Essential Standard Operating Procedures
Sample Templates

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JHM IRB COMPLIANCE GUIDE FOR DEVELOPING STANDARD OPERATING PROCEDURES

INTRODUCTION

The Compliance Monitoring Team has created Standard Operating Procedure templates (SOPs) in response to action items discovered in IRB directed audits, FDA audit and site visits, and routine monitoring visits. These templates were designed in order to assist researchers in establishing their own set of rules, or SOP criteria, and to help study staff operate their respective studies in an organized and consistent manner, that demonstrates adherence to Federal regulations and Institutional guidance. The SOP templates and the corresponding Case Report Form/checklists cover the basic categories of study procedures and can be applied across studies. SOP samples are available below.

Samples of the SOPs listed here include:

- How to obtain Informed Consent from research subjects
- Documenting the Informed Consent process
- Maintaining Regulatory Documents
- Study Record retention
- Serious Adverse Event reporting
- Safety Reporting for routine Adverse Events and Protocol Deviations

The templates follow a formal format that includes the following structure:

I. A "header" indicating the title, date, author, version number, pages, and approval information (if applicable).

II. The body of the document includes the purpose, scope, references (if applicable), and a number of detailed procedures.

When developing your own specific SOPs, you may consider using a less formal structure. If your study requires more specific content, please consider tailoring your individual site and/or protocol Standard Operating Procedures to suit your needs.

Other areas to consider when designing your site-specific SOPs:

- Communication Procedures (IRB, NIH, FDA, Sponsor, other)
- Protocol Continuing Renewal
- Protocol Termination
- IND Safety reports
- IND Annual reports
- IND Sponsor-required Written General Monitoring Plan
- IDE Progress Reports
- IDE Unanticipated Adverse Device Effect Reporting
- IDE Sponsor-required Written General Monitoring Plan
- Withdrawal of Subjects
- Oral Consent process
- Assent and Consent of Minors
- Change In PI /Inherited studies
- DSMB Reporting requirement

Sample User Standard Operating Procedure	Version:
Status:	Revised by:
Original Date:	Approved by:
Revision Date:	Approval Date:

Standard Operating Procedures: JHM Training/Certification Documentation

The Principal Investigator is responsible for:

1. Completing and passing the following training modules:

    a. Human Subjects Research Compliance
    b. Course on Research Ethics (C.O.R.E)
    c. Conflict of Interest
    d. HIPAA and Research Course

2. Designating study personnel as "consent designees" who, upon being approved by the IRB to obtain informed consent, shall receive training in the consent process.

3. Assuring the training of all applicable research personnel regarding study procedures, study conduct, and research compliance.

4. Performing additional training and certification as required by the Institution, sponsor, or other regulatory authorities, with such certificates retained for verification.

5. Maintaining a record for all Research Personnel of all training certifications, including all certificates of completion of applicable training modules and, if necessary, any sponsor required documents (e.g., CVs) in the Regulatory Binder. Use the specific table template found in section II.B.2 of this manual.

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Standard Operating Procedures: Delegation of Responsibility

The Principal Investigator is responsible for:

1. Designating all Co-Investigators and other research personnel on the initial review application submitted to the IRB.

2. Ensuring that co-investigators have read and understood the protocol and their specific role in the research, and all other study-related materials (e.g., the investigator brochure, if applicable).

3. Assigning specific tasks and responsibilities for each member of the study team; and communicating and providing training for these roles and responsibilities to each member.

4. Authorizing all members of the study team, who are included in the initial application or later added to the protocol, to perform specific study related tasks but only after receiving approval from the IRB.

5. Maintaining a study responsibility delegation table on which all study team members are named, their respective duties/tasks are outlined, and each member's entry is signed and dated to indicate the team member's willingness to perform his/her designated tasks. Use the specified table found in Section II.B.1 in this manual.

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Standard Operating Procedures: Process for Obtaining Informed Consent

The Principal Investigator and IRB approved study staff members are responsible for:

1. Describing in the IRB application (eFormA) how, when, and where, and by whom informed consent will be obtained. In addition, establishing the following elements to the informed consent process:

    a. Presenting the research subject with adequate opportunity to read the entire informed consent form before it is signed, which may include taking the document home to discuss with family, prior to signing.
    b. Allowing the subject and/or subject's legally authorized representative ample time and opportunity to ask questions about the study. All questions should be answered to the satisfaction of the subject and/or the subject's legally authorized representative.
    c. Assessing and confirming the subject's comprehension of the Informed Consent Form content.
    d. Obtaining legally effective informed consent (i.e. signed, dated and, if applicable, witnessed) from the subject or the subject's legally authorized representative, prior to the initiation of any study specific procedures.

2. Implementing and consistently following the IRB approved consent process.

3. Training, if applicable, study team member approved as consent designees on the process of obtaining informed consent.

4. Signing and dating the IRB approved written informed consent form on the same day as the subject and/or the subject's legally authorized representative.

5. Giving a copy of the informed consent form, signed by the subject, to the subject, and filing another in the subject's medical record (if applicable); the original should remain in the subject's research record.

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Standard Operating Procedures: Documenting Informed Consent

The Principal Investigator is responsible for:

1. Documenting the IRB approved informed consent process was followed by recording and confirming the following information:

    a. The current IRB approved (noting the version number and expiration date) consent form was used, and signed by the subject;
    b. The name of the person who discussed the consent form with the potential subject;
    c. The name of the person who obtained the consent form signature(s) from the research subject (additional witness, or proxy); or why it was not obtained;
    d. The date of subject and investigator (or IRB approved consent designee) signatures;
    e. Verification that a copy of the signed consent was given to the subject, that the original remains in the research record, and that a copy is filed in the medical record, if applicable.

2. Verifying the validity of the informed consent form, and assuring proper completion of the approved informed consent process, using the Informed Consent Process checklist found in Section, II.A.1 of this manual.

3. Filing the valid, signed and dated consent form, along with any supporting documentation (e.g., a consent process checklist), in the subject's research record.

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Standard Operating Procedures: Documenting Eligibility Assessment

The Principal Investigator or authorized staff is responsible for:

1. Describing in the IRB application (eFormA) all procedures used to determine eligibility and having these procedures approved by the IRB.

2. Completing IRB approved eligibility verification tasks to determine that all study inclusion and exclusion criteria are met prior to study enrollment.

3 Ensuring that appropriate documentation is kept in the subject's research record to confirm study eligibility, including all study-related, clinically obtained information (i.e., "source documentation") used to qualify a subject for study enrollment.

4. Developing and utilizing a study-specific checklist (or sponsor provided form) containing study eligibility criteria, using the template in Section II.A.2 of this manual. This checklist should be signed and dated by the person performing the eligibility assessment and completing the form.

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Standard Operating Procedures: Submitting Changes in Research

The Principal Investigator is responsible for:

1. Requesting and obtaining IRB approval for all proposed changes to the protocol or informed consent form, and documenting IRB approval prior to executing any such changes.

2. Determining the level of modification and describing it to the IRB as:

    a. A major modification, which involves a change to the protocol and consent, or
    b. A minor or administrative modification, which may not necessitate a change to the protocol or consent form.

3. Submitting a "Change in Research Application" to the IRB, accompanied by all documentation affected by the proposed changes, including:

    a. Sponsor's protocol; or
    b. IRB Protocol Form A; and/or
    c. Continuing Review Application (change should be summarized); and/or
    d. Informed Consent Form; and/or
    e. Any new documents/materials added to the approved protocol.

4. Retaining in the site's Regulatory File all documentation and IRB correspondence regarding all changes to an approved protocol or consent.

5. Keeping track all modifications to the protocol or consent form, and when such changes were IRB approved, using the Changes in Research Log found in Section II.C.2 in this manual.

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Standard Operating Procedures: Protocol Deviation Reporting and Documentation

The Principal Investigator is responsible for:

1. Conducting the study in accordance with the IRB approved protocol as it is written.

2. Not making any non-emergent changes to, or deviating from, the IRB approved protocol without prior notification to and approval from the IRB as an approved Change in Research.

3. Submitting administrative and minor deviations that precipitate a change to the protocol (per the IRB's flow diagram: http://irb.jhmi.edu/Guidelines/deviationsflowchart.pdf, and Section IV of this manual) to the IRB for approval using the "Changes in Research" application.

4. Recording any minor or administrative deviation from the approved protocol that do not precipitate a change to the protocol by utilizing the Deviation Tracking Log found in Section II.C.1 of this manual, and submitting this information to the IRB in the annual continuing review application.

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Standard Operating Procedures: Reporting Study Non-Compliance

The Principal Investigator is responsible for:

1. Notifying the IRB of any incident where the IRB approved protocol was not followed, or Federal, state, and/or Institutional regulatory requirements or directives were overlooked.

2. Informing the IRB of the immediate specific response to reconcile the incident or oversight.

3. Describing to the IRB a corrective action plan, which may include

    a. site personnel educational/training
    b. change(s) to the research protocol to minimize the recurrence of incidences of non-compliance.

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Standard Operating Procedures: Reporting Unanticipated Problems/Events

The Principal Investigator is responsible for:

1. Reporting the following specific unanticipated problems or events to the JHM IRB:

    a. Events such as injuries, side-effects, breaches of confidentiality (including lost/stolen computers, hard copy files, magnetic storage media, etc.), or other problems that
        1) harm or increase the risk of harm to the subject or others
        2) are unexpected (i.e., not described in the consent form or study)
        3) AND are related to research procedure(s).
    b. New Information that changes the risks or potential benefits of the research as described in the consent form.
    c. Any FDA restriction on a marketed drug, device, or biologic used in research.
    d. Any emergent change to the protocol to reduce immediate harm to subject. (Such reports will almost always include a "Change to Research" application to address the protocol limitation that caused the emergent change.)
    e. Incarceration of the subject.
    f. Any event that requires prompt reporting to the study sponsor(s).
    g. Subject complaint that indicates an unanticipated risk, or remains unresolved by the research team.
    h. Protocol violation (meaning an accidental or unintentional change to the IRB approved protocol) that placed one or more participants at increased risk, or has the potential to occur again.
    i. An unexpected adverse device event for IDE studies.

3. Reporting Unanticipated Problems to the IRB promptly, in between 3 and 10 working days, depending upon the seriousness of the problem/event (per the IRB reporting process flow diagram: http://irb.jhmi.edu/Guidelines/unanticipatedflowchart.pdf and Section IV of this manual).

4. Using the most current IRB Unanticipated Problem Event Notification form (http://irb.jhmi.edu/Forms/RF1.doc).

5. Keeping a log of Unanticipated Problems/Events submitted to the IRB, using the log-sheet found in http://irb.jhmi.edu/Forms/RF3.doc or Section II.C.3 of this manual.

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Standard Operating Procedures: Reporting a Death of a JHM Research Participant

The Principal Investigator is responsible for:

1. Reporting to the IRB within three (3) working days, the death of a JHM research participant that occurs within 30 days of the study intervention, and that is

   a. Unexpected and unrelated to the risks described in the IRB approved Informed Consent and protocol, AND
   b. More likely than not, caused by a research procedure or intervention.

2. Reporting the IRB within ten (10) working days, the death of a JHM research participant that is

   a. Expected due to the subject's underlying condition or disease state, OR
   b. Expected as identified as a risk in the approved Informed Consent form and protocol.

3. Reporting to other regulatory authorities (FDA, NIH, etc.) and/or to the Sponsor, if applicable.

4. Recording and retaining all documentation associated with the Death and filing these materials in the Subject's research record.

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Standard Operating Procedures: Study Subject Data Collection

The Principal Investigator and authorized Study Team members are responsible for:

1. Ensuring the accuracy, completeness, legibility, and timeliness of the data entered in sponsor provided Case Report Forms (CRFs) or customized data collection forms, and in all required reports, including logs and checklists.

2. Recording observed data (or data derived from source documents) consistently, or explaining any discrepancies in a *Note-to-File*, using the template found in Section II.D. of this manual.

3. Designating members of the staff who are authorized to change or correct data entries.

4. Conforming to the following steps in regards to any changes or corrections to a CRF, progress note, research lab result, etc.:

    a. Draw a single line through the incorrect entry;
    b. Date and initial the strike-through;
    c. Enter the correct information and/or explanation proximal to the original entry.
    d. Instruct staff that correction-fluid cannot be used to make corrections.

5. Establishing a research record review process, to check data accuracy.

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Standard Operating Procedures: Paper Case Report Form Design and Use

The Principal Investigator and authorized Study Team Members are responsible for:

1. Including information in the header of the paper Case Report Form (CRF) to identify the site, the specific protocol title (and study number, if applicable), and the IRB approval number.

2. Creating the body of the CRF to include fields for:

    a. Unique Subject ID
    b. Visit Date
    c. Specific visit number/interval, if applicable
    d. Section(s) for Visit specific data

3. Using additional space in the footer for signature of study personnel who may complete the CRF, the date of CRF completion, and the Principal Investigator/Co-Investigator's signature to demonstrate a review of the CRF for completion, accuracy, and overall quality control.

4. Completing the CRF in black ink.

5. Making a single line strike-out of the errant data, the necessary correction(s), and the initial and date of the personnel making the correction. Correction-fluid can not be used.

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Standard Operating Procedures: Site Generated Electronic Case Report Forms

The Principal Investigator and authorized Study Team Members are responsible for:

1. Entering information in the site-generated electronic Case Report Form (CRF) or database record to identify the site, the specific protocol title (and study number, if applicable), and the IRB approval number.

2. Completing site-generated CRF or database fields to indicate

    a. Unique Subject ID
    b. Visit Date
    c. Specific visit number/interval, if applicable
    d. Section(s) for Visit specific data

3. Using additional fields in the electronic CRF record, for the electronic signature of study personnel authorized to complete the CRF, the time/date stamp of CRF completion, and the Principal Investigator/Co-Investigator's electronic signature to demonstrate a review of the CRF for completion, accuracy, and overall quality control.

4. Maintaining an electronic audit trail to keep track of corrections/additions to the database and electronic case report form record(s), who made them, and when via user IDs and time/date stamping routines.

5. Employing adequate security clearance, encryption, archiving, and recovery systems to maximize secure access, subject confidentiality, and record-retention quality assurance.

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Standard Operating Procedures: Responsibilities for FDA Regulated Research

The Principal Investigator conducting IND (new Drug) or IDE (new Device) research is responsible for:

1. Conducting the study in accordance with the most current, IRB approved protocol.

2. Notifying the sponsor (in commercially funded research) prior to making changes to the protocol, except when necessary to protect the safety, rights, or welfare of subjects.

3. Personally conducting or supervising the investigation.

4. Informing the subject that the study drug or device is being used for investigational purposes, and obtaining informed consent.

5. Reporting to the sponsor adverse experiences that occur in the course of the investigation.

6. Reading and understanding the information in the investigator's brochure (For IND/IDE research), including the potential risks and side effects of the drug or device.

7. Ensuring that all associates, colleagues, and employees assisting in the conduct of the study are informed about their obligations in meeting the above commitments.

8. Maintaining adequate and accurate records, and making those records available for inspection by the FDA, Institution, or any authorized regulatory body.

9. Obtaining initial and continuing review and approval of the clinical investigation.

10. Promptly reporting to the IRB all changes in the research activity and all unanticipated problems involving risks to human subjects or others.

11. Awaiting IRB approval, prior to making any changes in the research except where necessary to eliminate apparent immediate hazards to human subjects.

12. Complying with all other requirements regarding the obligations established in 21 CFR Part 312 (Drug research) or 21 CFR 50, 812 (Device research).

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Standard Operating Procedure: Establishing a General Monitoring Plan for the FDA IND Application

In compliance with 21 CFR 312.50 and 53, the JHM sponsor/investigator of an Investigational New Drug ("IND") application is responsible for

Procedures:

1. Selecting a Monitor or Monitors to oversee the conduct of the protocol
    a. The sponsor will designate one or more monitors, as appropriate.
        i. The sponsor may select an individual to carryout monitoring
        ii. The sponsor may elect to sub-contract any and all monitoring to a Contract Research Organization (CRO)
    b. Each monitor shall have proper education, certification, and or other necessary qualifications to perform monitoring duties.
    c. The Monitor(s) should be chosen based upon the investigation's scope, scale, complexity, investigative agent(s), and disease/condition of the population being studied.
    d. If applicable to the study, the designated monitor(s) shall remain blinded to study-arm assignments.
2. Establishing a General Monitoring Plan
    a. The Monitoring Plan can be adapted for the needs of an individual study
    b. The basic operations of a monitoring plan include
        i. Designating a monitor or monitors, per Step #1 above
        ii. Instituting a written Monitoring schedule to review the progress of the study, including
            1. A pre-investigation visit to confirm
                a. the investigator(s) and research site are prepared
                b. the investigator(s) is(are) aware of the applicable responsibilities, as outlined on FDA Form 1572 and the FDA's monitoring guidance: http://www.fda.gov/ICECI/EnforcementActions/BioresearchMonitoring/ucm135075.htm
                c. the study staff is adequately qualified, educated, and/or trained to conduct the study
            2. Periodic or interim visits to review and confirm
                a. regulatory documentation for compliance with all applicable regulations and requirements
                b. study test-article accountability

c. all changes to research have been submitted and approved by the IRB
d. the continued adequacy of the facility and its resources for the conduct of the study
e. the investigator is following the protocol
f. the study team membership and delegation of responsibilities are current and IRB approved

3. Close-out monitoring visit to
    a. reconcile any outstanding regulatory documentation issues
    b. resolve outstanding research participant matters (e.g., following "adverse events" to resolution, outstanding follow-up visits, etc.)
    c. correct any residual data-queries

iii. An inspection of a portion, but not excluding all, of the research subject record for
    1. proper informed consent procedures
    2. subject eligibility, with source documentation to confirm
    3. protocol compliance
    4. data integrity, consistency, and correctness
    5. safety reporting
    6. protocol deviations are noted and reported

iv. Generation of a written report identifying the monitoring findings, including
    1. What regulatory compliance issues were observed and corrected
    2. What research record deficiencies were noted and corrected

v. A process for distributing the monitoring report(s) to the sponsor and individual investigator(s) receiving an on-site monitoring visit

vi. A monitoring/on-site visit record maintained by the sponsor and/or monitor, documenting
    1. When the monitoring was completed
    2. Who conducted the monitoring

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Standard Operating Procedures: Required Reporting for FDA IND/IDE Studies

The Principal Investigator, as sponsor-investigator, is responsible for:

1. Determining an event to be a reportable adverse drug reaction as:
    a. *life-threatening* (i.e., the subject is at immediate risk of death); and/or
    b. *unexpected* (i.e., not known to the PI); and/or
    c. *serious* (i.e., resulting in death, hospitalization, disability, or congenital anomaly).

2. Notifying the FDA by phone or fax immediately, but in no more than 7 days, if conditions a, b, or c are established.

3. Completing the FDA MEDWATCH Form 3500A, or a narrative report (identified as an IND Safety Report, if applicable) and submitting the documentation to the FDA as soon as possible, but in no more than 15 days, if the above conditions a, b, or c are established.

4. Submitting supporting documentation for any event that meets the criteria for prompt reporting to the IRB, utilizing the Problem Event Form in the required time-frame.

5. Sending required annual progress and safety summary reports with the FDA, per 21 CFR 312.33 (IND) or 21 CFR 812.36 (IDE).

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Standard Operating Procedures: Drug Accountability

The Principal Investigator or authorized Study Team Members, if not utilizing the JHM Investigational Drug Service (IDS), are responsible for:

1. Receiving the study drug
    a. Maintain adequate records confirming the receipt, shipment, expiration dates, or other disposition information of the investigational drug.
    b. Documenting any discrepancies.
    c. Assuring that records include the name of the individual to whom the drug is shipped, the date, quantity, and batch/code number for each shipment.
    d. Verifying shipment with packing slip or invoices.
2. Storing the study drug
    a. Securing drug in a locked storage area, and, if applicable, monitoring to assure proper storage conditions.
    b. Completing regular inventory to assure balance among stock received, dispensed, and returned.
3. Labeling the study drug for product dispensed to subjects
    a. Prior to dispensing the study drug, generating a label to include the date dispensed; drug name; drug strength, dose, quantity, and expiration information; subject's identifier; PI's contact information; and directions for use.
    b. Affixing the label to the dispensed drug.
4. Prescribing the study drug
    a. For all pharmacy-based IND drug studies, completing the Investigational Drug Data Sheet with information on the dispensing procedure and/or the list of authorized prescribers.
    b. For drug products requiring a prescription, the PI or Co-I will follow applicable JHH and State prescription policies.
5. Dispensing and Drug Disposition with the following information
    a. Date dispensed/administered
    b. Patient initials/Identifier
    c. Drug name as defined for this study (does not necessitate unblinding)
    d. Drug strength (unless blinded)
    e. Quantity dispensed/administered
    f. Lot number (unless dispenser is blinded to this)
    g. Initials of dispenser/person administering drug
    h. Date and amount of patient returns documented in study records (this is returned drug that cannot be dispensed again)
6. Returning the study drug
    a. Documenting drug supply return indicating date sent, quantity (including lot numbers), and names of sender and receiver.
    b. Documenting, if applicable, date, amount, and method of destruction.

7. Documenting
    a. Filing all drug documentation within a dedicated section of the study records.
    b. Utilizing the IDS Drug Audit form for required procedures.
    c. Employing a Drug Accountability Log sheet to track items 1-6.

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Standard Operating Procedures: Required Reporting to FDA for IDE studies

The Principal Investigator, as sponsor-investigator, is responsible for:

1. Determining an event to be an Unanticipated Adverse Device Effect as:

    a. a *serious* adverse effect upon the subject's health or safety; and/or
    b. is *life-threatening*; and/or
    c. *results in death*; and
    d. *was unexpected*

2. Or determining the event to be a *Product Problem* that could lead to a death or serious injury if the malfunction were to recur.

3. Completing the FDA MEDWATCH Form 3500A, or a narrative report, and submitting the documentation to the FDA as soon as possible, but in no more than 10 days after discovery of the event.

4. Submitting any supporting documentation for any event that meets the criteria for prompt reporting to the IRB, utilizing the Problem Event Form in the required time-frame.

5. Reporting to any funding agencies, if applicable.

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Standard Operating Procedure: Establishing a General Monitoring Plan for the FDA IDE Application

In compliance with 21 CFR 812.25(e), 40, and 43, the JHM sponsor/investigator of an Investigational Device Exemption ("IDE") application is responsible for

Procedures:

1. Selecting a Monitor or Monitors to oversee the conduct of the protocol
    a. The sponsor will designate one or more monitors, as appropriate.
        i. The sponsor may select an individual to carryout monitoring
        ii. The sponsor may elect to sub-contract any and all monitoring to a Contract Research Organization (CRO)
        iii. The name and address of the designated monitor(s) or CRO is to be recorded on the IDE application
    b. Each monitor shall have proper education, certification, and or other necessary qualifications to perform monitoring duties.
    c. The Monitor(s) should be chosen based upon the investigation's scope, scale, complexity, investigative agent(s), and disease/condition of the population being studied.
    d. If applicable to the study, the designated monitor(s) shall remain blinded to study-arm assignments.
2. Establishing a General Written Monitoring Plan as part of the Investigational Plan
    a. The Monitoring Plan can be adapted for the needs of an individual study
    b. The basic operations of a monitoring plan include
        i. Designating a monitor or monitors, per Step #1 above
        ii. Instituting a Monitoring schedule to review the progress of the study, including
            1. A pre-investigation visit to confirm
                a. the investigator(s) and research site are prepared
                b. the investigator(s) is(are) aware of the applicable responsibilities from **21 CFR 812 Sub-Part E** and the FDA's monitoring guidance: http://www.fda.gov/ICECI/EnforcementActions/BioresearchMonitoring/ucm135075.htm
                c. the study staff is adequately qualified, educated, and/or trained to conduct the study

2. Periodic or interim visits to review and confirm
    a. regulatory documentation for compliance with all applicable regulations and requirements
    b. study test-article accountability per 21 CFR 812.
    c. all changes to research have been submitted and approved by the IRB
    d. the continued adequacy of the facility and its resources for the conduct of the study
    e. the investigator is following the protocol
    f. the study team membership and delegation of responsibilities are current and IRB approved

3. Close-out monitoring visit to
    a. reconcile any outstanding regulatory documentation issues
    b. resolve outstanding research participant matters (e.g., following "adverse events" to resolution, outstanding follow-up visits, etc.)
    c. correct any residual data-queries

iii. An inspection of a portion, but not excluding all, of the research subject record for
    1. proper informed consent procedures
    2. subject eligibility, with source documentation to confirm
    3. protocol compliance
    4. data integrity, consistency, and correctness
    5. safety reporting
    6. protocol deviations are noted and reported

iv. Generation of a written report identifying the monitoring findings, including
    1. What regulatory compliance issues were observed and corrected
    2. What research record deficiencies were noted and corrected

v. A process for distributing the monitoring report(s) to the sponsor and individual investigator(s) receiving an on-site monitoring visit

vi. A monitoring/on-site visit record maintained by the sponsor and/or monitor, documenting
    1. When the monitoring was completed
    2. Who conducted the monitoring

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Standard Operating Procedures: IDE Device Accountability-Receipt and Storage

The Principal Investigator is responsible for:

1. Retaining shipping invoices, waybills, manifests, bills of lading, or other documentation verifying the receipt of the Investigational Device(s).

2. Maintaining a record (log) of the receipt of the investigational device(s). The log will be placed in the study regulatory binder and should contain the following information, consistent with retained shipping documentation:

    a. Date of device receipt
    b. Batch number or code mark associated with each device
    c. Type and quantity of the device received
    d. Name or initials of the person who received the shipment

3. Filing written documentation of any discrepancies between the invoice and what was actually Received and entered into the Device Accountability log. Such documentation should be placed in the study regulatory binder.

4. Storing investigational device separately from other approved devices or standard inventory or stock.

    a. If the study uses a supply of investigational devices, these will be stored in a locked cabinet that is permanently mounted to the floor or wall.
    b. If the study uses a large piece of equipment, such as an MRI machine, then the equipment will be maintained in a specified, secure location.

5. Ensuring that the investigational device(s) is (are) labeled in accord with FDA regulations.

6. Ensuring that access to the investigational device(s) is limited to study personnel.

7. Reviewing the device receipt log periodically and, if device stock is maintained, verifying it against the physical count of devices on site.

Sample User Standard Operating Procedure	Version:
Status:	Revised by:
Original Date:	Approved By:
Revision Date:	Approval Date:

Standard Operating Procedures: Device Accountability-Usage of the Device

The Principal Investigator is responsible for:

1. Maintaining an accurate record of the investigational device(s) dispensed and used. The log should be placed in the study regulatory binder and contain the following information:

    a. The date device dispensed and/or used
    b. The batch number or code mark of each dispensed device (if applicable)
    c. The number of devices dispensed (if applicable)
    d. The name or initials of the person who dispensed or used the device
    e. The initials or unique study identification number of the study participant receiving the device
    f. Any repairs or adjustments made to the device(s), with date and time of service

2. Reviewing the device log periodically, and verifying the reported inventory against the stock on hand.

Sample User Standard Operating Procedure	Version:
Status:	Revised by:
Original Date:	Approved By:
Revision Date:	Approval Date:

Standard Operating Procedures: Device Accountability-Device Return

The Principal Investigator is responsible for:

1. Maintaining an accurate record of the return of the investigational device(s) to the study Sponsor. The log should be placed in the study regulatory binder and contain the following information:

    a. The date of device return to the Sponsor
    b. The batch number or code mark associated with each returned device
    c. The number of devices returned to the Sponsor
    d. The name or initials of the person packaging the devices for return

2. Obtaining written authorization from the Sponsor for alternate disposal, and placing the authorization on file in the study regulatory binder, if the device(s) is (are) not returned to the Sponsor.

Sample User Standard Operating Procedure	Version:
Status:	Revised by:
Original Date:	Approved By:
Revision Date:	Approval Date:

Standard Operating Procedures: Regulatory Documentation Organization

The Principal Investigator and authorized Study Team Members are responsible for:

1. Assembling a binder or electronic database in which to file all regulatory documentation. The minimum recommended material included should be:

    a. A Table of Contents
    b. A copy of the original human subjects research application submitted to the JHM IRB (and, if applicable, the application may be located in eIRB)
    c. A copy of the sponsor's protocol (if applicable)
    d. A copy of the federal grant application (if applicable)
    e. A copy of the investigator's brochure for an investigational new drug (if applicable)
    f. A copy of the investigational device exemption information (if applicable)
    g. A copy of an investigator-initiated IND or IDE application (if applicable)
    h. A copy of the IRB approved Informed Consent form (if applicable)
    i. A copy of all correspondence with the IRB, sponsor, funding source, FDA, or others
    j. Monitoring/Auditing documentation

2. Filing the documents in date order.

3. Maintaining the binder, for paper records, in a secure location.

4. Maintaining secure electronic records from which regulatory documents may be retrieved, viewed, and printed, if necessary for monitoring/auditing purposes.

Sample User Standard Operating Procedure	Version:
Status:	Revised by:
Original Date:	Approved By:
Revision Date:	Approval Date:

Standard Operating Procedures: Retention of Study Records

The Principal Investigator is responsible for:

1. Maintaining all research records according to local, Institutional (Cf. http://www.hopkinsmedicine.org/som/faculty/policies/facultypolicies/responsible_conduct.html#data), and Federal requirements, and storing them in a securely.

2. Storing study records for ANY study that involves private health information and is subject to the HIPAA Privacy Rules, for seven years after the last subject has completed the study.

3. Storing all study records for studies involving an Investigational New Drug (IND) for the FDA required period of two years after the approval of the study drug, or the delivery of the study drug is discontinued.

4. Storing all study records for studies involving an Investigational Device Exemption (IDE) for the FDA required period of two years after the study is terminated/completed, or when a PMA application supporting data is not necessary.

5. Storing study records for research on children at the School of Medicine until the pediatric subject reaches the age of 21.

Sample User Standard Operating Procedure	Version:
Status:	Revised by:
Original Date:	Approved By:
Revision Date:	Approval Date:

Standard Operating Procedures: Writing Standard Operating Procedures (SOPs)

The Principal Investigator or authorized Study Team Member should delineate study procedures and regulatory processes in a standard format:

1. Structure Elements

    a. Use a header, which may include the principal investigator's name, and department information; page number, the SOP's title, version number, approval date, and the name of the person authorized to approve the SOP.
    b. An optional "Purpose" section may be used to summarize how to use the SOP.
    c. An optional "Scope" may be used to indicate to whom the SOP applies.
    d. Develop a detailed "Procedures" section to delineate all the steps to perform a specific procedure.

2. Documentation Organization and Quality Assurance

    a. The site should use the most current versions of the SOPs
    b. Previous versions of the SOPs should be available for Quality Assurance audits, using the Version Number to provide an "audit trail."
    b. A binder or electronic file should contain copies of all SOPs.
    c. The Principal Investigator should review the SOPs for adequacy and applicability.

Sample User Standard Operating Procedure	Version:
Status:	Revised by:
Original Date:	Approved By:
Revision Date:	Approval Date:

Standard Operating Procedures: Note-to-File

The Principal Investigator and/or authorized study personnel may generate a Note-to-File to provide information or clarification concerning a study-related issue. It should include the following elements:

1. Header information indicating the date of the Note-to-File, the study to which it pertains, who is completing the document, and where it is filed.

2. A narrative explanation describing:

    a. The specific recent event or new information necessitating the creation of the Note-to-File.
    b. The details of the immediate response or resolution to the event, or outcome to the new information.
    c. A revision to the protocol or quality assurance mechanism to demonstrate a systematic corrective action to improve the conduct or organization of the study.
    d. A confirmation that all information has been appropriately reported to all required recipients, per applicable regulations and guidelines.

3. A signature and date of the study-team member generating the Note-to-File.

4. A signature and date of the Principal Investigator, confirming review of the report.