

**IRB Member Handbook**

**Division of Research**

**IRB Administration Office**

**March, 2015**

**IRB** **Member** **Handbook**

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**Chapter** **1:**

**Being** **an** **IRB** **Member** **for** **WSU**

**Thank** **You** **for** **Your** **Service**

Welcome and thank you for agreeing to become a member of one of Wayne State University’s (WSU) Institutional Review Boards (IRB). Your work on the committee is instrumental in helping to protect the rights and welfare of those humans who volunteer to participate in studies being conducted within WSU and its affiliate institutions. IRB committees are federally mandated to protect those persons enrolled in studies that are funded or conducted by a federal department or agency. All studies conducted at WSU and its affiliate institutions are participant to the regulations found at 45 CFR 46 (The Common Rule).

**Training** **to** **Help** **Prepare** **IRB** **Members**

New Members: After a new member is appointed by the Vice President for Research, the new member must complete the following training to prepare him or her for the role of an IRB member:

 One‐on‐one training session with the Education Coordinator at the IRB Administration

Office.

 Completing the relevant Collaborative Institutional Training Initiative (CITI) online modules

(www.citiprogram.org):

 *Basic Course in Human Participant Research*

 *Responsible Conduct of Research*

 *Health Information Privacy and Security*

Please allow time to complete these lengthy modules. If you need assistance navigating the CITI training modules, please contact the Associate Director, Responsible Conduct of Research, at our main office (313) 577‐1628.

Current Members: There will be an annual refresher training retreat every October to help members stay abreast of the many regulations, and to review member roles and responsibilities. This is also a great way to connect with the members on your IRB committee and across the 5 WSU IRB committees. There are also refresher CITI trainings for members.

**Membership** **Composition**

An IRB must have at least 5 members comprised of *at least* one non‐scientist, one scientist, and one non‐affiliate. The non‐affiliate member is someone that is not affiliated with WSU or any of

the institutions for which WSU serves as the IRB of record. The non‐scientist member serves to represent the potential pool of volunteers for research conducted in the institution. At WSU the goal is to have at least 2 persons who are non‐affiliated and non‐scientists present at each meeting. Please note that a non‐scientist member must be present during all discussion and voting; a meeting is not properly constituted without a non‐scientist member present. The committees also are made up of members with the expertise and experience to review a variety of protocols from many different disciplines.

**About** **the** **Meeting** **&** **Voting**

 Quorum is a simple majority (for an IRB of 12 members, this would be 7; for 13 members, this would be 7).

 A non‐scientist must be present in order to hold the meeting and in order to have a properly constituted meeting. Meeting business must stop if a non‐scientist is not present.

 If quorum is lost, discussion and voting cannot occur.

 An abstention is when a member does not want to vote on a proposed item, for a reason

*other than* conflict of interest. An abstention is counted toward quorum.

 A Veterans Affairs representative, who is also an IRB member for your committee, must be present in order to discuss and vote upon VA protocols, continuations and amendments.

 Likewise, a prisoner representative, who is also an IRB member for your committee, must be present in order to discuss and vote upon protocols, continuations, and amendments that involve the use of prisoners. Please note, the prisoner representative *cannot be associated or affiliated* with the prison that the research is being conducted at.

 Please be on time so business can start on time.

 Keep your hand up until the vote count is taken.

**Member** **and** **Consultant** **Conflict** **of** **Interest** **(COI)** **and** **Financial** **Conflict** **of**

**Interest** **(FCOI)**

Conflict of Interest – This refers to situations in which IRB member and or his/her immediate family has personal interests (COI) or financial interests (FCOI) that may compromise, or have the appearance of compromising, the person’s professional judgment in reviewing human research protocols. Institutional Conflict of Interest (ICOI) may occur when the institution, any of its senior management or trustees, or a department, school, or other sub‐unit, has an external relationship, or financial interest in a company that itself has a financial interest in a research project. An IRB member or consultant, and or his/her immediate family, may have a COI that relates to the company that is providing support for a proposed study.

 If you have a financial or non‐financial conflict of interest, you cannot be present for the discussion or vote. You should recuse yourself and announce to IRB staff that you are doing so in order for the minutes to reflect your recusal. Recusals cannot be counted toward quorum.

 The IRB committee may ask a recused member with a FCOI or COI to return to the meeting to answer specific questions about the protocol in question. After the questions are

answered, the member with the COI or FCOI should again leave the meeting during further discussion and voting on the protocol.

 IRB members are required to file a FCOI disclosure regarding all potential sponsors with the

FCOI Committee within one month of their appointment to the IRB. The disclosure must be updated on an annual basis and more frequently when significant changes have occurred.

 IRB members and IRB administrative staff are required to leave the room during the discussion of research protocols involving sponsors with whom they have a potential ICOI.

IRB members with a conflict of interest are not counted towards quorum.

 IRB consultants are required to file a FCOI disclosure regarding all potential sponsors with the FCOI Committee as soon as they agree to assist an IRB with the review of a research protocol. This disclosure should include any relevant ICOI and must be updated on an annual basis and more frequently when significant changes have occurred.

**Privacy** **and** **Confidentiality**

Privacy interests of participants‐ Privacy refers to persons and to their interest in controlling the access of others to themselves.

 This definition of privacy recognizes that control and autonomy, rather than isolation, are at issue.

 Accordingly, the above definition recognizes the vital role of informed consent (properly formulated and administered) in giving participants control over whether they will allow the researcher access to themselves and to their attitudes, behavior, beliefs, and opinions( e.g., a participant's willingness or unwillingness to disclose personal details about his or her own life).

Confidentiality ‐Confidentiality is an extension of the concept of privacy. It refers to data (some identifiable information about a person, such as notes or a videotape of the person) and to agreements about how data are to be handled in keeping with participant’s interest in controlling the access of others to information about themselves.

 The researcher must be able to assure participants that the access of others to information about themselves will be controlled in a way that is acceptable to them.

 It also reminds one that confidentiality is whatever arrangement about disclosure the researcher and participant agree upon.

 Confidentiality is more than just a promise or an intention on the part of the researcher. It is an arrangement to use certain techniques that are available for protecting information from

people that should not have access to it.

**An** **IRB’s** **Authority**

An IRB:

 Has the authority to request an audit of a protocol.

 Has the authority to suspend or terminate research.

 Has the authority to observe (member or designee) the informed consent process.

 Can request mandatory education for a PI and staff members.

 Has the authority to review issues of non‐compliance.

 Must review all unexpected problems occurring at WSU involving risks to participants or others involved in the research.

**The** **IRB’s** **Research** **Compliance** **Administrator**

The Research Compliance Administrator (RCA) is a valuable asset to the IRB and its members. The RCA is a source before, during, after the review process. The RCA is responsible for coordinating, organizing, and providing guidance to IRB members in order to facilitate a well‐ documented and effective review. This includes documenting IRB’s deliberations and decisions, establishing the full board meetings agenda, and declaring/monitoring quorum for a duly constituted meeting. Therefore, it is imperative that you remain in contact with your IRB’s RCA. Please contact the RCA whether it is to notify the board of your absence, declare a potential conflict of interest, inquire about forms, policies and procedures, or to ask questions. The RCA is there to assist you and is a knowledgeable administrative guide in navigating the IRB’s process.

**About** **the** **Review**

***All*** ***Members***

 The materials for the meeting are available to you a week in advance of the IRB meeting via access to a confidential Black Board Internet site or by delivery of hard copies, depending

on the electronic status of the committee.

 Please review your materials in advance of the meeting. Give yourself plenty of time.

 Please read the minutes from the previous meeting, paying special attention to sections with your discussion and/or review.

 Contact the Chair or primary or secondary reviewers if you have questions for the PI or about the study, or if you expectantly have a COI.

 If you are missing documents (consents, assents, questionnaires, advertisements etc.) notify the Research Compliance Administrator (RCA) for your committee immediately.

***Scientific*** ***Reviewers***

 If you are the primary or secondary reviewer, feel free to contact the PI in advance to clarify questions or to request materials.

 Always contact the RCA for the committee if you receive new documents from the PI.

 Any revisions made by the PI prior to the meeting should be either sent to the committee in advance (via yourself or the RCA) or brought to the meeting for all members to review.

 Complete the reviewer form in entirety and sign it. This becomes a part of the official record and is our documentation that regulations were met in the review process. You may

alternatively complete the reviewer form on line ([www.irb.wayne.edu](http://www.irb.wayne.edu/) go to the *For IRB Members* link).

 Assign a level of risk for the protocol and provide justification of that level of risk on the reviewer form.

 If you have any questions, please contact the RCA for your committee, the Chair, or the

Education Coordinator.

 E‐mail (with signature page hardcopy) and/or give the completed and signed reviewer form to the RCA at the IRB meeting.

 Speak up at the meeting on any issues.

***Non‐Scientific*** ***Reviewers*** ***(“Community*** ***Members”)***

 The non‐scientific members are a key and valuable component of each IRB committee.

Indeed, the IRB committee is not properly constituted without a non‐scientific member present and voting cannot take place.

 Your expertise is your layperson’s review and impressions of the studies that come to the

IRB committee. We invite all members to consider and speak‐up on local cultural aspects to consider in the conducting of research, also.

 If you are the 2nd Reviewer on a protocol, the focus of your review will be on the consent form from a layperson’s perspective (please see the section on consent form issues).

 Complete the reviewer form in entirety and sign it. You may indicate that you do not feel qualified to answer certain questions that require a scientific background. This becomes a part of the official record and is our documentation that regulations were met in the review process.

 You may choose to complete the reviewer form on line ([www.irb.wayne.edu:](http://www.irb.wayne.edu/) go to the *For*

*IRB Members* link).

 E‐mail (with signed hardcopy) and/or give the completed and signed reviewer form to the

RCA at the IRB meeting.

 If you have any questions about completing the reviewer form, please contact the RCA for your committee, the Chair, or the Education Coordinator.

 Speak up at the meeting on any issues.

**The** **8** **Criteria** **for** **IRB** **Approval** **and** **SMR** **of** **Protocols,** **Amendments,** **and**

**Continuations**

The criteria used to judge whether or not a protocol can be approved are found at OHRP 45 CFR

46.111 in the Common Rule (see the Resource section for the link). These criteria must be met to approve or give specific minor revisions to an amendment, continuation, or initial submission. They are:

Risks:

1. Risks to participants are minimized by using procedures consistent with sound research design and which do not unnecessarily expose participants to risk and where appropriate, by using procedures already being performed on the participants for diagnostic or treatment purposes.

2. Risks to participants are reasonable in relation to anticipated benefits, if any, to participants, and the importance of knowledge that may reasonably be expected to result. The IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies participants would receive even if not participating in the research).

3. Research makes adequate provision for monitoring the data collected to ensure the safety of participants.

Participants:

4. Selection of participants in equitable. The research should distribute the risks and benefits fairly across different groups and cannot exclude a participant without good reason.

5. When some or all participants are likely to be vulnerable to coercion or undue influence,

(such as children, prisoners, pregnant women, people with cognitive impairments, etc.) additional safeguards have been included in the study to protect the rights and welfare of these participants.

Consent:

6. Informed consent will be sought from each prospective participant’s legally authorized representative, in accordance with, and to the extent required by 46.116.

7. Informed consent will be appropriately documented, in accordance with, and to the extent required by CFR 46.117.

Protect:

8. Research makes adequate provisions to:

 Protect the privacy of participants.

 To maintain the confidentiality of the data.

**Criteria** **for** **Approval** **or** **SMR** **of** **Research:**

|  |  |  |
| --- | --- | --- |
| 1. | Is a plan for data safety and monitoring necessary? | (Q.24) |
| 2. | Is the selection of participants equitable? | (Q.32) |
| 3. | Is there any potential for coercion or undue influence of participants? |  |
|  | o If so, what measures are taken? | (Q.33‐34) |
| 4. | Will informed consent be sought? | (Q.36‐37) |
| 5. | Will informed consent be documented, or a waiver of documentation with |  |
|  | information sheet granted? | (Q.38) |
| 6. | Are confidentiality measures sufficient? | (Q.44‐47) |
| 7. | Have the risks to participants been minimized? | (Q.48‐51) |
| 8. | Are the risks reasonable in relation to the benefits and resulting knowledge? | (Sec. g 48‐51) |

**When** **to** **Give** **Specific** **Minor** **Revisions:**

 The only changes required involve minor issues, such as type errors, spelling, and clarification of language (that does not change the meaning of the consent) or clarification of statistical methods that do not alter the merit of the research design.

 The IND or IDE letter is missing.

 ***No New*** information is needed to determine the risk/benefit ratio.

 When all of the information needed for approval (45 CFR 46.111) is provided, but the IRB

committee is asking that the information be consistent across the documents.

 Other minor changes not listed under Tabled.

**When** **to** **Table** **a** **Protocol**

 There are questions regarding the risk/benefit ratio or equitable recruitment.

 There is a potential for coercion.

 The committee cannot judge or determine the risk to participants.

 Obvious risks are missing.

 Scientific merit is not clearly obvious (IRB committee’s judgment).

 PI has not provided adequate justification for inclusion of vulnerable groups (children, pregnant women, etc.).

 Safeguards for vulnerable groups are not evident.

 PI has not justified why certain groups are excluded from the study.

 Safety or data monitoring plan is inadequate.

 Plan to protect confidentiality or privacy is inadequate.

 Informed consent process is unclear.

 Informed consent form is missing or inappropriate for design of study.

**When** **to** **Disapprove** **Research:**

Major scientific or ethical problems exist, which (in the IRB’s opinion) cannot be readily resolved by the PI, such as:

 Lacking key information needed to evaluate the objectives, methods, endpoints, benefits, or risks.

 The protection of participants is not addressed.

 The risks to participants appear to outweigh the benefits of the research.

 The proposal lacks merit or the methodology is unlikely to yield useful data toward answering the research question(s).

 The proposed research is deemed unethical.

**When** **to** **Defer** **Research** **to** **the** **Next** **Meeting:**

 Due to an administrative or IRB snafu, the protocol was either not made available for review or ***neither*** reviewer was able to review it.

 It is a VA protocol and the representative was not present.

 It is a prisoner protocol and the prisoner representative was not present and/or did not review it.

**Criteria** **to** **Determine** **the** **Frequency** **of** **IRB** **Review:**

If any of the following criteria exist, then the IRB may require that a protocol be reviewed more often than annually:

 The research involves new procedures, drugs, or devices not previously tested in humans.

 The nature and frequency of adverse events observed in similar research indicates that participants will likely experience serious adverse events.

 The research involves a high level of complexity or unusual types of risk to the participant.

 The medical conditions of the participants make them susceptible to problems as a result of participation in the study.

 There is an increased risk to participants as evidenced by new findings.

 The study participants are from an identified vulnerable group.

 The PI or staff have minimal qualifications, limited experience, or a history of continuing noncompliance in adhering to federal or IRB requirements or ethical principles that guide human participant research.

**Expedited** **Review** **Process** **for** **a** **Full** **Board** **Protocol** **that** **Receives** **Specific** **Minor**

**Revisions**

After the convened meeting of an IRB votes to require only Specific Minor Revisions to a protocol, the response from the PI will come back to the Chair for expedited review. The Chair must verify that all criteria (45 CFR 46.111) for IRB approval are still met.

 This expedited review must consider the specific criteria and requirements for vulnerable groups, if applicable: (See specific Appendices)

o The cognitively impaired

o Pregnant women, fetuses, and neonates

o Children

o Prisoners

o Students, Employees, and Staff

 This expedited review must consider the special requirements of the following funding sources, if applicable: (see specific Appendices for each group)

o Department of Defense

o Department of Navy

o Department of Energy

o Department of Veterans Administration

o Department of Education

o Department of Health and Human Services

*Note:* Each of these groups and special review requirements should be documented on the special sections of the Reviewer Forms

**Levels** **of** **Risk**

A level of risk should be stated at the meeting and appear in the minutes for all approved and SMR initial and continuing protocols. Reviewers: Please state the level of risk when you give your review.

All research with children must be assigned a level of risk (45 CFR 46.404, 405, 406, & 407).

 The level of risk should be assigned for all protocols involving adults:

**Level** **1**‐ no more than minimal risk

**Level** **2‐** more than minimal risk, but with potential for benefit

**Level** **3‐** no potential for direct benefit to participants, but with societal benefit in the future.

When a full board amendment is reviewed, please state what level of risk you are assigning, as a determination of whether the level of risk has changed must be made. Reviewers: Please state the level of risk when you give your review.

Continuations are assigned a level of risk again (usually the one assigned at initial approval, but it could have changed over the year). Please state the level of risk.

Reviewers: Justification for the assigned level of risk should be provided on the reviewer sheet. This is a regulatory requirement and becomes part of the record.

Examples of justification of level of risk for the reviewer sheet:

**Level** **1**‐

o Procedures are like those that participant would encounter in daily life or at a physician’s visit.

o No added procedures other than standard of care.

o Testing to be done is much like standardized testing in school.

o No extra time taken from classroom learning.

o Blood draw is within IRB policy.

**Level** **2**‐

o Previous studies demonstrated positive results from use of this drug/device.

o Test article not studied previously in this population, but inclusion/exclusion

criteria are such that risks are likely to be minimized.

o This population has had minimal toxicities in past studies using this drug.

o PI has adequate plan for monitoring risks and preventing problems.

o Some toxicities are expected, but drug is expected to help treat this condition.

**Level** **3**‐

o More than minimal risk, no direct benefit to participants but with long term benefit to society.

o Questions being answered may provide information on how to successfully diagnose and treat this orphan disease (applies with use of normal volunteers in a drug or device study.

o Testing being done presents risk, but may assist developing diagnostic tool that is less invasive to future patients.

**Informed** **Consent** **Issues**

 Informed consents need to be in language that a lay person can understand.

 The process for obtaining informed consent (described in the protocol and protocol summary form) by the PI is very important and should be considered in the review.

 An IRB may decide to waive the requirement for documentation of the consent and when this occurs, it must meet the 4 criteria found on the protocol summary form (# 43) and it

must be justified.

 A waiver of consent must be requested when a study involves the review of records to identify persons to recruit prior to the actual consent (yellow form).

 Reviewers: Please use the review form questions on required elements of a consent form to determine if the PI’s consent form is complete.

 Reviewers: The risks listed in the protocol should also be evident in the informed consent document and the protocol summary form (#50 and 51).

 The justification for granting a waiver of consent must be documented in the minutes for the IRB meeting. Reviewers: Please state this justification when you give your review.

Examples include:

 The committee/reviewer agrees with the justification for waiver provided by the PI

in the protocol summary form.

 The study does not adversely affect rights and welfare of participants because the privacy will be protected by a careful plan.

 The study involves a chart review of 200 records which would prohibit completion within time available.

 The study involves deception with an adequate debriefing plan. Participants are not fully informed prior to starting study.

 The PI will provide important findings to participants, if pertinent, after the study is completed.

 Study topic is no more than minimal risk.

 The reviewer or IRB committee may choose to grant an alteration to the requirement for documentation (signing) of a consent (orange form) when a phone interview is done, or anonymous survey is conducted, or when the only identifier would be the signature on the consent form.

 The justification for granting an alteration to the requirement for a documented signature needs to be documented in the IRB minutes. Reviewers: Please state this when you give your review.

Examples include:

 An anonymous survey will be distributed via the internet and the PI will not know who responds, therefore, an information sheet is appropriate consent for this study.

 The PI plans to call the patient and conduct an interview over the phone. This prevents the patient from needing to make an extra visit to the office.

 There is an adequate plan to provide for a witness to the phone consent.

 PI is proposing to use an information sheet providing all elements required on an IC.

 The only identifier being collected would be the signature.

**Assents**

 Assents are required for children in research (when developmentally appropriate).

 The PI should obtain parental permission prior to obtaining the child’s assent.

 A written assent should be used for children between the ages of 13 and 17.

 An oral assent should be conducted for children between 7 and 12.

 The PI needs to submit a script for the oral assent to make sure it is developmentally appropriate for the age of the child.

 If an assent is missing and the committee feels it is appropriate to use, the protocol cannot be approved and must be tabled.

 Justifications for waiver of assent must be in the minutes. Reviewers: Please state the justification when you give your review. Examples include:

o Indicate whether the PI’s request to waive assent is appropriate in Appendix C and in the PSF.

o A waiver is justified when the child’s condition is serious and the study article may provide a benefit.

o A waiver is justified when the children being studied cannot give assent because of developmental delays caused by condition being studied.

**Parental** **Permission**

 Signed parental permission is required for most studies involving minors.

 Parental permission may be waived when the well‐being of the minor may be threatened if parents had knowledge of the child’s involvement of the study. A child advocate must be present during assent and all study procedures to protect the child from coercion.

 Alteration in the requirement for parental signature may be granted when the parents are contacted via a letter and sent an information sheet about the study. The parent can choose

to allow their child participate directly (by signing the consent) or passively (by not calling the PI to opt‐out of the study after receiving the materials in the mail.

 Best practice is for both parents to sign the parental permission for a child’s involvement in research (assuming that both parents are alive, not incarcerated, and in the geographical

area).

 For all Level 3 studies with minors, both parent signatures are required unless one is unavailable, or does not have custodial rights.

**IRB’s** **Determination** **of** **Scientific** **Merit** **and** **Review**

When the IRB determines scientific merit, the following criteria should be considered:

 The IRB determines if the research design is scientifically sound and will not unnecessarily expose the participant to risk.

 The research question must be relevant and the use of human participants necessary to answer the questions being asked.

 The research should be adequately described and use procedures consistent with sound research design.

 Objectives should be clearly stated, with valid measurements and analysis proposed.

 The research can reasonably be expected to answer the proposed questions.

 The investigator has access to a population that will allow recruitment of the necessary number of participants.

* Research studies have the resources necessary to protect participants:
  + Adequate time for the researchers to conduct and complete the research
  + Availability of medical or psychosocial resources that participants might need as a consequence of the research.

**Vulnerable** **Groups**

 Expedited and full board protocols: If any vulnerable group is enrolled, the PI must provide specific safeguards for that group to prevent coercion and added risk.

 Expedited and full board reviewers/member must evaluate the information provided in the

Appendix submitted for a particular vulnerable group.

 The Appendix for each vulnerable group contains the information on justification for enrollment and added protections of the rights and welfare for each group. Please note that

there is a new Appendix for Children.

 In addition to the 8 criteria for approval or SMR, the specific regulations for the protection of vulnerable populations such as pregnant women, fetuses, children, and prisoners, etc.,

must be met for all protocols involving one of these groups.

 If the adult participant is unable to consent, additional safeguards to protect their rights and welfare must be considered. This applies to Chairs using the expedited process, as well.

 The IRB committee or a reviewer may want to ask the PI to elaborate on how he/she will engage adults with cognitive impairments out of respect for persons (e.g., adult assent, verbal script, etc.).

**Justification** **for** **the** **Inclusion** **of** **Vulnerable** **Groups**

The protocol submission form request that the PI provide justification for including vulnerable groups in the research study. Read it carefully and determine if you agree with the justification. Alternatively, a reviewer may state his or her justifications. The justification should be captured in meeting minutes.  *Reviewers:* Please state whether you agree when you give your review; or state the justifications.

Some sample examples of appropriate justification (made by the PI or by the reviewer) for the inclusion of a vulnerable group include:

**1.**  Inclusion of Children (45 CFR 46.Subpart D)

 “Use of this drug has been tested in adults, but has promise for use in children”

 “There have been limited toxic effects in a previous study using children of this age”

 “The FDA is requesting studies of test article in pediatric populations”

 “[The PI] has very close monitoring and controls in place to identify problems early and treat them”

 “Assent and parental permission documents are appropriate for age level”

**2.**  Inclusion of Participants with a Cognitive Impairment

 “Use of this group is necessary to test a drug that may improve memory and cognition”

 “[The PI] has an adequate assessment of cognitive function in place and plans to use it frequently during the trial”

 “The LAR status will be verified with court documents and/or follow the proxy consent hierarchy”

 “The research question cannot be answered without studying persons with cognitive impairments”

**3.**  Inclusion of Prisoners (45 CFR 46 Subpart C)

 “The study involves the effect of altering prison environments to reduce episodes of violence”

 “Results of the study may improve facility’s handling of this type of prisoner

behavior”

 “The study may improve methods to prevent the spread of influenza viruses among inmates”

4. Inclusion of Pregnant Women/Fetuses/Neonates (45 CFR 46.Subpart B)

 “The research procedures do not harm fetus”

 “The study involves an intervention with premature infants that may prevent the development of GI complications”

 “Previous studies with animal models indicate rare side‐effects for the fetus”

 “The PI will be closely monitoring the neonate during the study”

 “The study involves administration of questionnaires and observation of maternal behaviors during the post‐partum period”

 “The drug has potential for limiting development of pre‐clampsia during pregnancy”.

**Research** **with** **Children** **or** **College** **Students:**

The Family Education Rights and Privacy Act (FERPA) of 1974 is a federal law that protects the privacy of student education records. All schools that receive funds under an applicable program of the U.S. Department of Education are under this law’s jurisdiction. This law applies to student records in elementary, secondary and post‐secondary educational settings. Up to the age of 18 the law gives parents certain rights with respect to their children’s records. The rights transfer to the student when he or she reaches the age of 18 or attends school beyond the high school level. Please see the WSU site for information: <http://reg.wayne.edu/faculty/privacy.php>

**Consent** **of** **Non‐English** **Speaking** **Participants**

If the PI is planning to enroll non‐English Speaking Participants, then  ***both*** of the following must be done:

1. This requires a translated long version of the consent form, any questionnaires,

or materials given to participants. This must be reviewed and approved by the

IRB prior to their use according to 45 CFR 46. 116 & 117

 Documents can be translated via a certified translation service (stamp on consent) or documentation submitted with submission; or

 The PI can have the English version translated into language of choice, and a back translation into English done by an independent person. The PI then must make sure that the original English and back‐translated version are the same and include a note with the submission that this process was completed.

***And***

2. This requires that a person fluent (can read and speak the language of choice) be present as a witness to the consent process to verify that the consent was understood.

 Person obtaining consent can speak the language of choice, but a witness who is independent of the study and also is fluent in the language must be

present to verify that it was informed and not coerced.

 The person obtaining consent cannot serve as the witness.

If the PI did not plan to enroll non‐English speaking participants and such a participant is eligible for the study, ***ALL*** of the following must be done:

1. Obtain the sponsor’s permission to enroll, if the eligibility criteria excluded non‐

English speaking participants (waiver).

2. A short form that is translated into language of choice must be used (available on IRB website). If this form is available on the IRB website, then it does NOT need IRB review. If this form is not on the IRB website, then it DOES need IRB

review prior to use.

3. A translator must be present to translate the long English form into language of choice.

4. A witness must be present to verify that the consent was informed and not coerced.

5. An amendment to the protocol should be submitted to the IRB reporting: 1) a protocol deviation (change in the enrollment criteria), and 2) that a non‐English speaking participant was enrolled.

6. If the short forms are used 4 to 6 times in a study, the protocol should be amended changing the eligibility criteria and including a translated version of the long consent form.

7. When the protocol is being renewed, the use of the short form consent process

should be documented on the Continuation Form.

Please refer to the IRB Policy 9‐2 entitled “Informed Consents Involving Non‐English Speaking

Participants” located on the IRB website at [www.irb.wayne.edu.](http://www.irb.wayne.edu/)

**HIPAA**

 HIPAA applies when medical records (electronic, archival, paper, etc) are used at any point during the research process. If no medical records are used, then HIPPA does not apply.

 A HIPAA Summary Form must be submitted with a protocol whenever HIPAA applies.

 A HIPAA Authorization Form should be submitted with a protocol when HIPAA applies. This is found at the end of the WSU consent templates.

 HIPAA documents are given pre‐review in the IRB office prior to the convened meeting.

 The uses and disclosures of PHI are the important pieces of information provided on the documents.

 A waiver of HIPAA Authorization may be granted if a waiver of consent is being granted for the study or a portion of the study.

Justifications for waiver of HIPAA Authorization include:

 If the PI is mining the medical record for recruitment purposes, a waiver of consent and waiver of HIPAA Authorization must be requested and granted.

 The prospective portion of the study is covered with a consent and authorization that is signed.

 A waiver may be granted for a retrospective chart review of a large number of records if the

PI: 1) will only use the minimal PHI needed, 2) has an adequate plan to protect the data, and

3) has a reasonable plan to destroy the PHI when the study is completed.

For all exempt or expedited studies using the medical record as a data source or for verification of eligibility, a HIPAA Summary Form is required.

 The uses marked in Section B should be only those needed to accomplish the research‐

(usually name, elements of dates, MR#, and unique ID code).

 For retrospective record reviews, the PI must request a waiver of authorization (located on pages 4, 5 and 6 of HIPAA Summary Form.

 Make sure the PI signs the first page and signs on page 6 if requesting a waiver.

For expedited studies accessing the medical record:

 If PI is using the record to mine for recruitment, they must request a waiver of authorization on HIPAA Summary Form.

 If PI is going to obtain informed consent prospectively from the participant and continue to use medical records throughout the study, a HIPAA Authorization must be used along with the consent document.

 It is possible for one study to contain both a waiver of consent and authorization as well as

a signed consent and authorization, depending on the design.

 Someone with a clinical relationship must first introduce the study to the potential participant, if their contact information was obtained from the medical record. After this has occurred study personnel may approach the participant to provide more details and consent.

**Planned** **Emergency** **Research**

Planned Emergency Research is research that involves participants who, because of their condition (e.g., unconsciousness), are in a life‐threatening situation that makes intervention necessary, and the person is unable to give informed consent. To be effective, the intervention must be administered before informed consent from participant or the legally authorized representative is reasonably possible.

This exception under FDA regulations permits planned research in an emergency setting when human participants who are in need of emergency medical intervention cannot provide legally effective informed consent and their legally authorized representatives are unable to give consent as well.

This type of study requires a lengthy review process and thorough and extensive community notification and consent:

1. The IRB committee must review the protocol per the regulatory criteria for approval, in addition to the plan for the community consultation and consent.

2. A member of the IRB Administrative Staff must monitor the community consent and consultation activities.

3. After these activities have been completed, the IRB committee is provided with a report on the community consent activities and must provide final approval before the research activities commence.

4. The planned research study, that involved participants unable to consent, begins.

5. When the research is completed, the community must be notified of the results of the

study via a variety of venues such as press releases, newspaper reports, TV or radio

spots, and other types of presentations and publications.

*Note*: Planned Emergency Research is different from Single Time Emergency Use of a Test

Article (see section on this topic).

**PI** **Financial** **Conflict** **of** **Interest**

Relationship between the IRB and the Financial Conflict of Interest (FCOI) Committee:

The FCOI Committee will have primary responsibilities to review relationships between investigators, key personnel, and individuals who may have a FCOI. Based upon their review, they may require the implementation of a FCOI Management Plan to reduce and/or eliminate the potential FCOI. The FCOI Committee will communicate to the IRB the level of the conflict of interest and their approved management plan for the FCOI.

When a management plan has been established, the IRB will have the authority to review and add additional requirements to the FCOI Management Plan that pertain to the protection of human participants in the proposed research protocol.

The IRB will not have the authority to remove a condition in the Management Plan that was approved by the FCOI Committee. However, if appropriate, the IRB may request that the FCOI Committee remove a condition that they have previously incorporated into the Management Plan.

**Institutional** **Conflict** **of** **Interest**

Institutional Financial Conflict of Interest (ICOI) may occur when the institution, any of its senior management or trustees, or a department, school, or other sub‐unit, or an affiliated foundation or organization, has an external relationship, or financial interest (investments, gifts, other financial interests) in a company that itself has a financial interest in a faculty research project. Senior managers or trustees may also have conflicts when they serve on the boards of (or otherwise have an official relationship with) organizations that have significant commercial transactions with the University. The existence (or appearance) of such conflict can lead to actual bias, or suspicion about possible bias, in the review or conduct of research at the University. If they are not evaluated or managed, they may result in choices or actions that are incongruent with the missions, obligations or the values of the University.

When PI’s are aware of any ICOI relevant to their proposed project, they should disclose this to the FCOI committee and, through this committee, to the IRB for consideration.

Additional Conditions that the IRB may Place on a Research Protocol

When the IRB is reviewing a research protocol in which the FCOI Committee has a management plan for the conflict, the IRB may require that a statement be added to the research consent and assent documents about the financial holdings of investigators and key personnel. As part of the IRB review, the IRB will determine if parts of the management plan should be disclosed to the research participants in the research consent and assent documents.

If it is determined that the FCOI cannot be satisfactorily managed in order to adequately protect human participants in the research, then the IRB may decide that the research should be conducted outside Wayne State University by independent investigators at sites that do not have a financial stake in the outcome.

A summary of all IRB discussions regarding FCOI shall be noted in the minutes of the IRB.

**Reportable** **Unexpected** **Problems**

An Reportable Unexpected Problem is unforeseen and unexpected and may indicate that participants or others are at increased risk of harm, if the problem is related or possibly related to the research. An IRB is required to promptly report unexpected problems involving risks to participants and others to appropriate institutional officials, and departmental or agency heads.

The types of events that will be sent to the IRB for review and adjudication are those that are unexpected, related to the study activity, and cause actual or potential harm to human participants or others.

Examples:

 Adverse Event: Any harm experienced by a participant, regardless of whether the event was internal (on‐site) or external (off‐site), and regardless of whether the event meets the FDA definition of “serious adverse event”, which in the opinion of the principal investigator is

**unexpected, related to the study (definitely, probably, more likely than not, or unable to determine)**, **and suggests that participants are at greater risk than was previously known or recognized.**

o An adverse event is “unexpected” when its specificity and severity are not accurately reflected in the informed consent document, the protocol or the investigator’s brochure.

o An adverse event is “related to the research procedures” if, in the opinion of the principal investigator, it was more likely than not to be caused by the research procedures, or if it is more likely than not that the event affects the rights and welfare of current participants.

o In general, an adverse event observed during the conduct of a study should be considered an unanticipated problem involving risk to human participants, and reported to the IRB, only if it were unexpected, serious, and would have implications

for the conduct of the study (e.g., requiring a significant, and usually safety related, change in the protocol such as revising inclusion/exclusion criteria or including a new monitoring requirement, informed consent, or investigator’s brochure).

o An individual adverse event occurrence ordinarily does not meet these criteria because, as an isolated event, its implications for the study cannot be understood.

 Any harm experienced by a participant or others as a result of involvement in research activities (internal of external **excluding** adverse events).

 Information that indicates a change to the risks or potential benefits of the research. For example:

o An interim analysis or safety monitoring report indicates that frequency or magnitude of harm or benefit may be different than initially presented to the IRB.

o A paper is published from another study that shows the risks or potential benefits to your research may be different than initially presented to the IRB.

o Study put on hold by the PI, FDA, or the Sponsor for reasons that may include safety, toxicity and/or efficacy.

 A change in FDA labeling or withdrawal from marketing of a drug, device, or biologic used in a research protocol.

 Change to the protocol taken without prior IRB review to eliminate an apparent immediate hazard to a research participant.

 Research conducted without prior WSU IRB approval or conducted during a lapse of approval.

 Event that requires prompt reporting to the sponsor.

**Chapter** **2:**

**Expedited** **and** **Exempt** **Reviews**

**Expedited** **Review**

 8 Criteria for Approval or SMR: All of the required elements for IRB approval found at 45

CFR 46.111 should be reviewed for these protocols. These are listed in this Handbook on page 8 of Chapter 1.

 Verify that the study is no more than minimal risk to the participant‐physical, social, legal, psychological, etc. If you think it carries more than minimal risk, it should be reviewed by

the full board.

 The review form that you use for expedited studies is the same as for full board review.

Complete applicable questions and provide comments where appropriate and sign.

 Please verify that the expedited category provided by the investigator is accurate.

 If the study is being done outside of the PI’s department or at another institution, a letter of support or an IRB approval memo from that institution must accompany the submission.

 Don’t forget to check for DMC review, KCI review, etc., if applicable.

 The expedited review must consider the special requirements of the following funding sources, if applicable: (see specific Appendix and specific section of reviewer form)

o Department of Defense

o Department of Navy

o Department of Energy

o Department of Veterans Administration

o Department of Education

o Department of Health and Human Services

 Each of these groups and special review requirements should be documented on the special

sections of the Reviewer Forms.

 A full protocol must be attached to all expedited protocols (can be shorter, but it must be the scientific description of what was written in 15 a‐e of the protocol summary form)

 When a waiver of consent is requested, complete the orange form IRB Waiver or Alteration of Requirement to Obtain Informed Consent.

 When a request is made to alter the regular documentation process for consent (use of information sheet, oral consent, phone consent, faxed consent etc.) use the yellow sheet in

the packet to evaluate the PI’s justification for doing this (found in protocol summary form on page 18‐#43f).

 In sections requiring PI justifications such as waiver of consent, alteration of documentation of consent, use of assents, waiver of HIPAA authorization, exclusion or inclusion of certain

groups, levels of risk, please indicate whether or not you agree with the PI’s rationale. Document the status of your concurrence on the reviewer form. We need this to capture it in the minutes.

 As with any protocol, please review any attached documents, as appropriate - advertisements, surveys, interview questions, etc.

**Vulnerable** **Groups**

 Each expedited reviewer/ member must evaluate the information provided in the Appendix submitted for a particular vulnerable group. The expedited review must consider the specific criteria and requirements for vulnerable groups, if applicable: (See specific Appendix)

o The cognitively impaired

o Pregnant women, fetuses, and neonates

o Children

o Prisoners

o Students, employees, and staff

 The PI must provide specific safeguards for that vulnerable group to prevent coercion and

added risk.

 The Appendix for each vulnerable group contains the information on justification for enrollment and added protections of the rights and welfare for each group. As reviewer,

you should agree with these provisions or ask for changes. The study may need full board review if the issues are more than minimal risk.

 In addition to the 8 criteria for approval or SMR, the specific regulations for the protection of vulnerable populations such as pregnant women, fetuses, children, and prisoners must

be met for all protocols involving one of these groups.

• Expedited protocols may be submitted for children and pregnant women, if they are no more than minimal risk.

• Prisoner research may NOT be submitted for expedited review.

**Retrospective** **Chart** **Reviews**

The following areas are usually required:

 Make sure the PI has correctly answered #27.

 A data collection sheet should be submitted that includes the variables being taken from record. Make sure that sheet does not contain name, address, phone, etc. There should be a section for code number.

 A careful description of how they are going to keep the master list and coded data separate

(confidentiality measures‐since this is the risk of doing a chart review).

 They must request a waiver of consent in section #43 and fully justify it. You as reviewer must agree with that justification and state that (we need to capture that in minutes).

 If medical records are used, a waiver of authorization should be requested (on HIPAA Summary Form).

**Exemption** **Review**

 Verify that the study meets one of the criteria for exemption.

 A medical exemption must be submitted on the Medical Exemption Protocol Summary

Form.

 A Behavioral exemption study must be submitted on the Medical Behavioral Protocol

Summary Form.

 If the study involves an exempt chart review, the following apply:

1. Make sure the submission clearly states that they will not be keeping a master list during data collection.

2. Once the record is accessed and they retrieve the data, the identifiers must be destroyed. In other words, they cannot return to the source document to re‐ check data.

3. If they need to keep a master list with codes and identifiers, it must be an expedited study.

4. A data collection sheet needs to be submitted.

5. A protocol needs to accompany the submission (see directions at end of the form).

 Behavioral exemptions often use an information sheet with an anonymous survey.

 If the study is a tissue protocol, verify that no identifying information is used in the study. If they need access to the record and will be keeping identifiers throughout the data collection period, it should be given expedited review.

**Chapter** **3:**

**Drugs** **and** **Device** **Research**

**Definitions**

An  **IND** refers to an Investigational New Drug application. An IND is a request for authorization from the Food and Drug Administration (FDA) to administer an investigational drug or biological product to humans. Such authorization must be secured prior to interstate shipment and administration of any new drug or biological product that is not the subject of an approved New Drug Application or Biologics/Product License Application.

For purposes of this part, “IND” is synonymous with “Notice of Claimed Investigational Exemption for a New Drug.” *Investigational new drug* means a new drug or biological drug that is used in a clinical investigation. The term also includes a biological product that is used in vitro for diagnostic purposes. The terms “investigational drug” and “investigational new drug” are deemed to be synonymous for purposes of this part.

An  **IDE** refers to the regulations under 21 CFR 812. An approved IDE means that the IRB (and FDA for significant risk devices) has approved the sponsor’s study application and all the requirements under 21 CFR 812 are met. An investigational device is a device, including a transitional device that is the object of an investigation.

**General** **IRB** **Responsibilities** **for** **Drugs,** **Biologics,** **and** **Devices**

• An IRB must determine if a drug or device study requires an IND or an IDE.

• If one is required, a letter from the FDA with the IND/IDE number must accompany the submission in order to be approved, or the FDA must confirm that the IND or IDE is not needed.

• A missing IND/IDE does *not* require tabling.

• When the PI indicates that the IND or IDE can be waived, justification from the PI must be provided to the committee.

• The Reviewer should verify the IND/IDE Information and that the number is current.

**Drugs**

 If an IRB determines that a drug study requires an IND, a letter from the FDA with the IND

number must accompany the submission in order to be approved.

 The IRB committee should verify that the IND number is current for the submitted protocol.

 When the PI indicates that the IND can be waived, justification from the PI must be provided to the committee.

 IND‐§ 312.2(b)(1) regulations allow the **exemption** of some drugs from IND regulations if the study meets *all* of the following:

1. Is not intended to support FDA approval of a new indication or a significant change in the product labeling.

2. Is not intended to support a significant change in the advertising for the product.

3. Does not involve a route of administration or dosage level or use in a patient population or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with the use of the drug product.

4. Is compliant with institutional review board (IRB) and informed consent

regulations set forth in parts 56 and 50 (21 CFR parts 56 and 50).

5. Is compliant with § 312.7 (promotion and charging for Investigational drugs).

**Biologics**

Biologics refer to biological products, include a wide range of products such as vaccines, blood and blood components, allergenics, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins. The Center for Biologics Evaluation and Research (CBER) is responsible for ensuring the safety and efficacy of the biological products.

An Investigational New Drug Application (IND) is a request for authorization from the Food and Drug Administration (FDA) to administer an investigational drug or biological product to humans. Such authorization must be secured prior to interstate shipment and administration of any new drug or biological product that is not the subject of an approved New Drug Application or Biologics/Product License Application.

When an IND is required for a biologic, the same application process for drugs is required for biologics.

An IND is not required for a clinical investigation involving in‐vitro diagnostic biologic product if it is:

 Intended to be used in a diagnostic procedure that confirms diagnosis made by a medically established diagnostic product or procedure.

 Shipped in compliance with 312.16.

 Blood grouping serum, reagent red blood cells, and/or anti‐human globulin.

 Intended solely for tests in‐vitro in laboratory research with animals.

**Devices**

The IDE Regulations (21 CFR Part 812) cover three types of device studies: Significant Risk (SR), Non‐significant Risk (NSR), and Exempt. These studies are briefly described below. All clinical investigations of devices must have an approved Investigational Device Exemption (IDE) or be exempt from the IDE regulations.

**A Significant Risk Device (SRD)** presents a potential for serious risk to the health, safety, or welfare of a participant. It may include an implant, devices that support or sustain human life, and devices that are substantially important in diagnosing, curing, mitigating or treating disease or in preventing impairment to human health. A SRD does require an IDE.

**A Non‐significant Risk (NSRD) device** is one that does not pose a significant risk to the human

Participants and therefore does not meet the criteria described above.

• A NSRD study requires only IRB approval prior to initiation of study. IDE applications are not required.

• The sponsor (or PI, if acting as a sponsor) must present an explanation to the IRB of why the device does not pose a significant risk.

• If the IRB disagrees and determines that the device does pose a significant risk, the sponsor must report this to the FDA.

• When an IRB concurd devices with the non‐significant risk determination, the FDA considers an investigation of a non‐significant risk device to have an approved IDE.

 **Abbreviated** **Review** **for** **IDE**

When the IRB concurs with the non‐significant risk determination, the sponsor must also comply with the abbreviated IDE requirements under §812.2(b):

• **Labeling**‐the device must be labeled in accordance with the labeling provisions of the IDE regulation and must bear the statement “CAUTION: Investigational Device. Limited by Federal law to investigational use”.

• **IRB Approval**‐The sponsor must obtain and maintain IRB approval throughout the investigation as a non‐significant risk device study.

• **Informed Consent**‐the sponsor must assure that investigators obtain and document

consent from each participant according to 21 CFR 50, unless documentation is waived by an IRB according to §56.109(c).

• **Monitoring**‐all investigations must be properly monitored to protect human participants and assure compliance with approved protocols.

• **Records and Reports**‐sponsors are required to maintain specific records and make certain reports as required by the IDE regulation.

• **Commercialization**, promotion, test marketing, misrepresentation of an

investigational device, and prolongation of the study are prohibited.

* + The device is not a banned device.

**Exempt Devices:** Device studies that are **exempted** from the IDE regulation [21 CFR 812.2(c)]

include:

 a device, other than a transitional device, in commercial distribution immediately before May 28, 1976, when used or investigated in accordance with the indications in labeling in effect at that time.

* A device, other than a transitional device, introduced into commercial distribution on or after May 28, 1976, that FDA has determined to be substantially equivalent to a device in commercial distribution immediately before May 28, 1976, and that is used or investigated in accordance with the indications in the labeling FDA reviewed under subpart E of part 807 in determining substantial equivalence.
* A device undergoing consumer preference testing, testing of a modification, or testing of a combination of two or more devices in Commercial distribution, if the testing is not for the purpose of determining safety or effectiveness and does not put participants at risk.
* A custom device as defined in 21 CFR 812.3(b), unless the device is being used to determine safety or effectiveness for commercial distribution.
* a legally marketed device when used in accordance with its labeling.

 a diagnostic device if it complies with the labeling requirements in §809.10(c) and if the testing.

 devices that are noninvasive.

 does not use an invasive sampling procedure that presents significant risk.

 does not by design or intention introduce energy into a participant.

 is not used as a diagnostic procedure without confirmation by another medically established diagnostic product or procedure.

 has not been determined to be a significant risk device (SRD). See FDA: <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/HowtoMarketYourDevice/Investigational>DeviceExemptionIDE/default.htm

**Verification** **of** **IND’s** **and** **IDE’s**

 If a study requires an IND and IDE, the IRB committee should verify that the number provided by the PI is current and compare the number to the one in the letter.

 **For** **an** **IND**, the protocol summary form Appendix F has a question for those studies that asks the PI for the following:

o IND number

o Date of initial IND

o Whether current study is being done under the original IND or as part of an amendment

to the original IND.

o A letter from the FDA is generated when an original IND is received. The letter will either state that the investigation can go forward or it will specify changes that the PI needs to make. This letter should be provided to the IRB Committee to verify that an IND number has been generated for this drug or study and the date that it was written. Whenever the holder of the IND submits an amendment to the FDA, a letter is usually provided by the FDA acknowledging the receipt of that amendment.

 **For** **an** **IDE**, the protocol summary form Appendix F has a question for device studies that asks the PI to provide the following:

o IDE number assigned by the FDA.

o Date IDE application was received.

o Whether or not the IDE is original or part of an amendment to the original IDE.

 The letter from the FDA that is generated when the IDE application or amendment is

received should be provided to the IRB Committee.

 For both IND and IDE’s, the primary and secondary reviewer will need to check the accuracy of the numbers on the Protocol Summary Form Appendix F with the number provided in the

Study Protocol or information from the Sponsor.

**Humanitarian** **Use** **Devices** **(HUD)**

 A HUD is a medical device intended to benefit patients in the treatment or diagnosis of a disease or condition that affects or is manifested in fewer than 4,000 individuals in the US per year.

 A device manufacturer`s research and development costs could exceed its market returns for diseases or conditions affecting small patient populations. The HUD provision of the

regulation provides an incentive for the development of devices for use in the treatment or diagnosis of diseases affecting these populations.

 A Humanitarian Device Exemption (HDE) is an application similar to a premarket approval application but is exempt from effectiveness requirements.

 To obtain approval for an HUD, a humanitarian device exemption (HDE) application is submitted to FDA.

 The FDA needs to determine if a device is eligible for designation as an HUD.

 An HDE application is not required to contain the results of scientifically valid clinical investigations demonstrating that the device is effective for its intended purpose. The application, however, must contain sufficient information for the FDA to determine that the device does not pose an unreasonable or significant risk of illness or injury, and that the probable benefit to health outweighs the risk of injury or illness from its use, taking into account the probable risks and benefits of currently available devices or alternative forms of treatment. Additionally, the applicant must demonstrate that no comparable devices are available to treat or diagnose the disease or condition, and that they could not otherwise bring the device to market.

 An IRB must review the HUD submission before it can be used in an institution.

 If an HUD is used in a “clinical trial”, it must be reviewed under all appropriate regulations for an IDE protocol and a regular submission and review by the IRB Committee would be required.

 An approved HDE authorizes marketing of the HUD. However, an HUD may only be used in facilities that have a) established a local IRB to supervise clinical testing of devices and b)

after an IRB has approved the use of the device to treat or diagnose the specific disease. The labeling for an HUD must state that the device is an humanitarian use device and that, although the device is authorized by Federal Law, the effectiveness of the device for the specific indication has not been demonstrated.

**Emergency** **Single** **Time** **Use** **of** **a** **Test** **Article**

An exemption under Food & Drug Administration (FDA) regulations at 21 CFR 56.104(c) allows for the emergency use of an investigational drug, device, or biologic on a one‐time basis per institution without IRB review and approval when **all** of the following conditions are met:

1. A participant is in a life‐threatening situation.

2. No standard acceptable treatment is available.

3. There is insufficient time to obtain IRB approval.

4. The emergency use is reported to the IRB within five (5) working days (this is not to be construed as an IRB approval for the emergency use).

5. The PI obtains informed consent from the participant or legally authorized

representative for such emergency use, except when there are circumstances that prevent obtaining consent.

6. Use the “Emergency Single Time Use of a Test Article (Drug, Biologic, Device) Form”

found at: <http://irb.wayne.edu/forms>‐requirements‐categories.php.

7. Follow the IRB Policy on “Emergency Single Time Use of a Test Article” found at:

8. <http://irb.wayne.edu/policies>‐human‐research.php.

9. The patient is not eligible for enrollment in a local clinical trial or no such trial is available.

10. This is not considered a research protocol. If the person requesting emergency use for a patient wishes to establish a protocol for the drug or device, an IRB submission and full review by the committee is required.

11. When a PI chooses to use this process, the usual practice is to:

o Notify the IRB Chair of planned use via phone, e‐mail, fax, etc.

o Notify the manufacturer of the drug or device for permission to use the test article.

o Obtain permission from FDA to use test article for Emergency Use.

o Develop a consent form for use in this circumstance.

o Submit a signed Single Time Emergency Use of a Test Article Form to the IRB within 5

days of the use, if not before.

o A copy of the signed consent must be submitted to the IRB as well.

12. Each use of an emergency test article must be reported to the IRB Committee.

*Note*: this is a different concept from Planned Emergency research.

**Chapter** **4:**

**Radiation** **or** **Radioactive** **Drug** **Use**

**Review** **of** **Protocols** **Involving** **Radiation** **or** **Radioactive** **Drug** **Use**

 Appendix G has recently been revised to collect more specific information about procedures involving radiation: imaging, therapeutic and/or diagnostic use. These include standard of care procedures using radiation as well as those being done for research purposes only.

 The PI is directed to complete this appendix and submit it with the Protocol Summary Form to the appropriate Radiation Safety Review Committee(s) at the affiliated hospital(s) where

these procedures will be done.

 The PI must submit the radiation safety approval memo to the IRB along with their submission packet.

 The IRB must still consider the risks involved with the radiation exposure in the context of the risk/benefit ratio for a given protocol. Thus, the radiation safety approval supplements but does not replace the IRB’s consideration of radiation exposure as a risk of the study.

 It is especially important for the IRB to review the appropriateness of the information that is provided in the consent form. The Radiation Safety Committees will not routinely be

assessing the consent form language, although they have authority to ask the PI to submit the consent form for their review as they deem necessary.

**Protocols** **Requiring** **Review** **by** **a** **Radioactive** **Drug** **Research** **Committee** **(RDRC)**

 Human research protocols involving *radioactive drug research* require either an Investigational New Drug (IND) application or exemption, or review by an FDA‐approved Radioactive Drug Research Committee (RDRC).

 Radioactive drug research involving an IND is covered by the federal regulations found in 21

CFR § 312, while research that may be conducted under an RDRC is covered by 21 CFR §

361.1.

 Under § 361.1, human research using a radioactive drug or biological product may be conducted with approval from an RDRC under specific circumstances. The purpose of such

research must be to obtain “basic information regarding the metabolism (including kinetics, distribution, and localization) of a radioactively labeled drug or regarding human physiology, pathophysiology, or biochemistry”. These protocols involve basic science research that does not have immediate therapeutic, diagnostic, or similar uses; that is, they do not constitute clinical trial protocols for the drug or biological product.

 All protocols conducted under the purview of the WSU IRB and which meet the criteria found in 21 CFR § 361.1 must:

o First be reviewed and approved by the RDRC of Children’s Hospital of Michigan (CHM).

o This committee’s approval must be included in the protocol submission packet for IRB

review.

**Chapter** **5:**

**Veterans** **Administration** **Research**

When research involves the Veterans Administration, there are special rules to follow and special requirements that must be met.

**General** **Information**

 Wayne State University has 2 IRB Committees (M1 and B3) that have 2 members representing the John D. Dingell Veterans Administration Medical Center (VAMC). MP2 and PH1 do not review VA studies.

 In order to vote on a VAMC protocol, at least 1 of those two members representing the VA

must be present for the discussion and vote to go forward.

 All VAMC protocols including initial submissions, amendments (when the amendment pertains to the VA specifically) and continuations must receive review and approval by the Clinical Investigation Committee (CIC) at the VA prior to being sent to the IRB for review.

 A memo from the CIC must accompany the protocol documents submitted to the IRB.

 The VA uses the social security number as the medical record number; this is acceptable to the WSU IRB.

 No research can be conducted at a VA setting that involves in‐vitro fertilization or fetuses.

 When the research involves prisoners as participants, a waiver must be granted by the Chief Research and Development Officer.

* When the research involves children as participants, approval must be granted by the VA Medical Center Director.

 If the study involves non‐veterans, the PI must indicate that there are insufficient veterans available to complete the study on Appendix J.

**Consent** **Form**

 The consent template (Form 10‐1086) for the VA must be submitted for review.

 The consent must have a statement in it that states in the event of a research‐related injury, the Veterans Administration has to provide necessary medical treatment to a participant injured by participation.

 The consent form must disclose that a veteran‐participant will not be required to pay for care received as a participant in a Veterans Administration research project except in

accordance with federal law and that certain veterans are required to pay co‐payments for medical care and services provided by the VA.

 The consent form includes language explaining the VA’s authority to provide medical treatment to research participants injured by participation in a VA research project.

 Although the VA no longer mandates a witness to the consenting process in addition to the participant’s signature, the IRB or sponsor may require this be added to the consent form.

**HIPAA**

 The WSU IRB’s serve as the Privacy Board for research at the VAMC.

 The HIPAA Authorization for the VA is a separate document (as of 3/31/11) and not included in the body of the consent.

 A HIPAA Summary Form should be submitted with every VA protocol if medical records are being used for the study.

**Payments** **to** **VA** **Participants**

Payment to participants may be permitted, with IRB approval, in the following circumstances:

 No Direct Participant Benefit. When the study to be performed is not directly intended to enhance the diagnosis or treatment of the condition for which the volunteer participant is

being treated, and when the standard of practice in affiliated non‐VA institutions is to pay participants in this situation.

 Others Being Paid. In multi‐institutional studies, when human participants at a collaborating VA or non‐VA institution are to be paid for the same participation in the same

study, participants may be paid at a rate comparable to that proposed at the other sites, if deemed reasonable by the local IRB.

 Comparable Situations. In other comparable situations in which, in the opinion of the IRB, payment of participants is appropriate.

 Transportation Expenses. When transportation expenses are incurred by the participant that would not be incurred in the normal course of receiving treatment and that are not reimbursed by any other mechanism.

Investigators must not pay human participants to participate in research when the research is integrated with a patient's medical care and when it makes no special demands on the patient beyond those of usual care.

**Flagging** **the** **Medical** **Record**

For full board studies, the IRB must agree or not agree with the VA decision to flag the electronic medical record. This is applicable if:

 The research involves any invasive procedure.

 Interventions or clinical services that are used in the medical care of the participant, or that could interfere with other care the participant is receiving or may receive (e.g.,

administration of a medication, treatment, use of an investigational device, orders for labs or x‐rays for the study).

 The use of a survey or questionnaire may provoke undue stress or anxiety unless the IRB determines that mandatory flagging is not in the best interests of the participant (e.g., an interview study of victims of sexual assault).

 In other situations, the IRB determines that the patient health record must be flagged to protect the participant’s safety by indicating the participant’s participation in the study.

The medical record does not need to be flagged if:

1) The participation in the study involves only one encounter.

2) Participation involves the use of a questionnaire or previously collected biological specimens,

**and**

3) Identification of the participant in a particular study would place the participant at greater than minimal risk.

*Note:* If the decision involves the last item, the ICF must have language advising the participant to review the risks of usual care with the health care providers and must define the research risks clearly.

**VA** **Studies** **Involving** **Pregnant** **Women**

In order for the VA to conduct research involving pregnant women, the following criteria must be met:

 The VA Medical Center Director must certify that the medical facility has sufficient expertise in women’s health to conduct the proposed research.

* Appropriate studies on animals and non‐pregnant women have been completed and data for assessing potential risks to pregnant women and fetuses is provided.

 The purpose of the activity is to meet the health needs of the mother or the particular fetus, the risk to the fetus is minimal, and in all cases, is the least possible risk for achieving the objectives of the study.

 Individuals engaged in the research activity will have no involvement in:

o Any decisions as to the timing, method or procedures used to terminate the pregnancy.

o Determination of the viability of the fetus at the termination of the pregnancy.

o Introducing any procedural changes, for research purposes, into the procedures for

terminating the pregnancy.

 No inducements, monetary or otherwise, may be offered to terminate pregnancy for purposes of research activity.

 The mother and father are legally competent and have given their informed consent after having been fully informed regarding possible impact on the fetus, except that the father’s informed consent need not be secured if the purpose of the activity is to meet the health needs of the mother, his identity or whereabouts cannot be reasonably ascertained, he is not reasonably available, or the pregnancy resulted from rape.

**Unanticipated** **Problems** **and** **the** **VA**

The VA Investigator must report all unanticipated internal or local Serious Adverse Event (SAE’s), whether related or unrelated to the research, to the IRB as specified under local SOPS and VHA Handbook 1058.01.

A qualified IRB voting member reviewer or the convened IRB must review the reports of internal or local SAE’s and must determine and document whether the event is serious, whether it is anticipated or unanticipated, and whether it is related, possibly related, or probably related to the research in accordance with VHA Handbook 1058.01.

After determining whether or not the study still meets IRB approval in light of the information provided in the report (whether or not risk to benefit ratio has changed; and whether or not this constitutes new information that should be given to participants) the qualified IRB voting member‐reviewer or convened IRB must document whether or not one of the following applies:

 Immediate action is warranted to prevent an immediate hazard to a study participant.

 No immediate action is warranted but IRB review is needed.

If the previous determinations have been made by an IRB voting member, the report must be taken to the next IRB convened meeting.

If the IRB member reviewer or convened IRB determines that the AE is serious, unanticipated, and related, or possibly related to the research, the IRB Chair must report the event to the VA facility Director as soon as possible, but no later than 5 business days after the determination.

If informed consent modifications are warranted, the convened IRB must determine and document in its records whether or not previously enrolled participants must be notified of the change and if so, when and how.

For a VA multi-site study, not only the principal researcher, but also all local site researchers, must obtain written approvals from the relevant local VA facilities’ IRBs of record and all other local committees, subcommittees, and other approvals according to the respective applicable local, VA, and other federal requirements.

* Research cannot be initiated at any given site until the local researcher has obtained written notification that the research can be initiated from the local associate chief of staff for research and development.

**Chapter** **6:**

**Department** **of** **Defense**

When research is sponsored by the Department of Defense, additional special requirements must be met. Wayne State University has signed an addendum with the DoD; this is recognized by all branches: Navy, Army, and Air Force. Each branch of the DoD may have their own specific requirements for reviewing research protocols that they support and these requirements must be followed.

Reviewers for convened meetings and expedited reviews must follow this guidance when reviewing DoD protocols. Please see the DoD Appendix and Reviewer Form for guidance. The IRB may rely on outside experts to provide an evaluation of the scientific merit.

**What** **Qualifies** **as** **DoD** **Research**

 Research that is funded by a component of the DoD‐Army, Navy, Air Force.

 Research that involves cooperation, collaboration, or other type of agreement with a component of the DoD.

 The participant population will intentionally include personnel from a component of the

DoD.

*Note*: DoD policies do not apply when DoD personnel incidentally participate in studies that are not supported by the DoD and DoD personnel are not an intended population of the research.

*Note*: The research must not involve prisoners of war as participants [any person captured, detained, held, or otherwise under the control of Department of Defense personnel (military and civilian, or contractor employee)].

**Required** **Training**

Initial and continuing research ethics education is required for all personnel who conduct, review, approve, oversee, support, or manage human participants research.

Completion of all required CITI modules as specified by the WSU IRB, meet the DoD requirements. For Department of Navy, CITI modules plus 4 additional modules are required.

The DoD component may evaluate the education policies to ensure the personnel are qualified to perform the research, based on the complexity and risk of the research.

It is the responsibility of the PI to ensure that all additional DoD and/or Department of the Navy (DoN) requirements for human subject protection are met. It is also the PIs responsibility to inform members of the research team and the IRB of the additional requirements.

**Additional** **Requirements** **for** **DoD** **Studies** **at** **Wayne** **State** **University**

 If the research involves interventions or interactions with participants, the research cannot involve a waiver of consent or parental permission unless permission has been obtained from the Secretary of Defense.

 If the research involves cognitively impaired adults, there must be an anticipated direct benefit to the participant.

 If the research involves more than minimal risk to participants:

o An independent medical monitor must be appointed by name.

o The medical monitor is a physician, dentist, psychologist, nurse, or other healthcare

provider capable of overseeing the progress of the research protocol, especially issues

of the individual participant/patient management and safety.

o The medical monitor is independent of the investigative team.

o The medical monitor possesses sufficient educational and professional experience to

serve as the participant advocate.

o The medical monitor has the authority to stop a research study in progress, remove individual participants from a study, and take whatever steps are necessary to protect the safety and well‐being of research participants until the IRB can assess the medical monitor’s report.

 Research involving the use of human participants for the testing of chemical or biological agents is generally prohibited, with the possible exception for research done

for prophylactic, protective, or other peaceful purposes.

 Evidence of review of scientific merit must be submitted to the IRB.

 When survey research is being conducted, DoD personnel may require DoD approval of the surveys or interview questions.

 For research involving more than minimal risk to participants and involving military personnel:

o Unit officers and noncommissioned officers will not influence the decisions of their subordinates to participate or not to participate as research participants.

o Unit officers and senior non‐commissioned officers in the chain of command will not be present during the time that research participant are solicited and/or consented when the research participants are members of units under their command.

o When applicable, officers and non‐commissioned officers so excluded will be afforded the opportunity to participate as research participants in a separate recruitment session.

o During recruitment briefings to a unit where a percentage of the unit is being recruited to participate as a group, an ombudsman (not connected in any way with the proposed research or the unit) will be present to monitor that the voluntary nature of individual participants is adequately stressed and that the information provided about the research is adequate and accurate.

 The disclosure regarding provisions for research‐related injury follows the requirements of the Department of Defense component.

 Issues related to non‐compliance with these requirements shall be referred initially to the next higher management echelon to manage. All findings of serious non‐compliance shall be reported to the Director, Defense Research and Engineering.

* When following Department of Defense regulations, non-exempt classified research must be conducted following the requirements of 3216.02.13.

**Additional** **Criteria** **for** **Department** **of** **the** **Navy**

 For research involving more than minimal risk to participants, the protocol must include an arrangement for emergency treatment and necessary follow‐up of any research.

 If research involves any of the following, the Secretary of the Navy must approve the research:

o Waiver or alteration of the consent process.

o Exceptions to the requirement for the consent process under 21 CFR 50.24.

o Request for waiver of requirements of Department of Navy Policy regarding research

protections.

o Research involving severe or unusual intrusions, either physical or psychological, on human participants such as consciousness‐altering drugs or mind control techniques.

o Prisoners.

o Potentially or inherently controversial topics (such as those likely to attract significant

media coverage or that might invite challenge by interest groups).

 If the research involves human participants who are not US citizens or Department of

Defense personnel, and is conducted outside the US, and its territories and possessions:

o The permission of host company has been obtained.

o The law, customs and practices of the host country and the US will be followed.

o An ethics review by the host country, or local Navy IRB with host country representation

will take place.

To access the Department of Defense Directive for human research protections, visit:

<http://www.dtic.mil/whs/directives/corres/pdf/321602p.pdf>

**Chapter** **7:**

**Department** **of** **Education**

If research involving human participants is funded by the Department of Education, there are special regulations that must be followed. In addition to the Common Rule requirements set forth in Subpart A, B, & D, the following are additional criteria that must be followed when research is sponsored by the Department of Education:

 If the research requires the inclusion of children with disabilities or individuals with mental illness as research participants, the IRB must have at least one person primarily concerned with the welfare of these research participants.

 If consent or written documentation of consent or parental permission is waived, the research **may** **not** **involve** gathering information about any of the following:

o Political affiliations or beliefs of the student or the student’s parent. o Mental or psychological problems of the student or student’s family. o Sex behavior or attitudes.

o Illegal, anti‐social, self‐incriminating, or demeaning behavior.

o Critical appraisals of other individuals with whom respondents have close family

relationships.

o Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers.

o Religious practices, affiliations, or beliefs of the student or student’s parent.

o Income (other than that required by law to determine eligibility for participation in a

program or for receiving financial assistance under such program).

 Alleged unanticipated problems involving risks to participants or others in research funded or sponsored by the US Department of Education, or of serious or continuing

noncompliance with the Common Rule for the Protection of Human Participants, and/or protection of children in research must be reported to the US Department of Education.

 Visit the Department of Education website to learn more about human subject research regulations at: [http://www.ed.gov/.](http://www.ed.gov/)

**Chapter** **8:**

**Department** **of** **Energy**

If research involving human participants is funded by the Department of Energy, there are special requirements that must be met. The Department of Energy has adopted the Common Rule and these additional requirements must be met:

1. The Department of Energy requires that all human participants research adhere to the Department of Energy’s “*Checklist For Use by Researchers Conducting Human Participants Research that Utilizes Personally Identifiable Information”* (PII).

2. The PI is required to submit this checklist with the protocol submission requirements.

**3.** The IRB must verify that the protocol complies with these protections.

Research involving human participants also includes studies of the intentional modification of the human environment, generalizable includes the study of tracer chemicals, particles, or other materials to characterize airflow.

Generalizable also includes studies in occupied homes or offices that:

* Manipulate the environment to achieve research aims.
* Test new materials.
* Involve collecting information on occupants’ views of appliances, materials, or devices installed in their homes or their energy-saving behaviors through surveys and focus groups.

Generalizable should be viewed in terms of the contribution to knowledge within the specific field of study.

To access the Department of Energy website, please visit: <http://www.energy.gov/>

**Chapter** **9:**

**Department** **of** **Justice**

If research involving human participants is funded by the Department of Justice, there are special requirements that must be met. In addition to adherence to the Common Rule to protect the rights and welfare of human research participants, the Department of Justice requires the following:

 If the research involves Federal Bureau of Prisons, the IRB’s approval will be submitted to the Bureau Research Review Board for final approval before the research can begin.

 The research must have has a Privacy Certificate approved by the National Institute of

Justice Human Participants Protection Officer.

 The consent document must disclose that:

1. Confidentiality can be broken if the participant reports immediate harm to participants or others.

2. The research staff does not have to report child abuse unless the participant agrees in writing to allow such reporting.

 A copy of all data must be de‐identified and sent to the National Archive of Criminal Justice

Data, including copies of the informed consent document, data collection instruments, surveys, or other relevant research materials.

 To find out the specific criteria for human participant research funded by the Department of

Justice, visit [:http://www.justice.gov/.](http://www.justice.gov/)

**For Research Conducted Within the Bureau of Prisons**

For research conducted within the Bureau of Prisons, the organization, IRB, and researchers and research staff must follow the requirements of 28 CFR 512, including:

* The project must not involve medical experimentation, cosmetic research, or pharmaceutical testing.
* The research design must be compatible with both the operation of prison facilities and protection of human subjects. The researcher must observe the rules of the institution or office in which the research is conducted.
* Any researcher who is a non-employee of the Bureau must sign a statement in which the researcher agrees to adhere to the provisions of 28 CFR 512.
* All research proposals will be reviewed by the Bureau Research Review Board.
* The project must have adequate research design and contribute to the advancement of knowledge about corrections.
* The selection of participants within any one organization must be equitable.
* Incentives may not be offered to help persuade inmate participants to participants. However, soft drinks and snacks to be consumed at the test setting may be offered.
* Reasonable accommodations such as a nominal monetary recompense for time and effort may be offered to non-confined research participants who are both:
  + No longer in Bureau of Prisons custody.
  + Participating in authorized research being conducted by Bureau employees or contractors.
* A non-employee of the Bureau may receive records in a form not individually identifiable when advance adequate written assurance that the record will be used solely as a statistical research or reporting record is provided to the agency.
* Except as noted in the consent statement to the participant, the researcher must not provide research information that identifies a participant to any person without that participant’s prior written consent to release the information. For example, research information identifiable to a particular individual cannot be admitted as evidence or used for any purpose in any action, suit, or other judicial, administrative, or legislative proceeding without the written consent of the individual to whom the data pertain.
* Except for computerized data records, maintained at an official Department of Justice site, records that contain non-disclosable information directly traceable to to a specific person may not be stored in, or introduced into, an electronic retrieval system.
* If the researcher is conducting a study of special interest to the Office of Research and Evaluation (ORE) but the study is not a joint project involving ORE, the researcher may be asked to provide ORE with the computerized research data, not identifiable to individual participants, accompanied by detailed documentation. These arrangements must be negotiated prior to the beginning of the data collection phase of the project.
* The researcher must have academic preparation or experience in the area of study of the proposed research.
* When submitting a research proposal, the applicant shall provide the following information:
  + A summary statement, which includes:
    - Names and current affiliations of the researchers
    - Title of the study
    - Purpose of the study
    - Location of the study
    - Methods to be employed
    - Anticipated results
    - Duration of the study
    - Number of participants (staff or inmates) required and amount of time required from each
    - Indication of risk or discomfort involved as a result of participation
  + A comprehensive statement, which includes:
    - Review of related literature
    - Detailed description of the research methods
    - Significance of anticipated results and their contribution to the advancement of knowledge
    - Specific resources required from the Bureau of Prisons
    - Description of all possible risks, discomforts, and benefits to individual participants or a class of participants, and a discussion of the likelihood that the risks and discomforts will actually occur
    - Description of steps taken to minimize any risks.
  + Description of physical or administrative procedures to be followed to:
    - Ensure the security of any individually identifiable data that are being collected for the study
    - Destroy research records or remove individual identifiers from those records when the research has been completed.
  + Description of any anticipated effects of the research study on organizational programs and operations.
  + Relevant research materials such as vitae, endorsements, sample consent statements, questionnaires, and interview schedules.
* A statement regarding assurances and certification required by 28 CFR 46, if applicable.
* The researcher must assume responsibility for actions of any person engaged to participate in the research project as an associate, assistant, or subcontractor to the researcher.

*Note:* Implementation of Bureau programmatic or operational initiatives made through pilot projects is not considered to be research.

**Required Elements of Disclosure**

For research conducted within the Bureau of Prisons, required elements of disclosure include:

* Identification of researchers.
* Anticipated uses of the results of the research
* A statement that participation is completely voluntary and that the participant may withdraw consent and end participation in the project at any time without penalty or prejudice (the inmate will be returned to regular assignment or activity by staff as soon as practicable).
* A statement regarding the confidentiality of the research information and exceptions to any guarantees of confidentiality required by federal or state law. For example, a researcher may not guarantee confidentiality when the participant indicates intent to commit future criminal conduct or harm himself or herself or someone else, or, if the participant is an inmate, indicates intent to leave the facility without authorization.

**For National Institute of Justice (NIJ) Funded Research:**

All researchers and staff are required to sign employee confidentiality statements, which are maintained by the responsible researcher.

**Chapter** **10:**

**Environmental** **Protection** **Agency**

If research involving human participants is funded by the Environmental Protection Agency, the following additional criteria must be met:

 The research cannot involve the intentional exposure of pregnant or nursing women to any substance.

 If the results of the research involving an intentional exposure of human participants are intended to be submitted to or held for inspection by the EPA, the IRB determinations and

approval will be submitted to EPA Human Participants Research Review official for final review and approval before the research can begin.

 If research involves children, the research must meet the criteria for either risk category 1 (no more than minimal risk) or category 2 (more than minimal risk but with potential

benefit). No category 3 research is allowed.

 Please visit the EPA Home Page and search for human research protections at:

[http://www.epa.gov/.](http://www.epa.gov/)

**Chapter** **11:**

**Misconduct,** **Non‐Compliance,** **Complaints,** **Suspensions, and** **Terminations**

**The** **IRB** **is** **required** **to** **promptly** **report:**

 Unexpected problems involving risks to participants and others.

 Serious or continuing noncompliance.

 Suspensions and/or terminations of previously approved research.

to the appropriate institutional officials and departmental or agency heads (Office of

Human Research Protections, The Food and Drug Administration, the VA

[See 45 CFR 46.103(a), 38 CFR 16.103(a) and 21 CFR 56.103(a) for more details].

**Research** **Misconduct** **and** **Non‐Compliance**

The IRB and IRB Administration Office will accept anonymous allegations, and will make every effort to protect the confidentiality of the complainant if necessary. Allegations are routed to the Sr. Research Compliance Specialist and in his/her absence it may be reported to the Associate Director, IRB Administration or the Director, Responsible Conduct of Research. Non‐compliance or potential non‐compliance may also be discovered by the IRB through audits or other routine review or quality control activities. Allegations of potential non‐compliance may also be reported to the IRB by non‐investigators or investigators who are not involved with the research in question.

**Participant** **Complaints**

If you receive a participant complaint, please direct it to the Associate Director, IRB Administration; the Director, Responsible Conduct of Research; and the appropriate Chair. Please refer to the end of this Handbook for contact info or call the IRB Administration Office’s main line at (313) 577‐1628.

**Suspensions** **and** **Terminations** **of** **IRB** **Approval**

The IRB is required to promptly report suspensions and/or terminations of previously approved research to appropriate institutional officials and departmental or agency heads [Office of Human Research Protections (OHRP), The Food and Drug Administration (FDA).] See 45 CFR

46.103(a), 38 CFR 16.103(a) and 21 CFR 56.103(a).

 **For** **VA** **requirements**, in addition to reporting to VA Office of Research Oversight, the following offices must be notified:

1. The Privacy Office, when the report involves unauthorized use, loss, or disclosure of

individually identifiable patient information.

2. The Information Security Officer when the report involves violations of information security requirements.

***Suspension*** – A suspension occurs when the AVPR, HIC Chair, IRB Committee or IRB Chair places a temporary hold on research that had previously been approved so that no new participants can be accrued, no research interventions may occur (unless necessary for the safety and well‐ being of the enrolled participants) and no follow‐up can be conducted unless it is in the best interest of the participant and approved by the IRB. An IRB can suspend research.

***Termination of a previously approved protocol*** – Termination of a previously approved protocol occurs when the IRB withdraws approval or stops all research activity permanently. No new participants may be enrolled and no additional research interventions can occur. However, future follow‐up may be conducted with the approval of the IRB to monitor the well‐being of and any potential risk to participants enrolled prior to termination.

***Termination of activities that have never received prior review and approval*** ‐On the occasion when research activities have occurred that did not receive prior review and approval from the IRB, the IRB shall stop all such activities permanently. None of the data collected in this activity can be used in any future publication or presentations.

**Reporting** **Suspensions/Terminations**

To The Principal Investigator (PI)

If a protocol is suspended or terminated, the PI must be notified in writing immediately by the IRB that originally approved the protocol. This is done the day the notification letter is prepared. The information in the notice/letter must specify the reason(s) for the suspension and/or termination, any required corrective action plan, any required notification of the participants already enrolled in the research and the mechanism available to the PI to address the actions taken and respond to the decision.

To Institutional Officials, Department Chairpersons, Deans, or Appropriate Research Team

Members

Copies of the above‐referenced notice are sent to the Vice President for Research, appropriate Department Chairs, Deans, and/or Directors within the Institution, and members of the research team as deemed appropriate. All suspensions and terminations of Veteran’s Administration (VA) protocols must be reported to the VA Research and Development Committee within 24 hours.

To The Sponsor

The IRB Administration Office requires that research sponsors be notified of any suspension or termination of research. The IRB Administration Office will forward a copy of the suspension/termination notice directly to the sponsor.

To: Appropriate Regulatory Agencies or Departments

Any suspension or termination must be reported to the OHRP, and the FDA (if applicable), within 1 month of the suspension or termination. A preliminary report may be sent earlier to alert the agencies of the occurrence with a final report submitted later.

**Chapter** **12:**

**Research** **versus** **Quality** **Improvement**

**Distinctions** **Between** **Research** **versus** **Quality** **Improvement** **or** **Quality** **Assurance**

|  |  |  |
| --- | --- | --- |
|  | **Research** | **Quality Improvement or**  **Quality Assurance** |
| **Purpose** | Test a formal hypothesis or research question and advance science/discipline | Assess a process, program, or system |
| **Starting Point** | A prospectively designed, formal, written research hypothesis | An established set of standards |
| **Benefits** | Knowledge sought may not benefit participants involved in study | Knowledge sought directly benefits process/program/system/and may benefit patients |
| **Risks/Benefits** | May put participants at risk | No risk, with exception of possibly privacy/confidentiality concerns |
| **Data Collection** | Systematic data collection | Systematic data collection |
| **End Point** | Answer research question | Improve program/ process/ system |
| **Testing/Analysis** | Involves an in‐depth review of relevant literature.  Determine validity of hypothesis. | Compare the program/process/system to established set of standards. |
| **Intended Result** | Share findings with individuals associated with investigation and individuals not associated with investigation. | Share findings with only those individuals associated with the process/ program/system. If findings are shared with individuals unassociated with the process/program/system, then activities are considered research. |
| **IRB Review & Approval** | **Required** | **Not Required** |

*\*Modified from guidance used by George Washington University Committee on Human*

*Research IRB & Cambridge Health Alliance. Permission granted for use on 3/2/2011 by George*

*Washington University.*

**Chapter** **13:**

**The** **Role** **of** **the** **Chair**

**Responsibilities** **of** **an** **IRB** **Chair**

The individual IRB Committee Chairs, or Vice Chair if the Chair is unavailable, include the following responsibilities:

• Chairs all full board meetings, directs discussions, leading review and voting on all business at meeting.

• Reads proposals, identifies issues needing discussion and guides discussion and decision making. Pre‐review each protocol to determine if a full board review is necessary (i.e., research involving human participation).

• Assigns protocols to primary and secondary reviewers based upon expertise at least 1 week

prior to the next scheduled meeting (4 days prior for weekly IRBs). Serve as reviewer when he/she has appropriate expertise.

• Votes as member of IRB.

• Ensures that there is a permanent continuation reviewer on each committee.

• Reviews and signs all memos generated from meeting decisions prior to them being sent to the Principal Investigators.

• Reviews responses to committee‐specific minor revision requests.

• Answer questions and complaints from PIs, research staff, the participants or community members, and direct issues to the appropriate administration person.

• Assists with identifying the need for policy changes, proposing changes, reviewing changes and establishing new policies and procedures for the IRB.

• Monitors and reports any attempts to influence or coerce IRB members.

• Reviews all unexpected problems and adverse events brought to the IRB meeting for discussion and adjudication.

• Facilitates cohesive and meaningful group discussion on al IRB business brought to a convened meeting.

• Resolves issues arising during work of the board or refers unresolved issues to the institutional officials.

• Ensures adequate selection of IRB membership, including members knowledgeable of specific vulnerable groups.

• Participates in the ongoing evaluation of the performance of committee members.

• Represents the IRB with other constituencies within the University and in the research community.

• Ensures adherence to all applicable State and Federal regulations and to all WSU and IRB

policies and procedures in all IRB activities and deliberations.

• Facilitates group cohesiveness and group problem‐solving.

• Commitment to the required time to conduct business of the IRB.

**IRB** **Chair** **Checklist** **for** **Face‐to‐Face** **Convened** **Meetings**

During Meeting:

1. Introduce visitors.

2. Refer to the agenda.

3. Ask if there is any conflict of interest (financial or scientifically associated with the study;

or if a member wishes to recuse self because he/she feels there is an issue of conflict).

4. For adverse events and unexpected events, the committee should consider if further required action is needed, such as audit, suspension, termination, and report to feds.

5. Discuss justification and level of risk (or changes to risk level) for all new or tabled protocols, amendments, and continuations.

6. Discuss new or tabled protocol specific justification for vulnerable participant groups and for waiver or alteration of consent process.

7. All members are encouraged to participate equally and fully in all protocol discussions.

8. Everyone must raise their hand during a vote count and hold their hand up long enough to be counted.

9. The Chair counts and states the vote count out loud at face‐to‐face IRB meetings.

10. The Chair should direct the Vice Chair to run the meeting if he/she:

 Is the 1st or 2nd reviewer on a protocol, amendment, or continuation;

 Has a COI or FCOI;

 Has to leave, cannot attend or has to recluse self from the meeting.

Helpful Points:

1. Need to have a non‐scientist present in order to conduct a meeting.

2. Need to have a quorum to vote.

3. A member leaving the room is considered absent, not abstaining from a vote.

4. Consultants should present, answer questions, and then leave. They are not privy to the discussion, vote, or other parts of the meeting.

5. An IRB member that has recused themself due to a COI or FCOI, may be called back into

the IRB meeting by the IRB in order to answer specific questions about the protocol. After the questions are answered, the member should again recluse themselves and may not be present during discussion or voting.

6. Specific Minor Revisions must be given to protocol, amendments and continuations with typographical errors, spelling mistakes, re‐wording, etc. Per our policy we cannot give a protocol approval and request any of these needed changes at the same time.

7. If a member or reviewer would like to suggest changes to the protocol, the changes can

be e‐mailed out (via the RCA) to everyone on the committee in advance of the meeting, so that these changes can be reviewed prior to the meeting. Everyone must be able to read or hear the suggested changes for the changes to be considered. Suggested changes cannot be considered after the meeting.

8. Alternates should be given advanced notice to allow adequate time for the person to review all of the documents prior to the meeting. If there is not adequate time and quorum is not met, the meeting will be rescheduled.

9. The IRB can request: a) that a PI be referred to the Education Coordinator for further education, b) an audit, c) to observe the informed consent process.

10. When a protocol involves working with vulnerable populations (children, prisoners,

pregnant women, people with cognitive impairments, etc.), an IRB member with experience working with or who has knowledge of this population must be present.

11. When a VA protocol is being reviewed, an IRB member of your committee that also represents the VAMC must be present and must have scientific expertise.

12. When prisoners are participating in research, an IRB member of your committee that is also a prisoner representative must be present.

13. VA, DoD, prisoner and other specific research areas have special regulations.

**IRB** **Chair** **Checklist** **for** **Teleconference** **and** **Webinar** **Convened** **Meetings**

During Meeting:

1. Introduce visitors.

2. Refer to the agenda.

3. Ask if there is any conflict of interest (financial or scientifically associated with the study;

or if a member wishes to recuse self because he/she feels there is an issue of conflict).

4. State at each meeting that all members are encouraged to participate equally and fully in all protocol discussions.

5. For adverse events and unexpected events, the committee should consider if further required action is needed, such as audit, suspension, termination, and report to feds.

6. Discuss justification and level of risk (or changes to risk level) for all new or tabled protocols, amendments, and continuations.

7. Discuss new or tabled protocol specific justification for vulnerable participant groups

and for waiver or alteration of consent process.

8. A roll call is used to document votes.

Helpful Points:

1. Need to have a non‐scientist present in order to conduct a meeting.

2. Need to have a quorum to vote.

3. A member temporarily leaving the call or leaving the room is considered absent, not abstaining from a vote.

4. Consultants should present, answer questions, and then leave. They are not privy to the discussion, vote, or other parts of the meeting.

5. An IRB member that has recused themself from the call/videoconference due to a COI or FCOI, may be called back into the IRB meeting by the IRB in order to answer specific questions about the protocol. After the questions are answered, the member should again recluse themselves from the call and may not be present on the call/videoconference during discussion or voting.

6. Specific Minor Revisions must be given to protocol, amendments and continuations with typographical errors, spelling mistakes, re‐wording, etc. Per our policy we cannot give a protocol approval and request any of these needed changes at the same time.

7. If a member would like to suggest changes to the protocol, the changes can be e‐mailed out (via the RCA) to everyone on the committee in advance of the meeting, so that these changes can be reviewed prior to the meeting. Everyone must be able to read or hear the suggested changes for the changes to be considered. Suggested changes cannot be considered after the meeting.

8. Alternates should be given advanced notice to allow adequate time for the person to review all of the documents prior to the meeting. If there is not adequate time and quorum is not met, the meeting will be rescheduled.

9. The IRB can request: a) that a PI be referred to the Education Coordinator for further education, b) an audit, c) to observe the informed consent process.

10. When a protocol involves working with vulnerable populations (children, prisoners, pregnant women, people with cognitive impairments, etc.), an IRB member with experience working with or who has knowledge of this population must be present.

11. When a VA protocol is being reviewed, an IRB member of your committee that also

represents the VAMC must be present and must have scientific expertise.

12. When prisoners are participating in research, an IRB member of your committee that is also a prisoner representative must be present.

13. VA, DoD, prisoner and other specific research areas have special regulations.

**Chapter** **14:**

**Contact** **Info** **and** **Resources**

**Contact** **Information**

The IRB Administration Office main line....................577‐1628 ........Fax 993‐7122

IRB Operations Manager………………………………….…….577-0895

Education Coordinator .............................................577‐9534

Program Project Assistant.........................................577‐1628

Sr. Director, Compliance .........................................577‐0646

Associate Vice President for Research ....................577‐9064

**Resources**

**WSU** **IRB** **Website**

[www.irb.wayne.edu.](http://www.irb.wayne.edu/) This website contains all policies and procedures, reviewer forms, submission forms, consent/assent forms, and other information. Soon there will be a sign‐up for a listserv on the website and other new resources.

**Federal** **Regulations** **and** **Guidance**

**OHRP**

 Office for Human Research Protections <http://www.hhs.gov/ohrp/>

 Human Participants Regulations Decision Charts <http://www.hhs.gov/ohrp/policy/checklists/decisioncharts.html>

 Institutional Review Board Guidebook <http://www.hhs.gov/ohrp/archive/irb/irb_guidebook.htm>

 Protection of Human Participants: 45 CFR 46 <http://www.hhs.gov/ohrp/humanparticipants/guidance/45cfr46.html>

**FDA**

 Food and Drug Administration <http://www.fda.gov/>

 Human Participant Protection (Informed Consent): 21 CFR Part 50 <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRsearch.cfm>

 IRB Regulations: 21 CFR 56 <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm>

 Information Sheets: Guidance for IRBs, Clinical Investigators, and Sponsors <http://www.fda.gov/ScienceResearch/SpecialTopics/RunningClinicalTrials/GuidancesInf>ormationSheetsandNotices/ucm113709.htm

 Investigational New Drug Application: 21 CFR Part 312 <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRsearch.cfm>

 Investigational Device Exemptions: 21 CFR Part 812 <http://www.access.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRsearch.cfm>

**Ethical Principles & Codes**

 American Society for Bioethics & Humanities (ASBH)

<http://www.asbh.org/>

 Belmont Report <http://www.ohsr.od.nih.gov/guidelines/belmont.html>

 Declaration of Helsinki (World Medical Association)

<http://www.wma.net/en/30Publications/10policies/b3/index.html>

 NIH Bioethics Resources on the Web <http://www.nih.gov/sigs.bioethics/>

 Nuremberg Code <http://ohsr.od.nih.gov/guidelines/nuremberg.html>

 National Bioethics Advisory Commission (NBAC)

<http://bioethics.georgetown.edu/nbac/>

 Public Responsibility in Medicine and Research (PRIM&R)

[http://www.primr.org](http://www.primr.org/)

 The President’s Council on Bioethics <http://bioethics.gov/>

**Good Clinical Practices**

 Good Clinical Practice in FDA‐Regulated Clinical Trials <http://www.fda.gov.ScienceResearch/SpecialTopics/RunningClinical/Trials/default.htm>

 Good Clinical Practice Contacts <http://www.fda.gov/ScienceResearch/SpecialTopics/RunningClinicalTrials/ucm134476.h>tm

 ICH E6: Good Clinical Practice: Consolidated Guidance <http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Gui>

dances/ucm073122.pdf

 Medical Devices (Device Advice)

<http://www.fda.gov/cdrh/devadvice/>

**HIPAA**

 IRBs and the HIPAA Privacy Rule (NIH)

<http://privacyruleandresearch.nih.gov/irbandprivacyrule.asp>

 NIH Guidance on Protecting Personal Health Information in Research (NIH)

<http://privacyruleandresearch.nih.gov/pr_02.asp>

 NIH Guidance on Research Repositories, Databases, and the Privacy Rule (NIH)

<http://privacyruleandresearch.nih.gov/research_repositories.asp>

 NIH Guidance on Clinical Research and the HIPAA Privacy Rule <http://privacyruleandresearch.nih.gov/clin_research.asp>

**Veteran Affairs Administration**

 <http://www.va.gov/ORPM/index.asp>

**Department of Defense**

 <http://www.dtic.mil/whs/directives/corres/pdf/321602p.pdf>

**Department of Energy**

 <http://www.energy.gov/>

**Department of Education**

 <http://www.ed.gov/>

**Department of Justice**

 <http://www.justice.gov/>

**Environmental Protection Agency**

 <http://www.epa.gov/>