(s).

3.3 Disclosable financial interest: An outside financial interest that needs to be disclosed and reviewed by the COIOC includes one or more of the following for the researcher, their spouse/registered domestic partner and/or dependent children:

3.3.1 Income greater than $10,000 received from a single entity (excluding UC Regents) over the twelve months prior to disclosure. Income includes salary, consultant payments, honoraria, royalty payments, dividends, or any other payments or consideration with value, including payments made to the University of California Health Sciences Compensation Plans.

3.3.2 Equity in a publicly-traded entity greater than $10,000 (current market value) or greater than a 5% ownership interest. Equity includes stock or stock options, real estate, or any other investment or ownership interest. Equity does not include investments in a mutual fund, pension fund or other investment fund over which the Researcher or his/her immediate family member do not exercise any control.

3.3.3 Any equity in a non-publicly-traded entity, including stock or stock options, or any other investment or ownership interest.

3.3.4 Any management position, such as Board of Directors, director, officer, partner or trustee.

3.3.5 Intellectual property interest in a patent, patent application, or a copyright of software assigned or to be assigned to a party other than the UC Regents held by the Researcher, their spouse/registered domestic partner and/or dependent children

3.4 For Veterans Administration (VA) research:

3.4.1 Veterans Administration (VA) facilities are not required to follow PHS requirements, even when research is funded by a PHS agency (e.g., NIH).

3.4.2 When serving as the IRB of record for a VA facility, the VA financial conflict of interest form must be used, and the form may not be created, re-drafted, or changed.

4 PROCEDURE

4.1 COIOC will review the disclosures and provide a recommendation for disclosure including language for the consent.

4.2 COIOC will provide the IRB staff of the reviewing IRB with recommendation so the IRB can either accept the recommendation as is or make further modifications to ensure the rights and welfare of the participants are adequately protected.

4.3 The IRB will have final authority to decide whether an investigator's financial interest and the COIOC management plan, if any, allow the research to be approved.

4.4 When required provide the final determination to the funding or regulatory agencies.

4.5 Maintain a copy of determinations and management plans in the records.

5 MATERIALS

5.1 None

6 REFERENCES

6.1 42 CFR §50

6.2 45 CFR §94

6.3 UCI Administrative Policies and Procedures Policy Section 481-3 Conflicts of Interest in Human Subjects Research

SOP: Annual Evaluations of the HRPP

1 PURPOSE

1.1 This procedure establishes the process to conduct annual evaluations of the human research protection program.

1.2 The process begins the first business day of each June.

1.3 The process ends when all evaluations have been completed and communicated to those evaluated.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The human research protection program is evaluated annually.

3.2 The subject outreach program for enhancing the understanding of subjects, prospective subjects, and communities is accomplished through this HRP webpage.

4 RESPONSIBILITIES

4.1 IRB staff ensure completion of these procedures.

5 PROCEDURE

5.1 Evaluate whether the number of IRBs is appropriate to the volume and types of research reviewed.

5.1.1 Provide a copy of the evaluation to the IO/OO or designee.

5.1.2 If the number of IRBs is not appropriate to the volume and types of research reviewed, work with the IO/OO or designee to modify the IRB structure.

5.2 Have the IRB chair or IRB manager evaluate the knowledge, skills, and performance of each regular and alternate IRB member using HRP-327 - WORKSHEET - Performance Evaluation for IRB Members.

5.2.1 Have the IRB Chair or IRB Manager utilize HRP-327 - WORKSHEET - Performance Evaluation for IRB Members to complete the evaluation. Communicate the results of the evaluation to each IRB member and the IO/OO or designee.

5.2.2 Send a copy of HRP-562 - LETTER - IRB Member Appreciation to the IRB member's supervisor.

5.2.3 If needed, work with each IRB member to develop a plan to improve the individual's knowledge, skills, and performance.

5.3 Use HRP-304 - WORKSHEET - IRB Composition to evaluate whether the composition of the IRB meets regulatory and organizational requirements.

5.3.1 Provide a copy of the evaluation to the IO/OO or designee.

5.3.2 If the composition of an IRB does not meet regulatory and organizational requirements, work with the IO/OO or designee to modify the IRB composition.

5.4 Check whether each member of a Veterans Administration (VA) IRB or Veterans Administration (VA) representative has been a member longer than 2 years, and if so, send the member HRP-560 - LETTER - IRB Member Appointment.

5.5 Review HRP-080 - SOP - IRB Formation and Registration to determine if IRB registration requires updating.[i]

5.6 Check when the last time the federalwide assurance (FWA) was updated or renewed. The FWA is effective for 5 years and must be renewed every 5 years, even if no changes have occurred, in order to maintain an active FWA. Any renewal or update that is submitted electronically, and approved by OHRP, begins a new-5-year effective period.

6 MATERIALS

6.1 HRP-080 - SOP - IRB Formation and Registration
6.2 HRP-304 - WORKSHEET - IRB Composition
6.3 HRP-326 - WORKSHEET- Performance Evaluation for IRB Chairs
6.4 HRP-327 - WORKSHEET - Performance Evaluation for IRB Members
6.5 HRP-560 - LETTER - IRB Member Appointment
6.6 HRP-562 - LETTER - IRB Member Appreciation

7 REFERENCES

7.1 https://www.hhs.gov/ohrp/register-irbs-and-obtain-fwas/fwas/update-renew-fwa/index.html

[i] See http://www.hhs.gov/ohrp/assurances/. Use the Web site: http://ohrp.cit.nih.gov/efile/.

SOP: Quarterly Evaluations of the HRPP

1 PURPOSE

1.1 This procedure establishes the process to conduct quality improvement of the human research protection program.

1.2 The process begins the first business day of each quarter.

1.3 The process ends when all evaluations have been completed and if needed, acted upon.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The goal of the quality improvement plan is to achieve and maintain compliance and to achieve targeted levels of quality, efficiency, and effectiveness of the HRPP.

3.2 Objectives of the quality improvement program are to:

3.2.1 Improve compliance of investigators with their responsibilities.

3.2.2 Improve compliance of minutes with regulatory compliance.

3.2.3 Increase efficiency of recording and finalizing minutes.

3.3 The measures of the quality improvement program are defined in:

3.3.1 HRP-430 - WORKSHEET - Investigator Quality Improvement Assessment

3.3.2 HRP-431 - WORKSHEET - Minutes Quality Improvement Assessment

4 RESPONSIBILITIES

4.1 IRB staff finalize the minutes, using the worksheets to assure compliance. Minutes should be finalized and presented at the next convened meeting.

4.2 The Education and Quality Improvement Program (EQUIP) provides confirmation of these procedures.

5 PROCEDURE

5.1 Minutes Review – Review 3 random sets of IRB approved minutes from the previous quarter. Complete HRP-431 – WORKSHEET.

5.2 Informed Consent Review – Review up to 20 IRB approved informed consent documents.

5.3 IRB Protocol Review – Review up to 6 random, active studies. Review the last three years of an IRB approved protocol only.

5.4 Investigator QI Self-Assessment:

5.5 The HRP-430 - WORKSHEET - Investigator Quality Improvement Assessment tool is posted on the Zot IRB Toolkit webpage.

5.6 Send the results to the IRB manager and Institutional Official/ Organizational Official (IO/OO) or designee.

5.7 If the results of any evaluations demonstrate inconsistency, recurring noncompliance or misinterpretation of HRPP requirements, high variability, or are outside performance targets, work with the IRB manager and IO/OO to implement an intervention.

5.7.1 Interventions may include policy and procedure modifications, education and training efforts, system modifications, or other corrective actions.

6 MATERIALS

6.1 HRP-430 - WORKSHEET - Investigator Quality Improvement Assessment

6.2 HRP-431 - WORKSHEET - Minutes Quality Improvement Assessment

SOP: Expiration of IRB Approval

1 PURPOSE

1.1 This procedure establishes the process for a Designated Reviewer to determine whether current subjects may continue in expired research.

1.1.1 The expiration date (the last day the research is approved) is the last day of the approval period. Research may be conducted on the expiration date but may not be conducted after the expiration date without re-approval. For example, if the approval period is April 27, 2025-April 11, 2026, the expiration date is April 11, 2026. Research must stop at 11:59PM on April 11, 2026 unless IRB re-approval has been received.

1.2 The process begins when the Designated Reviewer is notified of a request by an investigator of a request for current subjects to continue in expired research.

1.3 The process ends when the Designated Reviewer has communicated a decision and documented the decision in writing.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 If research is granted “Modifications Required to Secure Approval” and expires before responsive materials are reviewed and approved, these procedures are to be followed.

4 RESPONSIBILITIES

4.1 A Designated Reviewer is responsible to follow these procedures.

5 PROCEDURE

5.1 Do not allow new subjects to be enrolled under any circumstances.

5.2 Determine from the investigator which subjects need to continue in the expired research, what procedures are being requested to continue, and why. The IRB Chair or IRB Vice-Chair or their designee(s) will review the request. Use the ‘Comment’ feature within the study workspace to obtain the information needed. Use text from HRP-532-Letter and paste within the Comment box.

5.3 Determine which subjects can continue in the research based on these principles:

5.3.1 In general, research procedures should be safely discontinued.

5.3.2 In general, the only research procedures that should continue are those that are not available outside of the research context and it is in the subject’s best interest to continue these procedures. If the required procedures can be provided as standard of care, these should be provided as such.

5.3.3 In general, research procedures conducted to collect data with no direct benefit to the subject should not continue.

5.3.4 In some cases, an ethical issue may be raised where the above general principles may not be followed.

5.4 In the case of Veterans Administration (VA) research, have the IRB chair determine within 2 business days whether participants may continue participating in the research interventions or interactions.

5.5 Communicate with the investigator using template text contained within HRP-532 - LETTER - Conti Subj Expired Research.

6 MATERIALS

6.1 HRP-532 - LETTER - Conti Subj Expired Research

7 REFERENCES

SOP: NIH Genomic Data Sharing (GDS) Institutional Certification

1 PURPOSE

1.1 This procedure establishes the process to certify approval for investigator submission of large-scale human genomic data to an NIH-designated data repository.

1.2 The process begins when an investigator contacts IRB staff for certification of the genomic data sharing plan.

1.3 The process ends when an IRB Manager (i.e., when an IRB transaction is in queue) or the Education and Quality Improvement Program (EQUIP) (no IRB transaction in queue) has certified and communicated to the investigator.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 Investigators must request certification from IRB staff prior to investigator submission of large-scale human genomic data or approval of funding.

4 RESPONSIBILITIES

4.1 The IRB Director or designee verifies that all data meet criteria for submission to the data repository.

5 PROCEDURE

5.1 Use HRP-332 - WORKSHEET - NIH GDS Institutional Certification to evaluate and document whether the investigator's genomic data sharing plan meets the criteria for submission to a NIH-designated data repository.

5.2 Populate the applicable NIH Extramural Institutional Certification form.

5.2.1 Provide NIH Provisional Institutional Certification when required by investigators prior to IRB review of the data sharing plan.

5.3 Save a copy of the signed form in IRB Office records.

5.4 Communicate certification approval to the investigator and provide a copy of the signed GDS Institutional Certification form for the investigator to forward to the NIH.

6 MATERIALS

6.1 HRP-332 - WORKSHEET - NIH GDS Institutional Certification

7 REFERENCES

7.1 National Institutes of Health Final Genomic Data Sharing Policy (https://grants.nih.gov/grants/guide/notice-files/NOT-OD-14-124.html)

7.2 NIH Points to Consider for IRBs and Institutions in their Review of Data Submission Plans for Institutional Certifications Under NIH's Policy for Sharing of Data Obtained in NIH Supported or Conducted Genome-Wide Association Studies (GWAS) https://sharing.nih.gov/sites/default/files/flmngr/GDS_Points_to_Consider_for_Institutions_and_IRBs.pdf

7.3 NIH Institutional Certification Forms https://sharing.nih.gov/genomic-data-sharing-policy/institutional-certifications/completing-an-institutional-certification-form

7.4 Provisional Institutional Certification https://sharing.nih.gov/sites/default/files/flmngr/GDS_Provisional_Institutional_Certification.pdf

SOP: Response Plan for Emergencies-Disasters Impacting the HRPP

1 PURPOSE

a. This SOP establishes the process for initiating a response to an emergency/disaster situation impacting the HRPP or HRPP operations. Challenges to HRPP operations or the conduct of Human Research may arise, for example, from:
   i. Extreme weather events.
   ii. Natural disasters.
   iii. Man-made disasters.
   iv. Infectious disease outbreaks.

b. The process starts when an emergency/disaster situation impacting the HRPP has occurred, or in preparation for scenarios where a potential emergency situation is imminent (e.g., natural disaster, man-made disaster, infectious disease pandemic, etc.) and HRPP operations and/or the ability of investigators to conduct Human Research is, or is likely to be, adversely impacted.

c. The process ends when the impact to the HRPP and the conduct of Human Research is assessed, and appropriate guidance is provided to HRPP personnel and the broader Human Research community.

2 REVISIONS FROM PREVIOUS VERSION

a. None

3 POLICY

a. HRPP leadership defers to designated institutional leadership and institution-wide disaster and emergency response planning and limits HRPP-specific disaster and emergency response planning only to those areas of operations or human research protections not otherwise covered by institution-level plans.

b. The HRPP evaluates its emergency response plans at least annually in accordance with the HRP-101 - Human Research Protection Program Plan and HRP-060 - SOP - Annual Evaluations of the HRPP.

4 RESPONSIBILITIES

a. The IRB Director or designee is responsible for carrying out these procedures.

5 PROCEDURE

a. If an emergency/disaster has occurred, or there is an imminent possibility of an upcoming emergency/disaster, assess the nature of the event and the appropriate response.
   i. Consult HRP-101 - Human Research Protection Program Plan to reference existing HRPP specific or institution specific emergency preparedness plans or information already in place.
   ii. Contact the IO/OO and or designated institutional personnel responsible for institutional level emergency preparedness, and determine whether there are new or revised institution level emergency preparedness plans relevant to the current or anticipated emergency.

If yes, proceed in accordance with those plans and determine whether further contact or notification of the human research community is necessary.

b. Assess whether the emergency/disaster could impact HRPP operations:

If the current or anticipated emergency/disaster will prevent any upcoming IRB meetings from properly convening, and a meeting was planned, determine whether to cancel or reschedule the meeting(s).

If currently approved Human Research has or will expire prior to IRB review due to the IRB meeting cancelation/rescheduling, follow HRP-063 - SOP - Expiration of IRB Approval.

i. If IRB staff will be unable to complete their protocol processing and review responsibilities during the emergency/disaster, or if capacity will be limited for a period of time:

Work with the staff to use any available capacity to prioritize protocol processing, pre-review, and review of continuing review submissions.

If currently approved Human Research has or will expire prior to IRB review due to IRB office capacity limitations follow HRP-063 - SOP - Expiration of IRB Approval.

Work with the IO/OO to notify the research community of the IRB Office's limited capacity to process and review submissions.

When the emergency/disaster no longer presents a limitation to IRB Office functions, work with the IO/OO to notify the IRB members and staff and research community that normal business operations have resumed.

ii. If impact to local HRPP operations will be extensive or long-lasting, determine whether reliance on an external IRB(s) is required.

If reliance on one or more external IRBs is required and the necessary reliance agreements are not currently in place, work with the IO/OO to identify appropriate candidates for external IRB reliance and follow HRP-801 - SOP - Establishing Authorization Agreements.

iii. If data or records (paper or electronic) are unavailable during the current or anticipated emergency/disaster, consult with local IT support and or electronic system vendors to implement alternative procedures to access data/backup data.

c. Assess whether the emergency/disaster could necessitate additional flexibility in IRB review processes. If yes:

i. Review HRP-352 - WORKSHEET - Additional Emergency-Disaster Review Considerations with the IRB Chair(s) and staff in advance of upcoming IRB meetings.

ii. Communicate to IRB Members (including Designated Reviewers performing non-committee reviews) that the additional considerations in the worksheet may be incorporated into IRB reviews where appropriate to maximize regulatory flexibility while continuing to assure research subject safety during the emergency/disaster.

iii. Determine whether additional communications to the research community are necessary to inform investigators of any additional measures the IRB will take to maximize regulatory flexibility during the emergency/disaster and notify the community as appropriate.

d. Assess whether the emergency/disaster could impact some or all investigators' ability to conduct Human Research. If yes:

i. Notify the research community of the need for protocol-specific emergency/disaster risk mitigation planning. Use HRP-542 - LETTER - Implementation of HRPP Emergency-Disaster Response Plan.

ii. Provide investigators with copies of (or links to) HRP-108 - FLOWCHART - Study-Specific Emergency-Disaster Risk Mitigation Planning.

iii. Provide investigators with copies of (or links to) HRP-351 - WORKSHEET - Protocol-Specific Emergency-Disaster Risk Mitigation Planning.

iv. If the emergency/disaster could impact clinical care standards which could in turn impact research, develop guidance for researchers that clarify what does and does not require IRB review (e.g., screening procedures mandated by the health care system in which a clinical trial is being conducted).

v. When the emergency/disaster no longer presents a limitation to Human Research activities, work with the IO/OO to notify the research community that normal business operations have resumed.

e. Evaluate whether the nature of the emergency/disaster may pose additional threats or risk to specific aspects of the institutions research activities or facilities. (For example, man-made disasters, industrial accidents, or terrorist threats could potentially impact some chemical, biological, or radiologic facilities to a greater extent than other facilities.)

i. If yes, and if broader institution-level emergency/disaster preparedness measures do not already address these specific activities or facilities, work with the IO/OO and appropriate institutional leadership to escalate and address any additional threats or risks.

6 MATERIALS

a. HRP-060 - SOP - Annual Evaluations of the HRPP
b. HRP-101 - HUMAN RESEARCH PROTECTION PROGRAM PLAN
c. HRP-108 - FLOWCHART - Study-Specific Emergency-Disaster Risk Mitigation Planning
d. HRP-351 - WORKSHEET - Protocol-Specific Emergency-Disaster Risk Mitigation Planning
e. HRP-352 - WORKSHEET - Additional Emergency-Disaster Review
f. HRP-542 - LETTER - Implementation of HRPP Emergency-Disaster Response Plan
g. HRP-801 - SOP - Establishing Authorization Agreement

SOP: IRB Records

1 PURPOSE

1.1 This procedure establishes the process to maintain paper-based and electronic IRB records.

1.2 The process begins when records are received or created.

1.3 The process ends when records have been filed.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 IRB records are to include:

- 3.1.1 Protocol files.
- 3.1.2 Minutes of IRB meetings.
- 3.1.3 Copies of all correspondence between the IRB and the investigators.
- 3.1.4 Current and all previous IRB member rosters.
- 3.1.5 Current and all previous IRB member files.
- 3.1.6 Current and all previous policies and procedures.

3.2 Protocol files are to include, as applicable:

- 3.2.1 All submitted materials.
- 3.2.2 Protocols (e.g., sponsored master protocol).
- 3.2.3 Investigator brochures.
- 3.2.4 Scientific evaluations.
- 3.2.5 Recruitment materials.
- 3.2.6 Consent and assent documents.
- 3.2.7 DHHS-approved sample consent document and protocol, when they exist.
- 3.2.8 Progress reports submitted by investigators.
- 3.2.9 Reports of injuries to subjects.
- 3.2.10 Records of continuing review activities, including the rationale for requiring continuing review of research that otherwise would not require continuing review when applicable under the 2018 Rule.
- 3.2.11 Data and safety monitoring board reports.
- 3.2.12 Amendments.
- 3.2.13 Reports of unanticipated problems involving risks to subjects or others.
- 3.2.14 Documentation of non-compliance.
- 3.2.15 Correspondence between the IRB and investigator related to the protocol.
- 3.2.16 Significant new findings and statements about them provided to subjects.
- 3.2.17 For initial and continuing review of research by the expedited procedure:
  - 3.2.17.1 The specific permissible category.
  - 3.2.17.2 Description of action taken by the reviewer.

3.2.17.3 Any findings required under the regulations.
3.2.17.4 The rationale for a determination that research that otherwise meets a category for expedited review is greater than Minimal Risk.
3.2.18 For exemption determinations the specific category of exemption.
3.2.19 Unless documented in the IRB minutes determinations required by the regulations and protocol-specific findings supporting those determinations for.
3.2.19.1 Waiver or alteration of the consent process.
3.2.19.2 Research involving pregnant women, fetuses, and neonates.
3.2.19.3 Research involving Prisoners.
3.2.19.4 Research involving children including wards of the state.
3.2.19.5 Research involving adults unable to consent.
3.2.19.6 Significant/non-significant device determinations.
3.2.20 For each protocol's initial and continuing review, the frequency for the next continuing review, including the rationale for requiring continuing review for protocols approved by expedited review that otherwise would not require continuing review.
3.2.21 The institution will maintain record of all research conducted by the organization reviewed by an external IRB. Records will include all materials identified in section 3.2
3.2.22 For Veterans Administration (VA) research:
3.2.22.1 Correspondence between the IRB and the Veterans Administration (VA) Research and Development Committee.
3.2.22.2 Internal or local serious adverse events.
3.2.22.3 Documentation of protocol deviations.
3.2.22.4 Reports of complaints from subjects
3.2.22.5 Records of expedited review activities
3.2.22.6 HIPAA Authorization documents
3.2.22.7 Audit results and documentation of compliance with remediation requirements

3.3 Policies and procedures include:
3.3.1 Worksheets.
3.3.2 Forms.
3.3.3 SOPs.
3.3.4 Template letters.
3.3.5 Template minutes.

3.4 IRB member files include a resume for each IRB member.

4 RESPONSIBILITIES

4.1 IRB staff members are responsible to carry out these procedures.

5 PROCEDURE

5.1 Minutes of IRB meetings: File in the electronic system.
5.2 Store all protocol-specific information (communications, documents, determinations) in the electronic system.
5.3 IRB member rosters: File in IRB member roster e-folder.
5.4 IRB membership records (e.g., curricula vita and resumes): File in IRB member e-folder.
5.5 Policies and procedures:
5.5.1 File current policies and procedures in the IRB Library in the electronic system.
5.5.2 File replaced policies and procedures in the policies and procedures history e-file.

5.5.3 IRB paper files for currently active or archived studies are stored off-site at an Iron Mountain Storage Facility.
5.5.4 IRB paper minutes and rosters are stored off-site at an Iron Mountain Storage Facility.
5.5.5 Beginning in 2019, IRB records are stored in UCI's electronic IRB databases.

6 MATERIALS

6.1 None

7 REFERENCES

SOP: Toolkit Management

1 PURPOSE

1.1 This procedure establishes the process to create and update standard operating procedures and associated worksheets.

1.2 The process begins when the IRB Directors or Institutional Official/ Organizational Official (IO/OO) or designee determines that a standard operating procedure needs to be created or modified.

1.3 The process ends when the new or revised standard operating procedure has been approved and filed.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 For all new or revised standard operating procedures, review is conducted of all associated Toolkit documents and if additional changes are warranted, each document is updated per the procedures below.

4 RESPONSIBILITIES

4.1 The IRB Directors or designee carries out these procedures.

5 PROCEDURE

5.1 For a new Toolkit document:

- 5.1.1 Assign a number.
- 5.1.2 Assign an author and approver.
- 5.1.3 Have the author create the standard operating procedure following HRP-505 - TEMPLATE SOP.
- 5.1.4 Have the approver review and approve the document.
- 5.1.5 Once approved by the approver:
  - 5.1.5.1 Update the approval/effective date.
  - 5.1.5.2 File and maintain the approved new or revised document in the standard operating procedure files.
  - 5.1.5.3 Post the approved procedure on the Human Research Protection Program Web site.
  - 5.1.5.4 File and retain the previous version in the standard operating procedure files.
  - 5.1.5.5 Send an email to affected individuals informing them of the change.

5.2 For a revision to a previously approved Toolkit documents:

- 5.2.1 Edit the current document using the tracked changes feature in MS Word.
- 5.2.2 Update Section 2 (Revisions from Previous Version) and include:
  - 5.2.2.1 A short summary of changes,
  - 5.2.2.2 The date of the most recent previous approval.
- 5.2.3 Have the approver review and approve the document.
- 5.2.4 Once approved by the approver:
  - 5.2.4.1 Update the approval/effective date.

5.2.4.2 File and maintain the approved revised document in the standard operating procedure files.
5.2.4.3 Post the approved procedure on the Human Research Protection Program Web site.
5.2.4.4 File and retain the previous version in the standard operating procedure files.
5.2.4.5 Send an email or otherwise notify affected individuals informing them of the change.

6 MATERIALS

6.1 HRP-505 - TEMPLATE SOP

SOP: IRB Records Retention

1 PURPOSE

1.1 This procedure establishes the process to retain IRB records.

1.2 The process begins each year in June.

1.3 The process ends when records that no longer need to be retained are destroyed.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 In accordance with UC Office of the President policy, research records must be retained for 10 years after the end of the calendar year in which the research is completed unless otherwise specified in the award agreement. RB records are stored for 10 years beyond the end of the calendar year in which the study is closed in both onsite and off-site locations. Records are stored electronically and on paper.

3.1.1 IRB paper files for currently active or archived studies are stored offsite at an Iron Mountain Storage Facility.

3.1.2 IRB minutes and rosters are stored off-site at an Iron Mountain Storage Facility with the more recent documents (post-2019) being stored in UCI's electronic IRB database.

3.2 Completion of a study occurs when the Lead Researcher submits a closing report or 30 days after IRB approval of the study expires, whichever comes first.

3.3 If a study is canceled without participant enrollment, records also are still maintained for 10 years beyond the end of the calendar year in which the study is closed.

3.4 All records not in protocol files are retained indefinitely.

3.5 Records may be maintained in printed form or electronically.

3.6 Protocols in which there was no subject enrollment or no research was conducted are to be retained the same as protocols where research was conducted.

3.7 All records for research conducted or funded by a Common Rule department or agency are to be accessible for inspection and copying by authorized representatives of that agency at reasonable times and in a reasonable manner.

3.8 Records maintained that document compliance or non-compliance with Department of Defense DOD) regulations shall be made accessible for inspection and copying by representatives of the DOD at reasonable times and in a reasonable manner as determined by the supporting DOD component.

3.9 All records for research subject to FDA regulations are to be accessible for inspection and copying by authorized representatives of FDA at reasonable times and in a reasonable manner.

3.10 Administrative records (e.g., minutes, member lists, and budgets) are maintained indefinitely.

3.11 Access to UCI's electronic IRB database is limited to Office of Research, OR staff and UCI partners as needed for business purposes (e.g., School of Medicine). Electronic systems are frequently backed up and have a data recovery and disaster management plan.

3.12 All records are to be accessible for inspection and copying by the Veterans Administration (VA) Research and Development Committee at reasonable times and in a reasonable manner.

3.13 Veterans Administration (VA) IRB records are retained in accordance with VHA's Records Control Schedule.

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

5 PROCEDURE

5.1 Destroy protocol files for Veterans Administration (VA) research per Records Control Schedule 10-1 (VHA RCS 10-1).

5.2 Destroy protocol files for the Department of Defense (DOD) research when approved by the Department of Defense. The agency may require submitting records to the Department of Defense for archiving.

6 MATERIALS

6.1 None

7 REFERENCES

7.1 VHA Directive 1200.05 dated January 7, 2019

7.2 DoDI 3216.02

SOP: IRB Formation and Registration

1 PURPOSE

1.1 This procedure establishes the process to form a new IRB or update the OHRP IRB registration of an existing IRB.

1.2 The process begins when the Institutional Official/ Organizational Official (IO/OO) or designee determines the need for a new IRB or updated OHRP IRB registration.

1.3 The process ends when the IRB is registered, the federalwide assurance (FWA) is updated (if needed).

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 IRB rosters are maintained using HRP-601 - DATABASE - IRB Roster.

3.2 A FWA will be submitted or updated as follows:

- 3.2.1 To engage in human subjects research that is not exempt from the regulations, and is conducted or supported by any HHS agency.
- 3.2.2 To list the institution's legal components that operate under different names that will be covered by the FWA and the city and state or country where the component is located.
- 3.2.3 To designate all internal IRBs (or external IRBs that review the largest percentage of research if the institution does not have an internal IRB) that will review research covered by the FWA.
- 3.2.4 Within 90 days after changes regarding the legal name of the institution, the Human Protections Administrator, or the Signatory Official.

3.3 FWAs are renewed every 5 years, even if no changes occur. Any renewal or update approved by OHRP begins a new 5-year effective period.

3.4 IRB registrations on file with OHRP will be made or updated as follows:

- 3.4.1 To register any additional IRB before it is designated under an FWA and reviews research conducted or supported by HHS.
- 3.4.2 Within 90 days after changes regarding the contact person who provided the IRB registration information, the IRB chairperson, or changes to the IRB membership roster.
- 3.4.3 Within 30 days of the change if an FDA-regulated IRB decides to review additional types of FDA-regulated products (e.g., to review device studies if it only reviewed drug studies previously) or to discontinue reviewing clinical investigations regulated by FDA.
- 3.4.4 Within 30 days of permanent cessation of the IRB's review of HHS-conducted or supported research when an institution disbands a registered IRB that it is operating.
- 3.4.5 IRB registration must be renewed every 3 years, even if no changes occur. Any renewal or update accepted by OHRP begins a new 3-year effective period.

3.5 Prior to seeking an FWA, VA medical facilities must secure approval from the VHA Office of Research & Development (ORD) to establish a Human Research Protection Program (HRPP).

3.6 Prior to registering an IRB that will be internally operated by a VA medical facility, VA facilities must secure approval from the VHA ORD.

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

4.2 The IO/OO or designee appoints IRB members, alternate members, IRB chairs, and if used, other officers (e.g., vice chairs.)

5 PROCEDURE

5.1 For new IRBs:

5.1.1 Determine from the IO/OO or designee whether the IRB will conduct all reviews without limitation or will be limited to certain types of reviews. Indicate this on the "IRB Scope" tab of HRP-601 - DATABASE - IRB Roster.

5.1.1.1 Select:

5.1.1.1.1 At least five individuals to serve as IRB members.

5.1.1.1.2 Additional individuals to serve as alternate IRB members, if needed.

5.1.1.1.3 At least one of the individuals to be the IRB chair.

5.1.1.2 Follow HRP-082 - SOP - IRB Membership Addition for each IRB member.

5.1.1.3 Use HRP-304 - WORKSHEET - IRB Composition and revise the selected individuals as needed to ensure that the IRB is appropriately constituted.

5.1.1.4 The biomedical IRB Committees are primarily made up of School of Medicine and UCI Medical Center faculty and staff with sufficient scientific expertise and scholarship to review each protocol to determine the study meets the criteria for IRB approval.

5.1.1.5 The social/behavioral/ educational IRB Committee is made up of faculty and staff from the School of Social Sciences, School of Social Ecology, School of Humanities; the Donald Bren School of Information and Computer Sciences; School of Medicine, School of Education; and School of Business with sufficient scientific expertise and scholarship to determine that each study meets criteria 45 CFR 46.111 and if applicable, 21 CFR 56.111.

5.1.1.6 In general, IRB E is comprised of IRB Chairs, IRB Vice-Chairs, senior members from IRB A, B and C, and a non-scientist member.

5.1.1.7 To support American Nurses Credentialing Center Magnet designation each biomedical IRB includes at least one UCI nurse as a voting member.

5.1.1.8 Using the "Create Committee" SmartForm, create the new committee in the system.

5.1.1.9 Once training is completed, add committee members to the system with the Committee Member role.

5.1.1.10 Assign any designees eligible to conduct non-committee reviews using the "Update Eligible Designated Reviewers" activity.

5.2 File a new FWA, or update an existing, by following the instructions available at the OHRP website: https://www.hhs.gov/ohrp/register-irbs-and-obtain-fwas/fwas/index.html

5.2.1 If the new FWA is for a VA medical facility, secure approval from the VHA ORD prior to filing and then notify the VHA Office of Research Oversight (ORO).

5.3 Register the new IRB, or update an existing IRB's OHRP registration as required by this policy, by following the instructions available at the OHRP website: https://www.hhs.gov/ohrp/register-irbs-and-obtain-fwas/irb-registration/new-irb-registration/index.html.

5.3.1 If the New IRB will be operated by a VA medical facility, secure approval from the VHA ORD prior to registration.

6 MATERIALS

6.1 HRP-082 - SOP - IRB Membership Addition
6.2 HRP-202 - FORM - IRB Member Information
6.3 HRP-304 - WORKSHEET - IRB Composition
6.4 HRP-601 - DATABASE - IRB Roster

7 REFERENCES

7.1 45 CFR §46.103, 45 CFR §46.107, 45 CFR §46.108, 45 CFR §46.115(a)(5).
7.2 21 CFR §56.107, 21 CFR §56.115(a)(5).
7.3 VHA Directive 1058.03 September 17, 2020

SOP: IRB Removal

1 PURPOSE

1.1 This procedure establishes the process to remove an IRB.

1.2 The process begins when the Institutional Official/ Organizational Official (IO/OO) or designee determines that an IRB is no longer needed.

1.3 The process ends when the IRB is unregistered with OHRP and the Federalwide Assurance (FWA) is updated.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 IRB rosters are maintained using HRP-601 - DATABASE - IRB Roster.

3.2 Any termination or non-renewal of OHRP IRB registration of any IRB relied on by a VA medical facility for review and oversight of VA research must be reported to the local VA medical facility per the facility's required reporting timelines.

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

5 PROCEDURE

5.1 For internal IRBs:

5.1.1 For each IRB member who will no longer serve as an IRB member prepare HRP-561 - LETTER - IRB Member Thank You, have them signed by the IO/OO or designee and send to the former IRB members.

5.1.2 Unregister the IRB with OHRP.[i]

5.1.3 Remove the IRB from the FWA.[ii]

5.1.4 Remove members from HRP-601 - DATABASE - IRB Roster.

5.1.5 Remove the individual's Committee Member role in the system.

5.1.6 File:

5.1.6.1 DATABASE: IRB Roster (HRP-601)

5.1.6.2 FWA

5.1.6.3 HRP-561 - LETTER - IRB Member Thank You

5.2 For external IRBs follow the requirements of the inter-institutional agreement or contract.

6 MATERIALS

6.1 HRP-561 - LETTER - IRB Member Thank You

6.2 HRP-601 - DATABASE - IRB Roster

7 REFERENCES

7.1 45 CFR §46.107, 45 CFR §46.103(b)(3), 45 CFR §46.115(a)(5).

7.2 21 CFR §56.107, 21 CFR §56.115(a)(5).

7.3 VHA Directive 1200.05(3), Amended July 13, 2023
7.4 VHA Directive 1058, November 8, 2024

[i] See http://www.hhs.gov/ohrp/assurances/. Use the Web site: http://ohrp.cit.nih.gov/efile/.
[ii] See http://www.hhs.gov/ohrp/assurances/. Use the Web site: http://ohrp.cit.nih.gov/efile/.

SOP: IRB Membership Appointment

1 PURPOSE

1.1 This procedure establishes the process to appoint and re-appoint an IRB member.

1.2 The process begins when an individual expresses interest, is nominated or applies to join the IRB in consultation with the Institutional Official/ Organizational Official (IO/OO) (this may be a completely new IRB member, or re-appointment of a previous member).

1.3 The process ends when the IRB roster is updated and the new member has completed training.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 IRB rosters are maintained using HRP-601 - DATABASE - IRB Roster.

3.2 IRB members /alternates are appointed for a three-year term. Members/alternates are eligible for re-appointment at the end of their term. In general, IRB Chairs and Vice Chairs are appointed for a two-year term.

3.3 The following individuals may not be appointed as IRB members or be involved in the day-to-day operations of the IRB:

3.3.1 Those responsible for business development for the organization (e.g., director of grants and contracting, the vice president for research, deans of research who are responsible for raising funds or garnering support for research, senior officers).

3.3.2 Those who own equity in the organization.

4 RESPONSIBILITIES

4.1 IRB staff members carry out these procedures.

4.2 The IO/OO or designee appoints/re-appoints IRB members, alternate members, IRB chairs, and if used, other officers (e.g., vice chairs.).

5 PROCEDURE

5.1 Have the individual complete HRP-202 - FORM - IRB Member Information.

5.2 Have the individual complete the IRB Member Conflict of Interest Disclosure.

5.3 Obtain a copy of the individual's résumé or curriculum vita.

5.4 Use the information in the completed HRP-202 - FORM - IRB Member Information and the individual's résumé or curriculum vita to determine if the individual qualifies as a scientist or nonscientist, and if they are affiliated or unaffiliated.

5.5 Interview the individual to assess suitability and availability.

5.5.1 Determine from the IO/OO or designee whether the individual will be a regular IRB member, alternate IRB member, or IRB chair.

5.5.2 In any instance for which the scientific or non-scientific status or affiliation status of a newly appointed or re-appointed IRB member may be questionable, the IO/OO or designee will be consulted before proceeding with the appointment.

5.5.3 For Veterans Administration (VA) representatives, communicate with the Veterans Administration (VA) Medical Center Director in writing to obtain confirmation of the appointment.

5.6 Schedule a time for the applicant to attend and observe an IRB meeting, as applicable.

5.7 Add the individual to HRP-601 - DATABASE - IRB Roster.

5.8 Complete HRP-304 - WORKSHEET - IRB Composition and revise the membership as needed to ensure that the IRB is appropriately constituted.

5.9 Prepare HRP-560 - LETTER - IRB Member Appointment for the individual.

5.10 Provide to the IO/OO or designee for review and approval:

5.10.1 HRP-202 - FORM - IRB Member Information.

5.10.2 Résumé or curriculum vita.

5.10.3 Completed HRP-560 - LETTER - IRB Member Appointment.

5.11 If not approved, select another individual and restart at 5.1.

5.12 Once the appointment letter is signed:

5.12.1 Send the signed HRP-560 - LETTER - IRB Member Appointment to the individual.

5.12.2 If the individual requires training, schedule the individual for training.

5.12.2.1 Forward information on the Collaborative IRB Training Initiative (CITI) Basic Human Research Protections Course for IRB Members: All IRB members are required to complete this tutorial within 3 months of their appointment.

5.12.2.2 A refresher course is required every five years for members to maintain their knowledge of ethical considerations and regulations regarding human research protections.

5.12.2.3 Health Insurance Portability and Accountability Act (HIPAA) Research Tutorial: The internet-based tutorial developed by the UC is designed specifically for researchers involved with Protected (Personal) Health Information (PHI). All IRB members are required to complete the HIPAA Research tutorial within 3 months of their appointment.

5.12.3 Update the registration of all affected IRBs.[i]

5.13 File:

5.13.1 HRP-601 - DATABASE - IRB Roster.

5.13.2 Signed IRB appointment/re-appointment letter.

5.13.3 HRP-202 - FORM - IRB Member Information.

5.13.4 Résumé or curriculum vita.

5.13.5 Any other signed agreements.

5.14 Notify the IRB manager when the individual has completed training.

5.15 Assign individual the “Committee Member” role in the system.

5.16 If the individual is designated to conduct non-committee reviews, update the “Update Eligible Designated Reviewers” activity.

6 MATERIALS

6.1 HRP-202 - FORM - IRB Member Information

6.2 HRP-304 - WORKSHEET - IRB Composition

6.3 HRP-560 - LETTER - IRB Member Appointment

6.4 HRP-601 - DATABASE - IRB Roster

7 REFERENCES

7.1 45 CFR §46.107, 45 CFR §46.108(a)(2), 45 CFR §46.115(a)(5).

7.2 21 CFR §56.107, 21 CFR §56.115(a)(5).

7.3 VHA Directive 1200.05 January 7, 2019

[i] See http://www.hhs.gov/ohrp/assurances/. Use Web site: http://ohrp.cit.nih.gov/efile/.

SOP: IRB Membership Removal

1 PURPOSE

1.1 This procedure establishes the process to remove an IRB member.

1.2 The process begins when an IRB member resigns or is removed from one or more IRBs. This procedure applies if an individual is a member of more than one IRB and is being removed from some but not all IRBs.

1.3 The process ends when the IRB registration is updated.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The Institutional Official/ Organizational Official (IO/OO) or designee may remove IRB members, alternate members, IRB chairs, and if used, other officers (e.g., vice chairs) with consultation from the IRB manager and IRB chair(s).

3.2 IRB rosters are maintained using HRP-601 - DATABASE - IRB Roster.

4 RESPONSIBILITIES

4.1 IRB Directors or designees carry out these procedures.

5 PROCEDURE

5.1 Remove the individual from HRP-601 - DATABASE - IRB Roster.

5.2 Complete HRP-304 - WORKSHEET - IRB Composition to ensure that the IRB is appropriately constituted.

5.2.1 If not, identify one or more replacement members and follow HRP-082 - SOP - IRB Membership Addition.

5.3 Prepare HRP-561 - LETTER - IRB Member Thank You, have it signed by the IO/OO or designee and send to the individual.

5.4 Update the registration of all affected IRBs.[i]

5.5 File:

5.5.1 HRP-601 - DATABASE - IRB Roster.

5.5.2 HRP-561 - LETTER - IRB Member Thank You.

5.6 Remove individual's "Committee Member" role in the system.

5.6.1 If applicable, update the "Update Eligible Designated Reviewers" activity.

6 MATERIALS

6.1 HRP-082 - SOP - IRB Membership Addition

6.2 HRP-304 - WORKSHEET - IRB Composition

6.3 HRP-561 - LETTER - IRB Member Thank You

6.4 HRP-601 - DATABASE - IRB Roster

7 REFERENCES

7.1 45 CFR §46.107, 45 CFR §46.103(b)(3), 45 CFR §46.115(a)(5)

7.2 21 CFR §56.107, 21 CFR §56.115(a)(5)

[i] See http://www.hhs.gov/ohrp/assurances/. Use the Web site: http://ohrp.cit.nih.gov/efile/.

SOP: IRB Meeting Scheduling and Notification

1 PURPOSE

1.1 This procedure establishes the process to schedule and notify individuals of convened meetings.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 Scheduled meetings are to occur at intervals appropriate for the quantity, complexity, and frequency of required actions, and to permit adequate oversight of the progress of approved research.

3.2 Additional meetings may be scheduled on an ad hoc basis.

4 RESPONSIBILITIES

4.1 The IRB manager or designee carries out these procedures.

5 PROCEDURE

5.1 Create a schedule of meetings for each IRB.

5.1.1 Execute the “Create Meeting” SmartForm in the system for each scheduled meeting.

5.2 Post the schedule on the organization’s Web site.

5.3 Notify the following individuals of the updated schedule with an email providing a link to the IRB Web page with the schedule information:

5.3.1 IRB members.

5.3.2 Investigators and research staff on the IRB email list.

5.3.3 Institutional Official / Organizational Official (IO/OO) or designee.

6 MATERIALS

6.1 None

7 REFERENCES

7.1 ICH-GCP E6 1.4.2

SOP: Informed Consent Process for Research

1 PURPOSE

1.1 This procedure establishes the process to obtain informed consent from subjects, the Legally Authorized Representative (LAR) of adults unable to consent, or the parents or guardians of children.

1.2 The process begins when an individual identifies a subject as a potential candidate for a research study.

1.3 The process ends when a subject or the subject's LAR provides legally effective informed consent or declines to do so.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 In this procedure "investigator" means a principal investigator or an individual authorized by the principal investigator (PI) and approved by the IRB to obtain consent for the specific protocol, such as a co-investigator, research assistant, or coordinator.

3.2 In this procedure "subject/representative" means:

3.2.1 The subject when the subject is an adult capable of providing consent.

3.2.2 LAR when the subject is an adult unable to give consent.

3.2.3 One or both biologic or adoptive parents when the subject is a child or in the absence of a parent a person other than a parent authorized under applicable law to consent on behalf of the child to general medical care.

3.2.4 In this procedure "finalize" means those authorized to obtain the final verbal or written consent from participants.

3.2.4.1 When considering which researchers names should be included on the informed consent as those who are capable of finalizing the consent process the following guidelines apply:

3.2.4.1.1 For minimal risk research, the PI must list their name on the consent document.

3.2.4.1.2 For greater than minimal risk research, the PI and Co-Investigators (Co-I) who are approved by the IRB to finalize consent must be listed on the consent document.

3.2.4.1.3 When UCI is the IRB of record for multisite, investigator-initiated trials (IITs), the UCI IRB may require a cover sheet specific to each relying site, listing the UCI PI, site-specific lead collaborating researcher/s and site-specific Co-I's approved to finalize consent. This cover sheet may be appended to the top of the single, IRB approved, consent document. This efficiency allows necessary Co-I changes at study sites to be handled at the respective site only (along with verification of human research subject trainings).

3.2.4.1.4 For greater than minimal risk research that involves the application of an investigational drug, device, or surgical procedure, only a United States (US) licensed medical doctor or US licensed nurse practitioner

may finalize the consent process. Departments may have specific policies related to consent that may be more restrictive. Researchers should be aware of these policies and adhere accordingly.

3.3 If the subject/representative understands more than one language, whenever possible, conduct the consent process in the preferred language of the subject/representative.

3.4 If the subject is an adult unable to consent:

- 3.4.1 The IRB must have specifically approved the protocol to allow the enrollment of adults unable to consent.
- 3.4.2 Permission is obtained from a LAR.
- 3.4.3 A LAR must be in the class or persons approved by institutional policy or the IRB. See HRP-013 - SOP - LARs, Children, and Guardians.

3.5 If the subject is a child:

- 3.5.1 The IRB must have specifically approved the protocol to allow the enrollment of children.
- 3.5.2 Permission is obtained from both parents unless:
  - 3.5.2.1 One parent is deceased, unknown, incompetent, not reasonably available;
  - 3.5.2.2 Only one parent has legal responsibility for the care and custody of the child; or
  - 3.5.2.3 The IRB has specifically approved the protocol to allow the permission of one parent regardless of the status of a second parent.
- 3.5.3 In the absence of a parent permission may be obtained from an individual authorized to consent under applicable law on behalf of a child to general medical care.
- 3.5.4 Refer to HRP-103 - SOP - Investigator's Manual

3.6 If the subject/representative cannot speak English:

- 3.6.1 The IRB must have specifically approved the protocol to allow the enrollment of non-English speaking subjects.

3.7 Conduct all discussions in a private and quiet setting.

3.8 Any knowledgeable individual may:

- 3.8.1 Review the study with subject/representative to determine preliminary interest.
- 3.8.2 If the subject/representative is interested, notify an investigator.
- 3.8.3 If the subject/representative is not interested, take no further steps regarding recruitment or enrollment.

3.9 UCI does not utilize broad consent. UCI's interpretation of broad consent is that it is a system-wide program that allows institutions to track via a central system biospecimens and data for which individuals provide their broad consent, or decline, as well as the terms of the broad consent to determine which future research uses remain within scope. This interpretation aligns with the Health and Human Services (HHS) Secretary's Advisory Committee on Human Research Protections (SACHRP) interpretation.

3.10 Involving a Participant Advocate in the consent process: The IRB Committee may require, at their discretion, that the Investigator use a participant advocate or provide an advocacy group as a contact to the participants. The role of a participant advocate is to assure that the participant receives equitable and ethical treatment during the informed consent process and/or throughout the course of the research study. The advocate could be a single person with an interest in the population studied or a group of people interested in the safety of human research participants, usually within a certain population (e.g., breast cancer patients, patients with schizophrenia, etc.).

3.11 When the research protocol requires creation, use or disclosure of PHI, Researchers must indicate whether subjects will sign a written HIPAA research authorization for release of PHI for research, formally titled, "UC Permission to Use Personal Health Information for Research" form, or request a waiver of authorization from the IRB. In addition, if a study involves PHI, all members of the research protocol team engaged in human subject research must complete the HIPAA Research tutorial.

3.12 The Protection of Human Subjects in Medical Experimentation Act (California Health and Safety Code Sections 24170-24179.5) requires that individuals be provided the Subject's Bill of Rights as part of the informed consent process prior to participation in a medical experiment.

3.12.1 When meeting the requirement to attest that informed consent to the California Medical Experiment Act have been satisfied, the consent form is signed and dated by any person other than the subject or the subject's guardian or legally authorized representative who can attest that the requirements for informed consent has been met, as specified in Section 24175 of the California Health and Safety Code. At UCI, the investigator's signature serves this purpose and an impartial witness is not required.

4 RESPONSIBILITIES

4.1 The principal investigator is responsible to ensure these procedures are carried out.

5 PROCEDURE

5.1 **If the consent process will be documented electronically:**

5.1.1 For FDA-Regulated Studies using an electronic process to document consent, the PI must use DocuSign Part 11 for obtaining signatures on the Informed Consent Form.

5.2 **If the consent process will be documented in writing with the long form of consent documentation:**

5.2.1 Verify that you are using the most current IRB-approved version of the study specific consent form and that the consent form is in a language understandable to the subject/representative.

5.2.1.1 Use only the IRB-stamped version of the consent. For UCI IRB approved consent documents, the expiration date is not specified. The most recent IRB approval dates, including the date of study expiration are stated on the UCI IRB approval letter.

5.2.2 Provide a copy of the consent form to the subject/representative. Whenever possible provide the consent form to the subject/representative in advance of the consent discussion.

5.2.3 If the subject/representative cannot read, or is physically unable to talk or write, obtain an impartial witness to be present during the entire consent discussion to attest that the information in the consent form and any other information provided was accurately explained to, and apparently understood by, the subject/representative, and that consent was freely given.

5.2.4 The role of the witness may be served by a member of the IRB or may be an impartial third party. A witness must be an adult who is not a member of the study team and who is not a family member of the subject.

5.2.5 If the subject/representative cannot speak English, obtain the services of an interpreter fluent in both English and the language understood by the subject/representative. The interpreter may be a member of the research team, a family member, or friend of the subject/representative.

5.2.6 Read the consent document (or have an interpreter read the translated consent document) with the subject/representative. Begin with a concise and focused presentation of key information that is most likely to assist the subject/representative to understand the reasons why one might or might not want to participate in the research. Explain the details in such a way that the subject/representative understands what it would be like to take part in the research study.

5.3 **If the consent process will be documented in writing with the short form of consent documentation:**

5.3.1 In general, for studies that involve greater than minimal risk a request for Short Forms will require full committee review. The IRB Chair or Vice Chair's has discretion on a protocol-by-

protocol basis however and may decide that review of a request for Short Forms can occur at a subcommittee level. The reason for the level of review (full committee or subcommittee) should be appropriately documented in the IRB Worksheet.

5.3.2 In the instance that the UCI IRB has approved Short Form use but the specific foreign language translation of the English Short Form is not immediately available on the UCI HRP webpage, UCI researchers may use the appropriate language translation of the Short Form as found on the following websites; WCG IRB, Advarra IRB, Central IRB for the National Cancer Institute (CIRB) or any UC HRP that has the needed translation available.

5.3.3 Obtain the current IRB approved short consent form and summary (same as the English consent form used for long form of consent documentation).

5.3.4 Verify that you are using the most current IRB-approved version of the study specific short consent form and summary and that the short consent form is in a language understandable to the subject/representative.

5.3.5 Provide copies to the subject/representative. Whenever possible provide the short consent form and summary to the subject/representative in advance of the consent discussion.

5.3.6 Obtain the services of an interpreter fluent in both English and the language understood by the subject/representative. The interpreter may be a member of the research team, family member, or friend of the subject/representative.

5.3.7 Obtain the services of an impartial witness who is fluent in both English and the language spoken by the subject/representative to be present during the entire consent discussion to attest that the information in the short consent form, summary, and any other information provided was accurately explained to, and apparently understood by, the subject/representative, and that consent was freely given. The witness and the interpreter may be the same person. If possible, it is recommended that the witness should not be related to the subject[i]. The witness may not be a person involved in the design, conduct, or reporting of the research study.

5.3.7.1 In cases where the interpreter or translator is an impartial third party to an oral / IRB approved short form consent process but is not physically present (e.g., a virtual consent process), the family member of the participant may be allowed to serve as a witness. The family member serving as a witness must be fluent in both English and the language of the participant. The witness must sign and date both the short form written informed consent document and a copy of the IRB approved English version of the consent document.

5.3.8 Have the interpreter translate the summary (not the short consent form) to the subject/representative. Begin with a concise and focused presentation of the key information that is most likely to assist the subject/representative to understand the reasons why one might or might not want to participate in the research.

5.3.9 Through the interpreter explain the details in such a way that the subject/representative understand what it would be like to take part in the research study. When necessary, provide a different or simpler explanation to make the information understandable.

5.3.10 Have the subject/representative read the short consent form or have the interpreter read the short consent form to the subject/representative.

5.3.11 The translated consent form must be provided to the participant within one month from the date that eligibility is confirmed.

5.3.11.1 Translation Requirements:

5.3.11.1.1 Greater than minimal risk studies: professional or certified translation of the consent form and recruitment materials is required for studies

that pose more than minimal risk to participants. For a professional translation the PI must provide the qualifications of the individual who translated the informed consent documents and recruitment materials. Include any credentials, certifications, education, native language fluency, etc. For a certified translation, a copy of the certification from the translator or translation service should be attached to the translation of any informed consent documents and recruitment materials.

5.3.11.1.2 Minimal risk studies: Studies that are eligible for expedited review also require translation of the consent form and recruitment materials; however, certified translation is not required. The IRB will accept documents translated by an individual fluent (i.e., can speak, read, and write) in a given language. The qualifications of the individual performing the translation will be assessed by the IRB. A letter or statement from the translator describing their qualifications must be provided with the translation documents.

5.3.11.2 The translated consent form must be provided to the participant within one month from the date that eligibility is confirmed.

5.4 **If the requirement for written documentation of the consent process has been waived by the IRB:**

5.4.1 Obtain the current IRB approved script.

5.4.2 Verify that you are using the most current IRB-approved version of the study specific script and that the script language is understandable to the subject/representative.

5.4.3 When possible, provide a copy of the script to the subject/representative.

5.4.4 If the subject/representative cannot speak English, obtain the services of an interpreter fluent in both English and the language understood by the subject/representative. The interpreter may be a member of the research team, a family member, or friend of the subject/representative.

5.4.5 Read the script (or have an interpreter translated the script) with the subject/representative. Begin with a concise and focused presentation of the key information that is most likely to assist the subject/representative to understand the reasons why one might or might not want to participate in the research. Explain the details in such a way that the subject/representative understands what it would be like to take part in the research study.

5.5 Invite and answer the subject/representative's questions.

5.6 Give the subject/representative time to discuss taking part in the research study with family members, friends and other care providers as appropriate.

5.7 Invite and encourage the subject/representative to take the written information home to consider the information and discuss the decision with family members and others before making a decision.

5.8 Ask the subject/representative questions to determine whether all of the following are true, and if not, either continue the explanation or determine that the subject/representative is incapable of consent:

5.8.1 The subject/representative understands the information provided.

5.8.2 The subject/representative does not feel pressured by time or other factors to make a decision.

5.8.3 The subject/representative understands that there is a voluntary choice to make.

5.8.4 The subject/representative is capable of making and communicating an informed choice.

5.9 If the subject/representative has questions about treatments or compensation for injury, provide factual information and avoid statements that imply that compensation or treatment is never available.

5.10 Once a subject/representative indicates that he or she does not want to take part in the research study, this process stops.

5.11 If the subject/representative agrees to take part in the research study:

5.11.1 If the subject is a child:

5.11.1.1 Whenever possible explain the research to the extent compatible with the child's understanding.

5.11.1.2 Request the assent (affirmative agreement) of the child unless:

5.11.1.2.1 The capability of the child is so limited that the child cannot reasonably be consulted.

5.11.1.2.2 The IRB determined that assent was not a requirement.

5.11.1.3 Once a child indicates that he or she does not want to take part in the research study, this process stops.

5.11.2 If the subject is an adult unable to consent:

5.11.2.1 Whenever possible explain the research to the extent compatible with the adult's understanding.

5.11.2.2 Request the assent (affirmative agreement) of the adult unless:

5.11.2.2.1 The capability of the adult is so limited that the adult cannot reasonably be consulted.

5.11.2.2.2 The IRB determined that assent was not a requirement.

5.11.2.3 Once an adult unable to consent indicates that he or she does not want to take part in the research study, this process stops.

5.11.3 Obtain written documentation of the consent process according to HRP-091 - SOP - Written Documentation of Consent. *Note any exceptions are reflected in HRP-90 – SOP – Informed Consent Process for Research.*

5.12 Clinical trials conducted or supported by a Common Rule department or agency initially approved by the IRB on or after January 21, 2019, must post one (1) IRB-approved clinical trial consent form at a publicly available federal website. The consent form must be posted after recruitment closes, and no later than 60 days after the last study visit. For additional guidance, refer to the OHRP FAQs on Informed Consent.

6 MATERIALS

6.1 Long form of consent documentation:

6.1.1 Consent form

6.2 Short form of consent documentation:

6.2.1 Short consent form

6.2.2 Summary (same information as the English consent form used for long form of consent documentation)

6.3 Requirement for written documentation of the consent process has been waived by the IRB:

6.3.1 Consent script (same as consent form used for long form of consent documentation except that signature block is optional)

6.4 HRP-013 - SOP - LARs, Children, and Guardians

6.5 HRP-091 - SOP - Written Documentation of Consent

7 REFERENCES

7.1 21 CFR §50.20, 50.25

7.2 45 CFR §46.116

7.3 UCI Health Office of Information Technology

[i] FDA's Informed Consent Guidance for IRBs, Clinical Investigators, and Sponsors (August 2023) https://www.fda.gov/media/88915/download

SOP: Written Documentation of Consent

1 PURPOSE

This procedure establishes the process to document the informed consent process in writing.

The process begins when a subject agrees to take part in a research study.

The process ends when the consent process is documented in writing, including in an electronic format, to the extent required by this procedure.

2 REVISIONS FROM PREVIOUS VERSION

None

3 POLICY

In this procedure “investigator” means a principal investigator or an individual authorized by the principal investigator and approved by the IRB to obtain consent for the specific protocol, such as a co-investigator, research assistant, or coordinator.

In this procedure “subject/representative” means:

3.1. The subject when the subject is an adult capable of providing consent.

3.2. The Legally Authorized Representative (LAR) when the subject is an adult unable to give consent.

3.3. One or both biologic or adoptive parents when the subject is a child or in the absence of a parent, a person authorized under applicable law to consent on behalf of the child to the child’s general medical care.

4 RESPONSIBILITIES

The principal investigator is responsible to ensure these procedures are carried out.

5 PROCEDURE

If the consent process will be documented in writing with the long form of consent documentation:

5.1. Verify that the consent form is in language understandable to the subject/representative.

5.2. Print the name of the following individuals on the consent document:

5.2.1. Subject/Representative

5.2.2. Person obtaining consent

5.3. Have the following individuals personally sign and date (or otherwise "make their mark” on) the consent document:

5.4. Subject/Representative

5.4.1. If the subject/representative can only “make their mark,” document in a note to the subject’s file: the method used for communication with the prospective subject/representative, the reason for the lack of a signature and date, and the date consent was obtained[i].

5.4.2. If the subject/representative is physically unable to sign the consent form, note this on the consent form and document in a note to the subject’s file: the method used for communication with the prospective subject/representative, and the specific means by which their agreement was communicated[i].

5.5. Person obtaining consent

5.5.1. If the IRB required written documentation of assent, note on the signature block one of the following:
5.5.1.1. Assent of the child was obtained.
5.5.1.2. Assent of the child was not obtained because the capability of the child is so limited that the child cannot reasonably be consulted.

5.6. If an impartial witness was part of the consent process:
5.6.1. Print the name of the impartial witness on the consent document.
5.6.2. Have the impartial witness personally sign and date the consent document to attest that the information in the consent document and any other information provided was accurately explained to, and apparently understood by, the subject, and that consent was freely given.

5.7. Provide copies of the signed and dated consent document to the subject/representative. This may be accomplished either by making a photocopy or by having the above individuals sign and date two copies of the consent document.

5.8. If the consent process will be documented in writing with the short form of consent documentation:
5.8.1. Verify that the short consent form is in language understandable to the subject/representative.
5.8.2. Print the name of the following individuals on the short form consent document and the summary:
5.8.2.1. Subject/Representative
5.8.2.2. Person obtaining consent
5.8.2.3. Impartial witness
5.8.3. Have the following individuals personally sign and date the short form consent document and/or the summary:
5.8.3.1. Subject/Representative sign short form consent document
5.8.3.2. Person obtaining consent sign summary
5.8.3.3. Impartial witness signs both short form consent document and summary

5.9. If the IRB required written documentation of assent, note on the signature block on the short consent document one of the following:
5.9.1. Assent of the child was obtained.
5.9.2. Assent of the child was not obtained because the capability of the child is so limited that the child cannot reasonably be consulted.

5.10. Provide a copy of the signed and dated short consent document and a copy of the signed and dated summary to the subject/representative. This may be accomplished either by making photocopies or by having the above individuals sign and date two copies of the short consent document and summary.

5.11. If non-English languages are anticipated[i], obtain a translated copy of the IRB-approved English version of the long form consent promptly and submit to the IRB for review.
5.11.1. After IRB approval of the translated version, provide it to the subject or LAR as soon as possible.

5.12. When the research protocol requires creation, use or disclosure of PHI, Researchers must indicate whether subjects will sign a written HIPAA research authorization for release of PHI for research, formally titled, "UC Permission to Use Personal Health Information for Research" form, or request a waiver of authorization from the IRB. In addition, if a study involves PHI, all members of the research protocol team engaged in human subject research must complete the HIPAA Research tutorial.

5.13. The Protection of Human Subjects in Medical Experimentation Act (California Health and Safety Code Sections 24170-24179.5) requires that individuals be provided the Subject's Bill of Rights as part of the informed consent process prior to participation in a medical experiment. When meeting the requirement to attest that informed consent to the California Medical Experiment Act have been satisfied, the consent form is signed and dated by any person other than the subject or the subject's guardian or legally authorized representative who can attest that the requirements for informed consent has been met, as specified in Section 24175 of the California Health and Safety Code. At UCI, the investigator's signature serves this purpose and an impartial witness is not required.

5.14. If the requirement for written documentation of the consent process has been waived by the IRB and the IRB determined that the subject/representative had to be offered the opportunity to document his or her consent in writing, offer the subject/representative the option to document his or her consent in writing.

5.14.1. If the subject/representative declines, take no further action.

5.14.2. If the subject/representative accepts, follow the process to document consent in writing with the long or short form of consent documentation.

5.15. Place the signed and dated documents in the subject's binder.

6. MATERIALS

6.1. If the consent process will be documented in writing with the long form of consent documentation:

6.1.1. Consent document

6.2. If the consent process will be documented in writing with the short form of consent documentation:

6.2.1. Short consent document

6.3. Summary (same content as the long form of consent documentation).

7. REFERENCES

7.1. HRP-090 - SOP – Informed Consent Process for Research

7.2. 21 CFR §50.27

7.3. 45 CFR §46.117

7.4. https://www.fda.gov/media/88915/download

[i] FDA's Informed Consent Guidance for IRBs, Clinical Investigators, and Sponsors (August 2023) https://www.fda.gov/media/88915/download

SOP: Veterans Affairs Research

1 PURPOSE

1.1 Within the Department of Veterans Affairs (VA) is the Veterans Health Administration (VHA). The VHA is America's largest integrated health system, providing care at over 1,300 health facilities. The VHA is also the only organizational component of the VA that can conduct human subject research. The VHA Office of Research and Development (ORD) is responsible for the creation of human research policies. This policy addresses the human subject research protections considerations when the UCI IRB reviews a human subject research protocol supported by the VHA.

2 REVISIONS FROM PREVIOUS VERSION

1.1 None

3 POLICY

3.1.1 The VHA has the ability to fund veteran-centric research led by VA investigators. To serve as a VA investigator, one must be a VA employee.

3.1.2 The VHA Directive 1200.05(3): Provides the requirements for the protection of human research subjects. This is generally aligned with Office for Human Research Protections (OHRP) guidance.

3.1.3 The VA also aligns with the 2018 Common Rule at 38 CFR 16. The 2018 Common Rule applies to VA research regardless of funding.

3.1.4 The VA follows the Privacy Rule (Health Insurance Portability and Accountability Act of 1996)

3.1.5 The VA Long Beach Healthcare System (VALBHS) Medical Center Director is the individual legally authorized as a Signatory Official to commit VCALBHS to an Assurance.

4 RESPONSIBILITIES

4.1 If the UCI-IRB determines a given VALBHS project does not constitute research, does not constitute human subjects research, or that a particular site is not engaged in human subjects research pertaining to that project, the UCI PI will provide written correspondence concerning its decision to the VALBHS Principal Investigator (PI) via the IRB electronic submission system.

4.2 The UCI-IRB Research Office will seek feedback from the VALBHS PIs, and VALBHS on the efficiency and effectiveness of UCI-IRB operations as part of a continuous quality improvement process.

4.3 If UCI obtains accreditation of the Human Research Protection Program (HRPP) from an accrediting body but fails to maintain accreditation, UCI will notify the VALBHS and ORD in writing within ten (10) business days.

4.4 The UCI-IRB Research Office and UCI-IRB will maintain all VALBHS project documentation, membership documents, and other relevant records in accordance with UCI-IRB SOPs, and all VA and other Local, State, and Federal requirements.

4.5 The VA facility is responsible for ancillary reviews, including Conflict of Interest, and an assessment of the Principal Investigator and Study Team (e.g., expertise, training, including human subject training, credentialed, etc.) not the reviewing IRB.

5 PROCEDURE

5.1 Initial Submission

5.1.1 The VA requires both an initial privacy and information security review, prior to IRB review. A final privacy and information security review occurs prior to VA Research and Development Committee (R&D) review.

5.2 Single IRB

5.2.1 The VA is agreeable to single IRB; Prior to the 2018 Common Rule, the VA created a central IRB for ORD-funded multi-site studies.

5.2.2 Exceptions from single IRB may be requested from the ORD by VA facility research leadership (i.e., not the investigator).

5.2.3 The VA IRB cannot serve as the IRB of record for any non-VA site.

5.2.4 Collaborative research involving non-VA institutions may not be undertaken without a signed written agreement (e.g., a Cooperative Research and Development Agreement [CRADA] or a Data Use Agreement) that addresses such issues as the responsibilities of each party, the ownership of the data, and the reuse of the data for other research. Any use or reuse of data must be consistent with the protocol, the informed consent document, and the Health Insurance Portability and Accountability Act (HIPAA) authorization.

5.3 **Greater than Minimal Risk Research**

5.3.1 Human research protocols involving greater than minimal risk must include a Data Safety Monitoring Board or Committee. The meeting frequency, as well as the scope of the Board or Committee must be described in the protocol.

5.3.2 Any minutes, reports or records related to the Data Safety Monitoring Board or Committee will be accessible to the VA.

5.4 **Informed Consent Considerations**

5.4.1 Informed consent documents must be both signed and dated by the subject or the subject's legally authorized representative.

5.4.2 Electronic consent is allowable should the process confirm to VA requirements for use of electronic signatures. The VA requirements for use of electronic signatures must meet governmental requirements for authenticity and identification.

5.4.3 Broad consent can only be used when identifiable data or biospecimens are collected solely for *research* purposes in accordance with the requirements in section 17.f of the VHA Directive 1200.05.[1]

5.4.4 Use of the VA ICF template is highly recommended to ensure all the VA mandate elements and boiler plate language is in place.

5.5 **Required Consent Language**

5.5.1 ORD Policy mandates the following consent language, as applicable:

5.5.2 A statement that the VA will provide treatment for research related injury.

5.5.3 A statement that informs VA research subjects that their insurance will not be charged for any costs related to the research. Note: co-payments for standard medical care or services not part of the research procedures may still apply.

5.5.4 When photos, video and/ or audio recordings are taken or obtained exclusively for research purposes:

5.5.4.1 A description of any photographs, video, and / or audio recordings to be taken or obtained for research purposes;

5.5.4.2 How the photographs, video, and / or audio recordings will be used for the research; and

5.5.4.3 Whether the photographs, video, and / or audio recordings will be disclosed outside of the VA

5.6. **When the VA conducts a study protected by a Certificate of Confidentiality (CoC):**

5.6.1. When information about the subject's participation will be included in the VHA medical record, information must be given to the prospective subjects as part of the informed consent process that informs them of this research component.

5.6.2. For studies that mandate informed consent, the consent document approved by the IRB must include the statement that a study has a CoC.

5.7. **Recruitment:**

5.7.1. If prospective participants are being contacted by telephone, the study team must make initial contact in person or by letter prior to any telephone contact and refer to those prior contacts

[1] The VA Long Beach does not allow for the use of Broad Consent.

when phoning the participant unless there is written documentation that the subject is willing to be contacted by telephone about the study in question or a specific kind of research.

5.7.2. The initial contact must provide a telephone number or other means that the potential participant can use to verify the study constitutes VA research.

5.7.3. Later Contact – the research team may use telephone calls to the participant by referring to previous contacts and when applicable, the information provided in the informed consent form.

5.7.4. The scope of telephone contacts with the participant is limited to topics outlined in IRB-approved protocols and informed consent forms.

5.8. **HIPAA**

5.8.1. The VHA is a covered entity under HIPAA.

5.8.2. The VA will handle the review of any HIPPA human subject research considerations.

5.8.3. VA Form 10-0493 must be used; a standalone HIPAA authorization document is required. The HIPAA authorization must not be combined with the consent document.

5.8.4. The VA facility must ensure the HIPAA authorization language is valid.

5.8.5. For collaborative research that involves both UCI and the VA, the VA will serve as the privacy board for the VA site. The VALBHS Privacy Officer (PO) and Information System Security Officer (ISSO) Representatives will perform the required privacy and information security reviews and provide these reviews to the IRB with submissions.

5.9. **Reportable Events**

5.9.1. Reviewing serious adverse events, unanticipated problems involving risks to subjects or others, protocol deviations, complaints, Research Compliance Officer (RCO) audit reports, and any audit reports from sponsors, VA oversight bodies or other oversight agencies, regarding projects for which the UCI-IRB is serving as the IRB of record, in accordance with VHA Directive 1058.01 and VHA Directive 1200.05.

5.9.2. Reportable events must be reported to OHRP even if not supported by an agency signed onto the Common Rule. Due to their Federalwide Assurance (FWA), reportable events that occur on non-exempt human subject research mandate reporting.

5.9.3. UCI Principal Investigator (PI) will provide timely written notice, usually within seven (7) calendar days, to VALBHS PI of UCI-IRB determinations involving the conduct of a research project at VALBHS. This includes contingent approvals and requested amendments, etc.

5.9.4. The VA has specific reporting requirements as follows:

5.9.4.1. Death/s at local site/s, both unanticipated and related to the research must be reported to the IRB “immediately.”

5.9.4.2. All local reportable events and unanticipated serious adverse device effects must be reported to the IRB within 5 business days.

5.9.4.3. Protocol deviations and other non-reportable events must be noted in the research file.

5.9.4.4. Local breaches of confidentiality and security must be reported to the IRB within 1 hour, as well as to the necessary privacy offices at the VA.

5.9.5. It is noted that UCI IRB however requires the submission of those events that appear reportable per federal regulations (e.g., unanticipated problems, serious and continuing noncompliance, suspension and terminations of research).

5.10. **Application Supplement Forms:**

5.10.1. **General DoD:** Researchers conducting DoD supported research must complete and submit to the IRB the DoD Supplement Form in addition to the protocol materials submitted to the IRB for initial review. The DoD Supplement Form can be found on the Office of Research (OR), Human Research Protection (HRP) Website at: https://research.uci.edu/human-research-protections/irb-forms/ https://research.uci.edu/wp-content/uploads/WCG-405-Worksheet-Addl-Criteria-DOD.pdf

5.10.2. **Investigational Drugs:** VA Form10-9012, Investigational Drug Information Record is to be provided at initial application when investigational drugs are involved.

6 MATERIALS

None

7 REFERENCES

A special thank you to Karen Jeans, Director for Regulatory Affairs for the Office of Research Protections, Policy and Education, Department of Veteran Affairs, whose Smart IRB presentation from March 2024 has been heavily referenced in the creation of this policy.

38 CFR 16
38 CFR 17.85
VHA Directive 1200.05(3) Requirement for the Protection of Human Subjects in Research: https://www.va.gov/vhapublications/
VHA Directive 1200.05(3), Paragraph 17.d.(10)
VHA Directive 1200.05(3), Paragraph 17.e.(10)
VHA Directive 1200.05(3), Paragraph 17.k.(10)
VHA Directive 1200-01(1) R&D Committee: https://www.va.gov/vhapublications/
https://grants.nih.gov/faqs
https://www.research.va.gov/programs/orppe/irb_relationships.cfm
https://www.research.va.gov/programs/orppe/Checklist-for-VA-Facilities-Using-Independent-Commercial-IRBs-ICDs-and-Combined-ICD-HIPAA-Authorization.docx
https://www.research.va.gov/programs/orppe/VA-HIPAA-Authorization-Requirements-When-Using-an-Independent-Commercial-IRB.docx
https://www.research.va.gov/programs/orppe/VA-Specific-and-Selected-2018-Common-Rule-Informed-Consent-Requirements-When-Using-an-Independent-Commercial-IRB.docx
https://www.research.va.gov/programs/orppe/ORD-IRB-Reliance-Request-Form.docx

SOP: Establishing Authorization Agreements

1 PURPOSE

1.1 The purpose of this process is to execute Authorization Agreements with other institutions and agreements with individuals for reliance for non-exempt human research.

1.2 This process begins when an institution/organization or collaborating independent investigator or collaborating institutional investigator at a non-assured institution has been identified for a potential Authorization Agreement.

1.3 This process ends when an Institutional Profile has been established or an Individual Investigator Agreement (IIA) has been executed.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None.

3 POLICY

3.1 HRP-101 - Human Research Protection Program Plan details the criteria for reviewing for or relying on other institutions/organizations or reviewing for unaffiliated individuals.

3.2 An institution or individual must be engaged in non-exempt Human Research as determined by using HRP-311 - WORKSHEET - Engagement Determination for IRB reliance to occur.

3.3 The institution may leverage an existing Institutional Profile to collect information requested in the Institutional Profile SmartForm. For example, Institutional Profiles created for IREx or the SMART IRB platform are acceptable.

3.4 The institution may leverage the SMART IRB agreement or the local UCI Institutional Authorization Agreement to establish reliance.

3.5 Where this institution serves as the reviewing institution every effort will be made to promote the use of SMART IRB agreement. A LOA is required between both institutions.

3.6 This institution does allow an unaffiliated individual or individual affiliated with an organization that does not have an Federalwide Assurance (FWA) to request reliance on this institution's FWA and IRB via an IIA.

3.7 This institution leverages the local IIA to establish reliance.

4 RESPONSIBILITIES

4.1 The Reliance Coordinator or IRB staff generally carry out these procedures. The IO/OO or HRPP Director may also participate in reliance determinations.

5 PROCEDURE

5.1 If the request is for IRB reliance on or by an institution, determine whether the criteria for reviewing for or relying on other institutions/organizations are met:

5.1.1 Review HRP-101 - Human Research Protection Program Plan to determine if basic criteria are met.

5.1.1.1 If the criteria have not been met, do not execute an Authorization Agreement. Prepare HRP-856 – LETTER – Decline Reliance on an External IRB, or HRP- 850 - LETTER - Decline to Serve and send to the other institution/organization.

5.1.1.2 If the request is for your institution to rely on another institution's IRB, use HRP-832 - PI WORKSHEET - Considerations for Relying on an External IRB to inform your determination of whether your institution will rely on another institution's IRB.

5.1.1.3 If an institution is requesting to rely on your institution's IRB, use HRP-833 - PI WORKSHEET - Considerations for Serving as the Reviewing IRB to inform your determination of whether your institution's IRB will serve as the sIRB.

5.1.2 If the criteria have been met, for an institution/organization, execute an Authorization Agreement with that institution/organization. (Use of the SMART IRB Agreement is documented via a letter of acknowledgement (SMART LOA) or use of their Online Reliance System on a study specific basis.)

5.1.2.1 Indicate in the Authorization Agreement the conditions under which you serve as the IRB of record for that institution/organization.

5.1.2.2 Indicate in the Authorization Agreement the conditions under which that institution/organization will serve as the IRB of record for you.

5.1.2.3 Include the following in the Authorization Agreement, or as (an) addendum(s):

5.1.2.3.1 When UCI is reviewing IRB and the authorization agreement is not SMART, include a communication plan. Use HRP-830 - WORKSHEET - Communication and Responsibilities to create a communication plan.

5.1.2.3.2 Consent form instructions, including instructions for the institution/organization to provide local contact information and details regarding compensation for research-related injuries.

5.1.2.3.3 Recruitment material instructions.

5.1.2.3.4 New information reporting instructions.

5.1.2.3.5 Required terms.

5.1.2.3.6 Negotiable terms.

5.1.2.3.7 The process for adding participating sites or additional research to existing Authorization Agreement (if this is a master agreement).

5.1.2.3.8 Relevant tribal, state, or non-US laws, regulations, or policies, such as age of majority, circumstances that affect the age of consent, who can serve as a Legally Authorized Representative, and other information that may not be identified elsewhere in the Authorization Agreement.

5.1.2.3.9 Use HRP-802 - SOP - Management of Institutional Profiles to record the collected information in the Institutional Profile SmartForm. File the HRP-815 - FORM - Institutional Profile if applicable and the Authorization Agreement (and any addendums) together for future reference.

5.1.3 If the criteria within HRP-832- PI WORKSHEET - Considerations for Relying on an External IRB or HRP-833- PI WORKSHEET - Considerations for Serving as the Reviewing IRB have not been met, do not execute an Authorization Agreement. Prepare HRP-856 – LETTER – Decline Reliance on an External IRB, or HRP-850 - LETTER – Decline to Serve and send to the other institution/organization.

5.2 If the request is for an unaffiliated individual or individual affiliated with an organization that does not have an FWA to rely on your institution, determine whether the criteria have been met:

5.2.1 Confirm the individual does not need their institution to obtain its own FWA (e.g., they are the prime awardee, or routinely conduct human subjects research).[i]

5.2.2 Review HRP-101 - Human Research Protection Program Plan to determine if basic criteria are met.

5.2.2.1 If the criteria have not been met, do not execute an IIA. Prepare HRP-850 - LETTER – Decline to Serve and send to this institution's study team.

5.2.2.2 If the criteria have been met, execute IIA with the individual.

5.2.2.3 Upload the finalized IIA under “Other Attachments” in the study application.

6 MATERIALS

6.1 HRP-021 - SOP - Pre-Review
6.2 HRP-101 - Human Research Protection Program Plan
6.3 HRP-802 - SOP - Management of Institutional Profiles
6.4 HRP-815 - FORM - Institutional Profile
6.5 HRP-830 - WORKSHEET - Communication and Responsibilities
6.6 HRP-832 - PI WORKSHEET - Considerations for Relying on an External IRB
6.7 HRP-833 - PI WORKSHEET - Considerations for Serving as the Reviewing IRB
6.8 HRP-850 - LETTER - Decline to Serve
6.9 HRP-856 - LETTER - Decline Reliance on an External IRB
6.10 HRP-861 - WORKBOOK - Institutional Profiles
6.11 Reliance Agreement Templates (IIA, IAA, SMART LOA): Available on HRP Toolkit

7 REFERENCES

7.1 Single IRB Exception Determinations: https://www.hhs.gov/ohrp/regulations-and-policy/single-irb-exception-determinations/index.html
7.2 SMART IRB Agreement: https://smartirb.org/agreement/
7.3 Extending an FWA to Cover Collaborating Investigators (2005): https://www.hhs.gov/ohrp/regulations-and-policy/guidance/extension-of-institutional-fwa-via-individual-investigator-agreement/index.html

[i] Extending an FWA to Cover Collaborating Investigators (2005) | HHS.gov: https://www.hhs.gov/ohrp/regulations-and-policy/guidance/extension-of-institutional-fwa-via-individual-investigator-agreement/index.html

SOP: Institutional Profile Management

1 PURPOSE

1.1 The purpose of this process is to manage Institutional Profiles.

1.2 This process begins when this institution receives new or updated information from another institution/organization that impacts the content of the Institutional Profile.

1.3 This process ends when updated information has been communicated to appropriate parties.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 Any substantive changes to an Institutional Profile may result in an amended Authorization Agreement. Any non-substantive changes, e.g., contact information updates, do not require an amended Authorization Agreement.

3.2 The institution may leverage an existing Institutional Profile to collect information requested in the Institutional Profile SmartForm. For example, Institutional Profiles created for IREx or the SMART IRB platform are acceptable.

4 RESPONSIBILITIES

4.1 The Reliance Coordinator or IRB staff generally carries out these procedures.

5 PROCEDURE

5.1 If no Institutional Profile exists for a site for which this institution is being asked to serve as the single IRB, or an IRB on which this institution is being asked to rely, update the Institutional Profile SmartForm with information about the external institution/organization.

5.1.1 Gather this information from any of the following sources:

5.1.1.1 SMART IRB Agreement online Profile

5.1.1.2 IREx Online Profile

5.1.1.3 Information included in the IRB Authorization Agreement (IAA)

5.1.1.4 Direct communication with the Human Research Protection Program (HRPP) of the external institution/organization

5.1.1.4.1 HRP-815 - FORM Institutional Profile can be used to collect this information

5.2 If a relying site or reviewing IRB provides updated information for an existing Institutional Profile, update the Institutional Profile SmartForm with the information.

5.3 If an amended Authorization Agreement is needed, file the updated HRP-815 - FORM - Institutional Profile with the amended Authorization Agreement.

5.4 Determine whether the updates impact any existing studies. If so, develop a plan for how to address the impact.

5.5 Communicate these updates and any plans to address impacts to appropriate parties as needed.

6 MATERIALS

6.1 HRP-815 - FORM - Institutional Profile

7 REFERENCES

7.1 None

SOP: External IRB Post-Review

1 PURPOSE

1.1 The purpose of this process is to conduct post-review for submissions where this institution is being asked to rely on an external IRB.

1.2 This process begins when a request to rely oversight has been submitted and pre-review has been completed.

1.3 This process ends when all correspondence related to IRB determinations and actions have been sent and additional tasks have been completed.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None.

3 POLICY

3.1 None.

4 RESPONSIBILITIES

4.1 The Reliance Coordinator or IRB staff generally carries out these procedures.

5 PROCEDURE

5.1 For studies where IRB oversight has been ceded to an external IRB:

5.1.1 Execute the “Record sIRB Decision” activity and complete the Smartform with the information in the external IRB approval letter. Upload the external IRB determination letter in the designated space for “External IRB Approval Letter” if not already attached under “Other Attachments” in the study application.

5.1.2 Execute the “Finalize Documents” activity if necessary.

5.1.3 Execute the “Prepare Letter” activity to generate and edit HRP-857 - LETTER - Acknowledge External IRB.

5.1.4 Execute the “Send Letter” activity.

6 MATERIALS

6.1 HRP-857 - LETTER - Acknowledge External IRB

7 REFERENCES

7.1 None

SOP: External IRB Updates

1 PURPOSE

1.1 The purpose of this process is to ensure that the relying institution is made aware of updates approved by the external IRB or when the local investigator makes changes at the site level.

1.2 This process begins when the local site investigator submits newly approved materials from the external IRB or when the local investigator submits local site changes.

1.3 This process ends when an external IRB submission has been updated.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None.

3 POLICY

3.1 An investigator relying on an external IRB must update the site record with changes approved by the external IRB, including providing notification of Continuing Review approval, by the external IRB, using the “Update Study Details” activity.

3.2 If changes are made at the local site that affect institutional requirements (including changes to personnel, conflicts of interest, funding, HIPAA, or changes to institutionally required consent language) on an external IRB study, the investigator must update the site record using the “Create Site Modification” activity.

3.3 Any reportable new information (RNI) that is determined to be Serious Non-Compliance or Continuing Non-Compliance should be reported by using the “Reportable New Information” activity.

4 RESPONSIBILITIES

4.1 The Reliance Coordinator or IRB staff generally carry out these procedures.

5 PROCEDURE

5.1 If the item includes updates to the local site information (Site Modification for study team members or other parts of the site), review the updates using HRP-830 - WORKSHEET - Communication and Responsibilities.

5.1.1 If the item is a personnel change, ensure the personnel are qualified and have required training.

5.1.2 If the item is a change to a conflict of interest management plan, follow HRP-055 – SOP - IRB Review of Financial Conflicts of Interest.

5.1.3 If the item is a change to HIPAA authorization waivers or alterations and the local site is serving as the Privacy Board, review and document the appropriate waivers using HRP-441-WORKSHEET for HIPAA Waiver of Authorization.

5.1.4 If the item is a change triggering an ancillary review, execute the Manage Ancillary Review activity and assign the appropriate ancillary review organization or individual as outlined in HRP-309 - WORKSHEET - Ancillary Review Matrix.

5.2 If the item was determined to be Serious Non-Compliance or Continuing Non-Compliance or an Unanticipated Problem Involving Risks to Subjects or Others (UPIRTSO) that occurred locally:

5.2.1 If the external IRB has not notified the local IRB of the event, contact the external IRB, request additional information and documentation as needed, and confirm reporting requirements as described in the reliance agreement terms.

5.2.2 Consult with the HRPP Director or designee to determine whether any additional actions are needed, including local review of the event.

5.2.2.1 Follow HRP-024 - SOP - New Information to review the event.

5.2.2.2 In coordination with the HRPP Director or designee, notify the IO/OO and other local departmental offices as appropriate (i.e., department leadership, deans, privacy, quality, or risk management).

5.2.3 Respond to the external IRB with any edits requested to any applicable reporting requirement letter(s) or file the report with any appropriate agency(ies) in accordance with oversight requirements outlined in the Authorization Agreement terms.

5.3 If the item is an update to the overall study (Update to Study Details for funding, study scope, or study related documents and template), review the updates in accordance with the roles and responsibilities of your institution as outlined in the Authorization Agreement or HRP-830 - WORKSHEET - Communication and Responsibilities.

5.3.1 The institutional policy requires that the IRB Reliance Coordinator or IRB staff execute the "Finalize Updates" activity in the system:

5.3.1.1 Review the updates and if they are satisfactory, determine if the changes require an update to the sIRB Decision:

5.3.1.1.1 If yes, execute the "Edit sIRB Decision" activity and complete the SmartForm, indicating whether documents need to be finalized or a letter needs to be sent.

5.3.1.1.2 If applicable, execute the "Finalize Documents" activity and then the "Send Letter" activity to send HRP-859 - TEMPLATE LETTER - Acknowledge External IRB Update.

5.3.1.1.3 If no, no further action is necessary.

5.3.1.2 If the item includes other updates and are not satisfactory:

5.3.1.2.1 Contact the investigator by posting a comment in the submission workspace with requested changes. Instruct the investigator to edit the submission.

5.3.1.2.2 When the investigator edits the submission, confirm that the requested changes were made.

5.3.1.3 Review the updates and if they are satisfactory, determine if the changes require an update to the sIRB Decision:

5.3.1.3.1 If yes, execute the "Edit sIRB Decision" activity and complete the SmartForm, indicating whether documents need to be finalized or a letter needs to be sent.

5.3.1.3.2 If applicable, execute the "Finalize Documents" activity and then the "Send Letter" activity to send HRP-859 - TEMPLATE LETTER - Acknowledge External IRB Update.

5.3.1.3.3 If no, no further action is necessary.

6 MATERIALS

6.1 HRP- 024 - SOP - New Information

6.2 HRP-055 - SOP - IRB Review of Financial Conflicts of Interest

6.3 HRP-309 - WORKSHEET - Ancillary Review Matrix

6.4 HRP-441- WORKSHEET - HIPAA Waiver of Authorization

6.5 HRP-830 - WORKSHEET - Communication and Responsibilities

6.6 HRP-859 - LETTER - Acknowledge External IRB Update

7 REFERENCES

7.1 None.

SOP: Review Request to Rely on an External IRB

1 PURPOSE

1.1 This procedure establishes the process to ensure the criteria for this Institution to rely on an external IRB for review and oversight of non-exempt human research have been met.

1.2 This process begins when a study team submits a request to rely on an external IRB.

1.3 This process ends when the request to rely on an external IRB has been approved or declined.

2 REVISIONS FROM PREVIOUS VERSION

2.1 None

3 POLICY

3.1 The IO/OO or their designee has the authority to determine what IRBs the Institution will rely upon, as well as approve and rescind authorization agreements for IRBs.

3.2 Reliance on an external IRB requires an Authorization Agreement and an active local Institutional Profile, as well as a local review for compliance with local policies of the Institution.

4 RESPONSIBILITIES

4.1 The Reliance Coordinator or IRB staff carry out these procedures.

5 PROCEDURE

5.1 Click on the Institutional Profile area in IRB system and determine if the external IRB has an active profile.

5.1.1 If there is an active profile and the IRB is not required to approve each individual request to rely for this external IRB (e.g. NCI CIRB), go to Section 5.2.2.

5.1.2 If there is not an active profile OR the IRB is required to approve each individual request to rely for this external IRB, proceed to next section.

5.2 Using HRP-832 - PI WORKSHEET - Criteria for Relying on an External IRB, determine if the study is eligible to rely on an external IRB of record.

5.2.1 If the study does not meet the criteria for reliance on an external IRB:

5.2.1.1 Execute the Confirm Reliance Activity.

5.2.1.2 Indicate NO to the question #3 “Confirm reliance on the single IRB of record?”

5.2.1.2.1 Manually prepare and send HRP-856- Reliance Determination Decline to Rely to communicate the determination to the Investigator.

5.2.1.2.2 If the Investigator chooses to submit a response to the IRB regarding the determination, proceed with step 5.1 above.

5.2.2 If the study is eligible to rely on an external IRB of record:

5.2.2.1 Determine if a valid authorization agreement is in the Institutional Profile.

5.2.2.1.1 If not, follow HRP-801 - SOP - Establishing Agreements to create a new authorization agreement.

5.2.2.2 Confirm that all local requirements and ancillary reviews are complete.

5.2.2.2.1 Human Subjects Training is complete.

5.2.2.2.2 Conflict of Interest management plan is in place when applicable and will be provided to IRB of Record.

5.2.2.2.3 Written consent to be used at this institution includes institutionally required language where applicable.

5.2.2.2.4 HIPAA Authorization language is provided as separate document to be used at this institution when applicable to the study.
5.2.2.2.5 Refer to the Institutional Profile or authorization agreement to determine institutional responsibilities.
5.2.2.2.6 Use HRP-441 PI WORKSHEET - HIPAA Waiver of Authorization when applicable and this institution will serve as Privacy Board.
5.2.2.2.7 Use HRP-064 -SOP- NIH GDS Institutional Certification and HRP-332 PI WORKSHEET NIH GDS Institutional Certification when applicable and this institution is responsible for certification.
5.2.2.2.8 All relevant local ancillary review requirements have been met or are in progress in accordance with HRP-309 - WORKSHEET - Ancillary Review.

5.2.2.3 If any institutional requirements are not met, execute the "Request Pre-Review Clarification" activity from the investigator.
5.2.2.4 Offer the investigator the opportunity to update the submission.
5.2.2.5 Execute the Confirm Reliance Activity:
5.2.2.5.1 Indicate YES or NO to the question "Confirm reliance on the single IRB of record?"
5.2.2.5.2 If you indicated YES and the investigator does not yet have external IRB approved documents, and your institution requires these be provided, leave the study in "Pending sIRB Review" state and wait for the Investigator to log a comment with IRB approved documents. Communicate this requirement to the Investigator via the "Correspond with sIRB" activity.
5.2.2.6 If the investigator already uploaded external IRB approved documents for this site (e.g., NCI CIRB), execute the "Record sIRB Decision" activity and complete any information required by the local IRB.
5.2.2.6.1 Indicate NO to the question "Do you need to finalize documents or send a letter" unless finalizing documents and/or sending a letter is required. This moves the study to the Review Complete state.
5.2.2.6.2 Indicate YES if finalizing documents and/or sending a letter is required. This will move the study to the Post Review state.
5.2.2.7 Refer to HRP-804 - SOP - External IRB Post-Review.

6 MATERIALS

6.1 HRP-064 -SOP- NIH GDS Institutional Certification
6.2 HRP-309 - WORKSHEET - Ancillary Review Matrix
6.3 HRP-332 - WORKSHEET - NIH GDS Institutional Certification
6.4 HRP-441 - WORKSHEET - HIPAA Waiver of Authorization
6.5 HRP-801 - SOP - Establishing Agreements
6.6 HRP-804 - SOP - External IRB Post-Review
6.7 HRP-815 - FORM - Institutional Profile
6.8 HRP-832 - PI WORKSHEET - Considerations for Ceding IRB Review
6.9 HRP-857 - LETTER - Acknowledge External IRB
6.10 HRP-856 - LETTER - Decline Reliance on an External IRB
6.11 HRP-859 - LETTER - Acknowledge External IRB Update
6.12 HRP-861 - WORKBOOK - Institutional Profiles

7 REFERENCES

7.1 SMART IRB Agreement: https://smartirb.org/agreement/
7.2 OHRP Authorization Agreement template: https://www.hhs.gov/ohrp/register-irbs-and-obtain-fwas/forms/irb-authorization-agreement/index.html