

SOP# HRP 02.04

Approval Date: 1/10/08

INVESTIGATOR RESPONSIBILITIES FOR INTERNAL QUALITY ASSURANCE  
OF THEIR RESEARCH PROGRAMS

OBJECTIVE:

- To assist investigators in meeting their responsibilities to oversee the conduct of their studies;
- To promote research programs of high quality through continual quality improvement activities;
- To establish internal quality management plans for investigators and staff to evaluate their research and human subjects protections processes.

SCOPE:

The Research Service requires that all VAMHCS research units and protocols involving human research participants have measures to assure compliance to human research protections policies and the research protocol. The Research Service has designated its Office of Research Compliance (ORC) to oversee quality management activities of VAMHCS investigators and programs. The ORC will not routinely include data integrity in its quality management program and will instead focus its attention on matters that more directly impact subject rights and safety (such as informed consent, eligibility criteria and adverse event reporting) and regulatory compliance (“audit triggers”).

Investigators and their staff should become knowledgeable about institutional and regulatory policies, in particular the VAMHCS Human Research Protections Plan (HRPP), Research Service SOPs, and IRB SOPs. Investigators and staff who follow these policies and procedures will generally be compliant with regulatory requirements and Good Clinical Practices.

The Office of Research Compliance has developed a number of Guidelines and SOPs that can assist investigators and staff in their quality management activities. The ORC is also available for mentorship and other resources that may be helpful for investigators. Investigators need to be aware that they will be held to the standards they set for themselves in their internal quality management plans. ORC audits may evaluate the compliance with and effectiveness of the investigator’s internal policies and procedures.

RESPONSIBILITIES:

1. The Principal Investigator is responsible for:
  - Becoming knowledgeable about institutional and regulatory policies and procedures regarding conduct of research involving human subject participants;
  - Establishing internal policies and procedures to ensure compliance with VAMHCS SOPs, IRB policies and procedures, study protocols, GCPs, and other human subject protection regulations.
  - Establishing internal policies to respond to comments, complaints, suggestions or allegations of noncompliance that may come from study participants, their families, research staff, or others.
  - Ensuring that his/her staff complies with these internal policies and procedures and facilitating their efforts in this area;
  - Using the Research Service staff, and other sources such as trainings, conferences, etc. as resources;
  - Using this process as a learning tool to improve her/his “good clinical practices”.
  
2. The Office of Research Compliance (ORC) is responsible for:
  - Proactively educating research staff on the proper and ethical conduct of human subject research;
  - Acting as a resource to investigators and research staff on issues of research practice and compliance, including investigators’ internal quality management plans;
  - Auditing the research activities of a VAMHCS investigator/staff based on audit triggers;
  - Assisting investigators with developing corrective action plans (CAPs) and following up on the resolution of audit findings;
  - Reporting findings to the R&D Committee, the ACOS/R&D, the MCD, the Executive Performance Improvement Committee (EPIC), and the IRB.

DOCUMENTS (ATTACHMENTS):

- Appendix 1 Self-Assessment Tools available at the Research Service website;  
Audit Tools available through the Office of Research Compliance
- Appendix 2 “Documents Typically Subject to Audit”

SEE ALSO the following Research Service documents, available on the Research Service website, [www.maryland.research.va.gov](http://www.maryland.research.va.gov):

Research Service Human Research Protection Plan (HRPP) (HRP 01.02)  
Research Service SOPs

- Audit Triggers (HRP 02.02)
- Auditing Source Documents Charts (HRP 02.03)
- Auditing Regulatory Documents Charts (HRP 02.04)
- Auditing the Investigational Pharmacy (HRP 02.05)
- Addressing and Responding to Comments, Complaints and Suggestions Related to the Human Research Protection Program (HRP 01.07)
- Addressing and Responding to Allegations of Noncompliance with Institutional Policies Related to the Human Research Protection Program (HRP 01.08)

Research Service Guidelines

- Informed Consent Guidebook (HRP 03.01G)
- Guidelines for Setting Up a Study Binder and Regulatory Documents Binder (HRP 07.02G)
- Guideline on Source Documents (HRP 07.03G)
- Writing Standard Operating Procedures (HRP 07.05G)

Research Service auditing and self-assessment forms

- See Appendix 1

PROCEDURE:

1. The investigator and staff should become extremely familiar with the documents listed in the “See Also” section above. The SOPs are binding upon investigators and staff; Guidelines are meant to be instructive and may be used as templates or as stand-alone policies and procedures for the research team.
2. The PI is expected to establish internal policies and procedures to ensure compliance with applicable policies and procedures and may do so in the following ways:
  - Write his/her own policies to cover research activities in his/her program.
  - Use the Research Service SOPs and Standards as a model to adapt to his/her own program.
  - Use other templates available from other programs, the internet, etc.
  - Write memos that reference standard SOPs/policies (such as VAMHCS, Research Service, UMB, GCP) and simply state that their program will use the referenced policy as its standard. Accrediting agencies prefer to see that policies and procedures reflect the actual workings of the research

unit. Therefore, simply referring to overall rules and regulations is the least preferable method.

The PI and staff must be aware that no internal policy may conflict with Research Service, VAMHCS, IRB or federal policy or regulation and that they (the PI and staff) will be held to the standards stated in their policies.

3. The PI should include a level of quality assurance in his/her internal policies and procedures. Internal QA plans should be realistically based on the scope of the PI's program and staff capacity. Internal audits should focus on compliance with the unit's internal SOPs as well as VAMHCS or IRB SOPs.
4. Audits should be conducted on a routine basis. However, the investigator and staff should recognize that other events, such as participant complaints or recognition of a recurring problem, should "trigger" audits targeted at detecting and remediating root causes.
5. If possible, internal functions should be evaluated by personnel who are not involved in the activities being audited. For example, study coordinators might assess each other's studies but not their own; OR cooperating investigators might share each other's personnel for this purpose (one PI's staff evaluates another's studies and vice versa). Another option is to request a proactive audit from the ORC (see SOP# HRP02.02, "Audit Triggers", section 3.3). Periodic self-assessments may also be acceptable and perhaps more practical in some instances.
6. Audit findings will be reported in a written format, filed in a systematic fashion, and used for program improvement purposes. If deficiencies are found (for example, a disorganized regulatory binder), there should be corrections and follow-up until resolution. If deficiencies cannot be corrected, for example, a missing signature on an informed consent form, then the investigator/designee develops a corrective action plan (CAP) documenting the root cause and describing how future deficiencies will be prevented.
7. Serious problems with reporting of "unanticipated events", protocol implementation, informed consent, or other activities that affect subject rights or safety must be reported to the Office of Research Compliance. Allegations of noncompliance must also be reported to the Office of Research Compliance.
8. Complaints from participants, families, or external sources should be handled by the PI or research staff if possible. If this is not possible, then the complaint should be referred to the PI's Division Head or the RCO, whichever is appropriate.

9. The PI must support internal QA functions by ensuring staff time, resources and cooperation. S/he should establish an atmosphere that communicates that QA activities and remediation are opportunities for staff development and strengthening of safeguards for research participants and protocol conduct.
10. The PI and staff should use their staff, Research Service staff, and other sources such as trainings, conferences, etc. as resources.

#### APPROVAL

This SOP entitled “Investigator Responsibilities for Internal Quality Assurance of their Research Programs” has been approved by the Medical Center Director, effective 1/10/08.

## Appendix 1

### Self-Assessment Tools

Available at the Research Service website

[www.maryland.research.va.gov](http://www.maryland.research.va.gov)

- Self-Assessments – Investigator Records Checklist
- Self-Assessments – Investigator Interview Checklist
- Self-Assessments – Subject Records Checklist
- SOP Template

### Audit Tools

Available through the Office of Research Compliance

X6512 or x7130

- QA Audit Tool - Summary Checklists for Regulatory and Source Documents
- QA Pre-Audit Interview Checklist
- QA Module A - Staff Requirements
- QA Module B - Entry Criteria
- QA Module C - Lab Inclusion-Exclusion
- QA Module D - Elements of ICF
- QA Module E - Execution of ICF
- QA Module F - Informed Consent Process
- QA Module G - Source Documents Audit
- QA Module H - Research Procedures
- QA Module I - Unanticipated events
- Report Template
- Other forms are available

**Appendix 2**  
Research Documents Suggested for Internal Audits

1. All original informed consent forms signed by all subjects enrolled in the study.
2. Presence of the following in CPRS:
  - Enrollment note (informed consent note)
  - Scanned signed informed consent form
  - Research Subject Clinical Warning (if applicable)
3. All source documents (e.g. hospital/medical records, clinic/outpatient charts, research/study charts) for all subjects selected for audit.
4. Subject visit log, sign-in record, and/or office appointment book, if applicable.
5. Records of payment to subjects, if applicable.
6. Drug accountability records
  - Shipping and receipt records
  - Dispensing records
  - Final disposition records
  - 10-9012s
  - Documentation of compliance with the Research Methods Accountability Form
7. Device accountability records
  - Shipping and receipt records
  - Maintenance and storage records
  - Dispensing records
  - Final disposition records
  - Documentation of compliance with the ---- Attestation Form
8. Records of staff licensure, credentialing, education and training
9. Regulatory/Study Binder – Essential Documents
  - Protocol and all signed amendments
  - BRAAN protocol and supporting documents
  - Investigator's Brochure and/or package inserts
  - FDA Form 1571/1572 – original and all versions
  - Investigator/sub-investigator curricula vitae
  - Financial disclosure forms
  - Study personnel identification and delegation log
  - Subject screening and enrollment log
  - Subject identification roster
  - Informed consent form – original and all versions
  - CRF completion guidelines, if applicable
  - Study aids (e.g. exclusionary concomitant medications), if applicable
  - Advertisements, if applicable
  - IRB documentation (e.g. submissions, correspondence, approvals for protocols, amendments, informed consent forms, advertisements; SAE notifications; continuing reviews; membership lists)
  - Laboratory licenses
  - Laboratory normal values
  - Monitor sign-in log
  - Correspondence
  - SAE reports
  - Reports of protocol deviations/exceptions
  - DSMP plans and reports