McLaren HEALTH CARE		Policy Title:	QA/QI Routine Review
Effective Date:	October 8, 2015	Policy Number:	MHC_RP0302
Review Date:	August 20, 2020	Section:	Research Integrity
Revised Date:	March 22, 2024	Oversight Level:	Corporate
Administrative Responsibility:	Corporate Manager of Research Integrity Institutional Office, HRPP		

1. Purpose

1.1. The purpose of this policy is to establish the process for the McLaren Health Care (MHC) Education and Quality Improvement Program (EQuIP) to perform QA/QI Routine Reviews of MHC research studies.

2. Scope

2.1. This policy applies to all industry sponsored, government funded, and investigator-initiated studies conducted at McLaren Health Care and any of its subsidiaries.

3. Definitions

3.1. Refer to Appendix I *"Definitions"*

4. Policy

4.1. As part of the McLaren's AAHRPP Quality Improvement and Quality Assurance Program, EQuIP is authorized to conduct QA/QI routine site visits to review research records, observe ongoing research projects, and the consenting process as well as continually educating and updating MHC researchers regarding human subject protection.

4.2. McLaren's Human Research Protection Program (HRPP) is committed to a consistent, proactive effort to continually ensure the human subject research conducted at McLaren occurs in accordance with all applicable federal regulations and/or agency specific requirements, state and local laws, and institutional policies and procedures.

4.3. QA/QI Routine Reviews of MHC research studies will be conducted to:

4.3.1. Ensure that the rights and welfare of research participants used in studies have been properly protected in accordance with federal regulations, local and state laws, and institutional policies.

4.3.2. Ensure the highest degree of research standards are being maintained regarding the safety of human subject research.

4.4. The EQuIP staff has the right to request any study records or records relevant to the research subject eligibility or medical history. Review of study records may include, but are not limited to:

4.4.1. Signed consent documents.

4.4.2. Source documentation.

4.4.3. Logs or checklists.

4.4.4. Narrative forms and/or notes-to-file (when applicable).

4.4.5. Regulatory and IRB binders or files.

4.4.6. Test articles – Drug and device.

4.4.7. Medical records that serve as source documents.

4.4.8. Any other relevant procedures, materials, or documents.

4.5. Based upon the results of routine reviews and feedback from investigators, quality improvement measures, a CAPA plan, or both may be implemented.

4.6. If non-compliance in the conduct of research is determined, the PI will be responsible for complying with a Corrective Action Preventative Action (CAPA) plan initiated by EQuIP.

4.7. If there are indications of serious or continuing non-compliance the IRB will be notified.

4.7.1. The IRB will make the determination of serious or continuing non-compliance and follow up actions (e.g., request for follow-up review, notification of Sponsor or regulatory authorities, monitoring of informed consent process, suspension, or termination.

5. Procedure

5.1. Selection of Protocol/Primary Investigator:

The total number of protocols reviewed in a year and focus of the QA/QI Routine Review will be determined by the QI and Education Specialist in consultation with the Corporate Manager of Research Integrity.

5.1.1. This information will be listed in the QA/QI Plan.

5.1.2. Each quarter the 6.1. Quality Improvement (QI) and Education Specialist will create of list of potential protocols that meet the following criteria:

5.1.2.1. Active studies that have not undergone previous EQuIP review.

5.1.2.2. All active studies using an investigational drug or device.

5.1.2.3. All active studies regardless of category of IRB review: Chart Review, Expedited, Exempt, HUD, or Full-Board Review.

5.1.2.4. All active studies with currently enrolling subjects.

5.1.3. Protocols selected for review are either:

5.1.3.1. Selected randomly by assigning a number to each protocol and running a random function in the Microsoft Excel program.

5.1.3.2. Selected purposely based on the following criteria:

5.1.3.2.1. Studies that involve vulnerable populations.

5.1.3.2.2. Investigators who conduct studies that involve a potentially high risk to subjects.

5.1.3.2.3. A new PI and/or Clinical Research Coordinator.

5.1.3.2.4. Past clinical trial non-compliance/problems.

5.1.3.2.5. Studies involving various waivers.

5.1.3.2.6. Protocols with lapses of IRB approval.

5.1.3.2.7. High enrolling studies.

5.1.3.2.8. Resident or student PI.

5.1.3.2.9. Involvement of multiple departments, i.e., cancer, cardiology, neurology, etc.

5.1.3.2.10. Investigators who conduct studies that involve large numbers of subjects.

5.2. Pre-audit Preparation

5.2.1. The QI and Education Specialist will notify the Principal Investigator (PI) and Coordinator that their study has been selected for routine review.

5.2.1.1. An email notification is sent approximately 4 weeks prior to the review. The PI will be asked to respond within 1 week of email notification.

5.2.1.2. If EQuIP does not receive the PI's response within one week of the initial notification, a *Reminder Routine Review Notification* will be sent by email.

5.2.1.3. The McLaren Center for Research and Innovation (MCRI) will be notified if they have oversight over the study.

5.2.1.4. If the PI is a resident or student, the academic advisor and Director of Medical Education will also be notified.

5.2.1.5. The Corporate Manager of Research Integrity will be copied on the notification.

5.2.2. Once the PI confirms availability for the routine review, the PI or designee will be asked to forward a list of all consented subject IDs, not names, no later than 2 weeks prior to the scheduled review date.

5.2.2.1. Once received, the QI and Education Specialist will randomly select a percentage of subjects for review and notify the PI prior to the review date which complete subject files should be available for review.

5.2.2.2. In addition to selected subjects' research files, the PI will be informed to have available for review all the signed consent forms.

5.2.2.3. If the study has no subjects consented on or if the study has been completed, terminated, closed to enrollment (data analysis only), or otherwise deemed ineligible for review, the study will be withdrawn from the review.

5.2.3. After the appointment date and time along with subject selections are confirmed, a *Routine Review Notification Confirmation Letter* is emailed to the primary investigator and research coordinator.

5.2.3.1. A QA/QI Routine Review Preparation Overview form will be included in the confirmation notification.

5.2.3.2. The primary investigator will be encouraged to complete the QA/QI Review Self-Assessment Form.

5.3. Review of IRB Files

5.3.1. The QI and Education Specialist may review the IRB files to become familiar with the protocol and to identify any issues that should be focused on during the site review. The following may be reviewed:

5.3.1.1. Initial IRB electronic application system application

5.3.1.2. Subsequent IRB electronic application system submissions:

5.3.1.2.1. Amendments, revisions, or modifications

5.3.1.2.2. Continuing reviews

5.3.1.2.3. Reports

5.3.1.3. All correspondence to and from IRB including approval letters and notifications.

5.3.1.4. Training records

5.3.1.5. Clinical Trial Agreements, if applicable

5.3.1.6. IRB meeting minutes

5.4. Onsite Review Activities:

5.4.1. **QA/QI Routine Review tools and methods** may include, but not be limited to:

5.4.1.1. Interview questions

5.4.1.2. Review of any study records, subject files, source documents, binders, etc.

5.4.2. Debriefing Interview

5.4.2.1. The QI and Education Specialist will meet with the PI and/or designee to discuss:

5.4.2.1.1. Purpose and activities of the routine review.

5.4.2.1.2. Problems or issues regarding study conduct.

5.4.3. Review of Records:

5.4.3.1. The PI does not need to be present during the entire review; however, a designated member of the study team must be available via phone/page or nearby for questions and retrieval of additional material.

5.4.3.2. The QI and Education Specialist may review the following, but not limited to:

5.4.3.2.1. Informed consent: forms, process, observation of consenting process

5.4.3.2.2. Confirmation of subject eligibility

5.4.3.2.3. Confirmation of protocol procedures and interventions

5.4.3.2.4. Collecting and reporting adverse events and UPIRSOs

5.4.3.2.5. Protocol violations or deviations

5.4.3.2.6. Confidentiality and security measures

5.4.3.2.7. IRB, Sponsor, Regulatory Agencies correspondences

5.4.3.2.8. Subject recruitment, screening, and compensation

5.4.3.2.9. Subject study and source files

5.4.3.2.10. Monitoring reports

5.4.3.2.11. Storage facilities for devices, drugs, and biologic

5.4.3.2.12. Training files

5.4.3.2.13. Discussion with any individuals involved in study activities.

5.4.3.3. Once the review is complete, the designated study team member will return study files/records.

5.4.3.4. The length of the review is dependent on many factors such as the type of study, the number of subjects, how long the study has been open, etc.

5.4.3.5. The QI and Education Specialist documentation of findings will be based on:

5.4.3.5.1. The information contained in the IRB electronic application system application approved by the IRB.

5.4.3.5.2. Review of written study records reflecting study conduct

5.4.3.5.3. Verbal report from the PI and research personnel

5.4.3.5.4. Applicable policies, regulations, and ICH GCP guidelines

5.4.3.5.5. Audit findings will be documented on EQuIP compliance worksheets.

5.4.4. Preliminary Findings Discussion

5.4.4.1. The QI and Education Specialist will meet with the PI and/or designee to discuss preliminary findings and to allow an opportunity to correct, explain, and/or ask questions.

5.4.4.2. Feedback will be sought regarding the IRB process, educational/training programs, as well as other aspects of the human research protections program at MHC.

5.4.4.3. The QI and Education Specialist will provide recommendations and describe the next set of steps in the process.

5.4.4.4. The exit interview occurs upon completion of the routine review activities but may be deferred if there is a conflict in scheduling.

5.4.4.5. A deferred discussion may occur via the phone or email.

5.5. Post Review Activities

5.5.1. After the review, the EQuIP staff will complete a review summary report. Possible outcomes will usually fall into 1 or 2 of 4 categories, which will determine post-review follow-up activities:

5.5.1.1. PI is conducting a research study in compliance with federal regulations, HRPP policies, and approved protocol.

5.5.1.2. PI is conducting research study with potential issues of minor non-compliance.

5.5.1.3. PI is conducting research studies with potential issues of serious or continuing non-compliance.

5.5.1.4. Routine review results indicate IRB non-compliance.

5.5.2. Follow-Up of Research Conducted in compliance with federal regulation, IRB policies, and approved protocol.

5.5.2.1. No CAPA plan is required.

5.5.2.2. A QA/QI Routine Review Summary Letter will be sent to the PI via email within 10 business days of the review.

5.5.2.3. The PI and Coordinator will review the findings and forward any comments to EQuIP.

5.5.3. Follow-Up on Potential issue of minor non-compliance

5.5.3.1. A CAPA plan is created (see 5.5.6. for CAPA plan procedures)

5.5.3.2. A QA/QI Routine Review Summary Letter with a CAPA Plan will be emailed within 10 business days of the review.

5.5.3.3. If additional investigation is required after the site review, the turnaround timeline will change accordingly.

5.5.4. Follow-up on Potential issues of serious or continuing non-compliance

5.5.4.1. If the findings reveal an immediate threat to subject rights or safety and welfare, the IRB chair and Corporate Manager of Research Integrity will be notified immediately. If this occurs, the *MHC_RP111_Study Suspension, Termination, and Investigator Hold* policy will be followed.

5.5.4.2. The IRB will make the formal determination of serious or continued non-compliance following the policies *MHC_RP0123_ Complaints and Non-Compliance in Human Subject Research* and *MHC_RP0124_Reporting to Regulatory Agencies and Institutional Officials.*

5.5.4.3. A CAPA plan will be created (see 5.5.6 for CAPA plan procedures).

5.5.4.4. A QA/QI Routine Review Summary Letter with a CAPA Plan will be emailed within 10 business days of the review.

5.5.4.5. If additional investigation is required after the site review, the turnaround timeline will change accordingly.

5.5.5. Follow-Up on Routine review results in which there are IRB non-compliance findings.

5.5.5.1. If the findings are relevant to IRB non-compliance, a separate IRB QA/QI Routine Review Summary Letter with recommendations will be emailed to the IRB Chair within 10 business days of the review.

5.5.5.2. If corrective actions are required, the Corporate Manager of Research Integrity will initiate a CAPA Plan.

5.5.6. Primary Investigator CAPA Plan Procedures

5.5.6.1. The PI will have 30 days from submission of the QA/QI Routine Review Summary Letter to submit a response to the CAPA Plan.

5.5.6.2. In the event the PI requires more than 30 days to develop, document, and submit the CAPA Plan, or has questions or concerns regarding the process, the PI or coordinator must contact the QI and Education Specialist.

5.5.6.3. If the CAPA Plan is not received by the given deadline, the QI and Education Specialist will send an email reminder to the PI.

5.5.6.4. Once the responses to CAPA Plan are received, the Corporate Manager of Research Integrity will review the responses.

5.5.6.5. If the CAPA Plan is approved, EQuIP will email a Closeout Letter.

5.5.6.6. The Closeout Letter will include a statement on future follow-up visits, if deemed necessary, to ensure adherence to the CAPA Plan.

5.5.6.7. If the CAPA Plan is not approved:

5.5.6.7.1. EQuIP will return the CAPA Plan with a cover letter.

5.5.6.7.2. The cover letter will explain the deficiencies in the response and request a revision.

5.5.6.7.3. The PI will have 2 weeks to revise and correct the CAPA plan.

5.5.6.8. The time between receipt of the CAPA Plan and Closeout Letter will depend upon request for additional information or revision of response by the PI.

5.6. Dissemination of the QA/QI Routine Review Summary and Closeout Letter:

5.6.1. Primary Investigator.

5.6.2. Corporate Manager of Research Integrity.

5.6.3. Academic Advisor and Director of Medical Education if PI is a resident or student.

5.6.4. McLaren Center for Research Innovation (MCRI) management will be notified if they have oversight over the involved MHC site.

5.6.5. QA/QI reviews are confidential and will not be submitted to the IRB unless there is evidence of serious or continuing non-compliance.

5.7. Retention of Review Documents

5.7.1. The PI's electronic audit files will be stored on a password-protected computer in the EQuIP offices.

5.7.2. Paper review files will be locked in a file cabinet in the EQuIP offices.

5.7.3. The audit documents will be stored for 3 years in the EQuIP offices.

6. Responsibilities

6.1. Quality Improvement (QI) and Education Specialist:

6.1.1. Responsible for conducting QA/QI Routine Reviews of MHC research studies to ensure compliance with applicable federal regulations and/or agency specific requirements, state or local laws, and institutional policies and procedures.

6.1.2. Generate written reports with results of site review and identified strengths, deficiencies, or deviations from federal regulations, local laws, institutional policies, and Good Clinical Practice.

6.2. Responsible for preparing and presenting reports to the Corporate Manager of Research Integrity and Principal Investigator (PI):

6.2.1. Responsible for the conduct and oversight of their research study, including oversight of personnel and for protecting the rights, safety, and welfare of the subjects enrolled in the research.

6.2.2. Responsible for making available study documents for review or audit and addressing concerns or deficiencies via interview and/or CAPA plan.

6.3. IRB:

6.3.1. Responsible for assuring that research studies are approved in accordance with federal, state, and local regulations as well as the HRPP policies and procedures.

6.3.2. Responsible for making available time, as well as addressing concerns or deficiencies via interview and/or CAPA plan.

6.3.3. Corporate Manager of Research Integrity

6.3.3.1. Responsible for developing, managing, and evaluating policies and procedures that ensure compliance with all state and federal regulations governing research.

6.3.3.2. Responsible for developing and implementing needed improvements and ensuring follow-up of actions, as appropriate, for the purpose of managing risk in the research program.

6.3.3.3. Instituting corrective action plans based upon audit findings.

7. References

7.1. 45 CFR 46.109(e) IRB Review of Research

7.2. 21 CFR 56.109(f) IRB Review of Research

7.3. 21 CFR 56.108(a) IRB Functions and Operations

7.4. 45 CFR 46.103(b)(4) Assuring compliance with this policy.

7.5. OHRP Guidance on Written Procedures, January 2007

7.6. Terms of the Federalwide Assurance, #4 on written procedures

7.7. MHC_RP111_Study Suspension, Termination and Investigator Hold

7.8. MHC_RP0123_Complaints and Non-Compliance in Human Subject Research

7.9. MHC_RP0124_Reporting to Regulatory Agencies and Institutional Officials

7.10. MHC_RP0125_Investigator Responsibilities

7.11. MHC_RP301_Education and Quality Improvement Program – EQuIP

7.12. EQuIP Compliance Worksheets

8. Previous Revisions: 11/28/21, 1/20/23

9. Supersedes Policy: None

10. Approvals:

Signature on File *3/22/2024*

_____ _____

Justin Klamerus, MD, MMM Date
Executive Vice President/ Chief Clinical Officer
Institutional Official of Research