1. PURPOSE

The purpose of this document is to define the process by which the office of Research Compliance and Quality Assurance (RCQA) conducts Quality Reviews of human subject research at the University of Miami. These reviews are intended to assess the research team’s level of compliance with Federal and State regulations and guidelines, and University policies and procedures, as well as to provide guidance and recommendations for good research practices.

2. DEFINITIONS

CAPA – Corrective and Preventative Action
CRF – Case Report Form
CRORS – Clinical Research Operations and Regulatory Support
CTO – Clinical Trials Office at JHS
DSMC – Data Safety Monitoring Committee at the SCCC
eProst – Electronic Protocol Submission and Tracking
FDA – Food and Drug Administration
HIPAA – Health Insurance Portability and Accountability Act
HSRO – Human Subjects Research Office
ICH-GCP- International Conference on Harmonization Guidelines for Good Clinical Practice
IDE – Investigational Device Exemption
IND – Investigational New Drug (Application)
IO – Institutional Official
IRB – Institutional Review Board
IRB-8 - Electronic protocol submission and tracking system to replace eProst
JHS – Jackson Health System
NIH – National Institutes of Health
OHRP – Office for Human Research Protections
PI – Principal Investigator
PRC – Protocol Review Committee
QA – Quality Assurance
QA Auditor- A member of RCQA that performs Quality Reviews
RCQA – Research Compliance and Quality Assurance
SCCC – Sylvester Comprehensive Cancer Center
UM - University of Miami
University – University of Miami
Velos – Clinical Trial Management System
3. **RESPONSIBILITY**

### 3.1 Institutional Official (IO)
- Authorizes and may request Quality Reviews of human subject research protocols
- Receives notification of Quality Reviews to be scheduled
- Receives copies of Quality Review reports
- Receives notification of potentially serious non-compliance issues

### 3.2 Sylvester Comprehensive Cancer Center (SCCC)
- Provides RCQA with an annual list of studies to be reviewed at SCCC
- Receives Quality Review reports and PI CAPA Plans from RCQA

### 3.3 Human Subjects Research Office (HSRO)
- Receives Quality Review reports and PI CAPA Plans and distributes them to the appropriate IRB committee
- Notifies RCQA of required follow-up actions requested by the IRBs
- Notifies RCQA of Quality Review closures and IRB determination letters

### 3.4 Institutional Review Boards (IRBs)
- May request a Quality Review of a human subject research protocol
- Receives and reviews Quality Review reports and PI CAPA Plans
- Determines the need for additional required follow-up actions

### 3.5 QA Function of RCQA
- Reports to the Vice Provost for Research
- Assigns QA Auditors to conduct Quality Reviews
- Notifies investigators of planned Quality Reviews and schedules Quality Reviews
- Performs Quality Reviews
- Issues Quality Review reports and facility observation reports

### 3.6 Principal Investigator (PI)
- Schedules Quality Review with RCQA QA Auditor
- Is available for meetings during the Quality Review
- Provides all study-related documents
- Allows study staff to be available to answer questions
- Responds to Quality Review observations
4. QUALITY REVIEW PROCESS

4.1 Quality Review Assignment

RCQA and the IO prioritize the schedule of Quality Reviews based on several factors such as the expected level of risk to subjects and the University, and the availability of resources. Directed Quality Reviews have priority over previously scheduled routine reviews.

4.2 Quality Review Notification

4.2.1 Notify the IO

The RCQA Executive Director or QA Manager will notify the IO of a Quality Review to be scheduled.

4.2.2 Notify the PI

The QA auditor will email a Quality Review Notification Memo to the PI of the selected study and copy the following leadership personnel:

- Departmental Chairperson, Division Chief and/or Center Director (if applicable)
- IO
- CRORS Director or designee (if study is monitored by CRORS)
- RCQA Executive Director and QA Manager
- For audits at the SCCC, include the SCCC central email address: scccrcqa@miami.edu
- For Quality Reviews at Bascom Palmer Eye Institute (BPEI), include the BPEI Vice Chair and Director Clinical Research Services

- The following documents will be attached to this notification email:
  - Essential Documents for Quality Review
  - Quality Review Flowchart
  - RCQA Review Categories

- The Quality Review will be scheduled for three days; however, less time may be needed if subject enrollment is low.

4.2.2.1 Focused Quality Reviews

- Notify the PI as stated in step 4.2.1
- Attach the Quality Review Flowchart to the email notification
- The Quality Review will be scheduled for one day
4.2.3 Request for IRB Minutes

The QA Auditor will send a request for IRB minutes regarding the study to be reviewed to the Associate Director, Regulatory Affairs at the HSRO.

4.2.4 Notify JHS CTO

If the study to be reviewed is also conducted at JHS and/or includes JHS patients, the QA Auditor will email the JHS Quality Review Notification memo to the JHS CTO, stating the scheduled review dates.

4.3 Quality Review Preparation

4.3.1 To prepare for the Quality Review, the QA Auditor will review the study documentation found in eProst, IRB-8 and Velos systems, prior to conducting the Quality Review.

4.3.2 The QA Auditor should also review the grant information to ensure that the protocol submitted to the IRB corresponds to the grant.

4.4 Initial Meeting with PI and Study Team

The QA Auditor will conduct an initial meeting with the PI and study team at the beginning of the Quality Review to discuss the scope of the review, the process, and what to expect from the auditors. The PI will be asked to describe the protocol, and the roles and responsibilities of the team during the conduct of the study.
4.5 Quality Review Conduct

4.5.1 The standards used to conduct Quality Reviews of human subject protocols will include:

- Applicable Federal and State regulations (FDA, OHRP, NIH, HIPAA, etc.)
- ICH-Guidelines for Good Clinical Practice
- University of Miami Policies and Procedures
- External IRB Policies and Procedures (if applicable)
- Research Site-specific Standard Operating Procedures

4.5.2 Quality Reviews will consist of the following, at a minimum:

Note: Focused Quality Reviews will focus on a particular topic such as informed consent where only related documentation will be reviewed

- Review of 100% of all consent documentation, up to a maximum of 50 signed consent forms.
  - For studies with high enrollment (> 50 subjects), a percentage of the consent forms may be selected by the auditor in conjunction with the RCQA Executive Director and QA Manager.
  - Confirm that all eight required elements of consent are included in the consent form. Verify that the six additional elements are included, as applicable.
  - Verify that the ClinicalTrials.gov statement is included verbatim, where applicable.
- Confirm the number of study subjects.
- Review of correspondence records and meeting minutes for IRB, PRC, DSMC, etc., where applicable.
- Review of regulatory/Trial Master File documentation.
- Review of protocol training and human subject research training records for all key study staff.
- Records of receipt, storage, usage, and return of investigational product, if applicable.
- Review of other study-related materials, equipment and/or documentation will be done at the discretion of the QA Auditor.
- A review of subject records:
  - A sampling of subject records to be reviewed will be determined by \((\sqrt{n})_{+1}\), where n is the total number of subjects that started study
procedures (except screen failures); or 5 subject records, whichever is the larger number of subject records.
- This review will include protocol compliance, verification of source data against data entered in CRFs or electronic data capture systems, regulatory compliance, serious adverse events, adverse events, and unanticipated problems, etc. as outlined in the Quality Review report template.
- For studies where University faculty members are holding an IND or IDE; compliance with sponsor responsibilities in addition to PI responsibilities will be reviewed and assessed.

4.5.3 The QA Auditor may also conduct interviews of current or past study staff.

4.5.4 During the course of the Quality Review, the QA Auditor will notify the RCQA Executive Director of any issues that may jeopardize the safety and welfare of human subjects or data integrity. The Executive Director will then immediately notify the IO, the Executive Director for Human Subject Research, and the office of Research and Research Education, as applicable.

4.6 PI Debriefing

At the conclusion of the onsite Quality Review, the QA Auditor will review the main observations with the PI and study team at a debrief meeting.

4.7 HSRO Debriefing

If observations relating to the review and approval of research are identified, the QA Auditor will summarize the observation in an email to the Executive Director for Human Subject Research and schedule a debrief meeting. The following will be copied on this email:

- RCQA Executive Director
- QA Manager
- CAPA Manager
4.8 Quality Review Report

4.8.1 Observations will be reported in a standardized format as defined in SOP RCQA-402.

4.8.2 RCQA will aim to issue a Draft Quality Review Report within 10 working days of the completion of a full Quality Review and within 5 working days for focused Quality Reviews. If additional time is needed, it will be discussed with the RCQA Executive Director and QA Manager and will be documented in the RCQA database.

4.8.3 The Draft Quality Review Report will be reviewed within RCQA prior to issuance.

4.8.4 The Draft Quality Review Report will be issued to the PI and main study team members via email with instructions to review it for factual content.

4.9 Exit Meeting

4.9.1 The QA Auditor will aim to schedule an exit meeting with the PI and study team within three working days of issuing the draft report to review the draft report for accuracy and to clarify any issues.

4.9.2 Based on discussions at the exit meeting, the QA Auditor will finalize the Quality Review report and issue the Final Report as per SOP RCQA-403.

Note: Observations regarding the review and approval of research will be reported to the IRB and HSRO via a separate Quality Review report. Refer to SOP RCQA-403.

4.10 Quality Review Response (CAPA Plan)

4.10.1 The PI will be given ten working days to provide responses to the Quality Review observations using the PI CAPA Plan form.

4.10.1.1 Additional time to provide responses may be granted to the PI, if requested. Additional time must be approved by the RCQA Executive Director and CAPA Manager.

4.10.1.2 The CAPA Manager will offer assistance to the PI in the creation of the CAPA Plan.
4.10.1.3 The CAPA Manager will review the PI’s draft CAPA Plan and provide feedback to the PI in order to obtain responses that are specific and measurable.

4.10.2 After ten working days, RCQA should receive the PI’s final CAPA Plan. The Quality Review Report and CAPA Plan will be submitted to the HSRO via email and leadership personnel will be copied on the email as per SOP RCQA-403.

4.11 Post Quality Review Customer Satisfaction Survey

After the issuance of the Final Quality Review Report, the QA Auditor will email the RCQA administrative assistant and request that a customer satisfaction survey be sent to the PI and study team.

4.12 IRB Determination Letter

The IRB will review the Final Quality Review Report and PI CAPA Plan and issue an IRB determination letter. This letter will notify RCQA and the IO if a follow up Quality Review is requested by the IRB, or if this Quality Review is considered closed. If the Quality Review did not identify any observations, an IRB determination letter will not be issued.

5. DOCUMENTATION

RCQA will maintain a copy of the Final Quality Review Report, PI CAPA Plan, and any correspondence concerning the report in the RCQA central file for a minimum of ten years.

6. REFERENCES

- SOP RCQA-402: Quality Review Report Generation
- SOP RCQA-403: Issuing and Maintaining Quality Review Reports

7. TEMPLATES / FORMS / TOOLS

These templates and forms can be found on the shared RCQA Box drive: S:/RCQA/Auditing/Auditing Forms/Audit Email Templates & Memos

- PI Quality Review Notification Memo
- JHS Quality Review Notification
- Draft Quality Review Report Submission Memo
The following templates and forms can be found on the shared RCQA Box drive: S:/RCQA/Auditing/Auditing Forms/Current Templates & Forms

- Essential Documents for Quality Review
- Quality Review Flowchart
- Review Categories
- Quality Review Report Template
- PI CAPA Plan Template

### 8. REVISION HISTORY

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Revision Date</th>
<th>Author</th>
<th>Description of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Apr 05</td>
<td>30 Mar 05</td>
<td>G. Lapinski</td>
<td>Name of office from ORC to RCA; Deletion of text “according to the HSRO Standard Operating Procedures Request to Access Protocol Files dated 26 Dec 2002” in section 4.3; Reports for investigators in the Department of Medicine; Deleted reference to HSRO Standard Operating Procedures Request to Access Protocol Files dated 26 Dec 2002 in section 6; Updated flow sheet attachment.</td>
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<tr>
<td>25 Oct 06</td>
<td>25 Oct 06</td>
<td>K. Roach</td>
<td>Name of Vice Provost for Research changed to Richard Bookman, PhD. Procedure to request directed audit clarified in section 4.1, last paragraph.</td>
</tr>
<tr>
<td>16 Jun 08</td>
<td>16 Jun 08</td>
<td>L. Smith</td>
<td>Name of office from RCA to ORCA, scope of policy to include directed audits of SCCC protocol, and new language in section 4.5 allowing ORCA to report findings to HSRO prior to scheduled distribution when warranted by findings.</td>
</tr>
<tr>
<td>05 Nov 09</td>
<td>21 Oct 09</td>
<td>J. Stamates</td>
<td>Section 4.2: addition of VP for research and JHS CTO Section 4.3.: addition of eProst Section 4.4: review details added; number of subjects for close review determined to be 5 Addition of Associate Director Attachment: Revised Flow Sheet</td>
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<tr>
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<td>Description of Changes</td>
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<tr>
<td>01 Aug 10</td>
<td>02 Feb 10</td>
<td>S. Mackey</td>
<td>Section 2: added definitions</td>
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<td></td>
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<td>Section 4.5: added facility finding requirements</td>
</tr>
<tr>
<td>19 Oct 10</td>
<td>08 Oct 10</td>
<td>H. Miletic</td>
<td>Changed numbering format of document and added version number 01. Minor changes to text throughout. Updated references. Changed approval signature from Vice Provost for Research to ORCA Associate Director. Moved revision history to end of document. Added author signature.</td>
</tr>
<tr>
<td>10 Mar 11</td>
<td>10 Mar 11</td>
<td>H. Miletic</td>
<td>Revised the version number and effective date in the header. Added the Dean of the respective school to the list of individuals who will receive audit notifications and audit reports in sections 4.2 and 4.5. The ORCA Associate Director was removed throughout the document.</td>
</tr>
<tr>
<td>08 Jun 12</td>
<td>01 Jun 12</td>
<td>H. Miletic</td>
<td>Changed the name of the department from Office of Research Compliance Assessment (ORCA) to Regulatory Support and Quality Assurance (RSQA) throughout the document. Revised the Purpose section such that routine audits requested by the SCCC DSMC are conducted according to this SOP. Changed Compliance Officer to QA Auditor throughout the document. Added the Institutional Official (IO) and removed the OR and Research Administration Office from section 3. Added focused, follow-up, and investigator-requested audits to section 4.1. Changed the hotline number to CaneWatch in section 4.1. Changed the Vice Provost for Research to the IO throughout the document. Changed section 4.4 to remove the requirement for the PI to sign a Conflict of Interest Statement. Changed section 4.5 to state that PIs and facilities have 10 working days to respond to audit findings. Modified section 4.6.3 to state that Facility Findings reports will be sent to the facility and leadership will be copied on the email. Removed the attachment. Deleted the JMH Referral Form from sections 4.6 and 7. Added forms to section 7 and additional references to section 6.</td>
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### Description of Changes

<table>
<thead>
<tr>
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<tr>
<td>26 Aug 13</td>
<td>21 Aug 13</td>
<td>H. Miletic</td>
<td>Reformatted the entire document. Updated the ORCA Director to the RSQA Executive Director. Changed CRRC to ORA in sections 2, 4.6 and 7. Updated section 3.5 to state that QA and Compliance function of RSQA reports to Vice Provost for Research. Removed the requirement to specify a date range for the audit in the PI notification in section 4.2.1. Replaced QA Director with QA Manager in sections 4.2.1 and 4.2.3. Modified section 4.2.3 to state that RSQA Executive Director or QA Manager will notify IO of audits to be scheduled. Changed section 4.4.2 to state that audits will generally be scheduled for 3 to 5 days. Modified sections 4.5.4, 4.5.6 and 4.5.6.1 to refer to SOP RSQA-403. Added the Chief Medical Compliance Officer and Assistant VP, Research Support Operations to section 4.6.1. Removed QA Director and Senior Associate Dean for Clinical Research throughout document. Updated section 7 to reflect location of templates and forms.</td>
</tr>
<tr>
<td>25 Aug 2014</td>
<td></td>
<td>H. Miletic</td>
<td>Changed the name of the office from Regulatory Support and Quality Assurance (RSQA) to Research Compliance and Quality Assurance (RCQA) throughout the document. Added IRB-7 to sections 2 and 4.3. A request for IRB minutes was added to section 4.2.2. Updated section 4.4.3 to include a review of the required elements in the ICF. Updated section 4.5.5 and 4.5.6 to state that RCQA will offer assistance to the PI to create a complete audit response and that RCQA Executive Director will review responses prior to sending to IRB. Modified section 4.5.6.1 to state that the audit report and responses will be sent to both the DSMC and HSRO simultaneously for DSMC-requested audits. Removed the Chief Medical Compliance Officer from section 4.6.1. Updated section 5 to state that audit reports, PI responses, etc. will be kept for a minimum of ten years.</td>
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<td>Description of Changes</td>
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<td>Updated section 6 to remove the document retention policy. Modified the revision history table.</td>
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</tr>
<tr>
<td>13 Feb 2015</td>
<td>H. Miletic</td>
<td>Revised section 4.2 to include notifying the CTD Compliance Officer of all audits of investigator-initiated trials. Updated section 4.4.3 to include verification of CTD statement.</td>
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</tr>
<tr>
<td>17 Feb 2016</td>
<td>H. Miletic</td>
<td>Updated section 3.2 to remove the statement saying that the DSMC will notify the HSRO of audit findings. Updated section 4.2.1 to remove the Provost from the list of leadership personnel. Added the SCCC central email to section 4.2.1. Updated section 4.5.6.1 to refer to SOP RCQA-403. Deleted 4.2.4 requiring a separate notification to SCCC. Added section 4.8 to state that post audit survey will be sent to PI and study team. Minor modifications made to text throughout document.</td>
<td></td>
</tr>
<tr>
<td>19 Feb 2016</td>
<td>H. Miletic</td>
<td>Added the CEO of UHealth and Senior Vice President of Health Affairs to section 4.2.1.</td>
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</tr>
<tr>
<td>19 Apr 2017</td>
<td>H. Miletic</td>
<td>Removed the notification of the CTD Manager in section 4.2. Added Center Director, Chief Compliance Officer of Medical School, CRORS, BPEI Vice Chair and BPEI central mailbox to section 4.2.1. Updated section 4.2.2 to specify who will receive the HSRO Audit Notification. Added that RCQA will aim to issue audit reports within 5 and 10 working days for focused and full audits, respectively. Sections were renumbered as the following processes were added: debriefing meeting with PI, debriefing with HSRO, and issuing a draft audit report to PI. Added the creation of a separate audit report issued to the IRB/HSRO for findings pertaining to IRB/HSRO. Deleted the section on Report of Findings to Other Parties. Minor modifications to the text were made throughout SOP.</td>
<td></td>
</tr>
</tbody>
</table>
| 23 Oct 2017   | H. Miletic        | Modified section 4.2.1 to remove the following leadership personnel from the initial audit notification, as per their request: Dean of medical school, Chief Compliance Officer, and CEO of UHealth. Added a step to include the Audit Flowchart and Review Categories documents to the initial PI Audit Notification. Updated section 4.5.2 to reduce the number of ICFs reviewed to a maximum of 50 and modified the text to clarify that only a sampling of subject records will
be reviewed. Added Audit Flowchart and Review Categories documents to section 7.

30 Mar 2018  H. Miletic  Changed the term “audits” to “Quality Reviews” throughout the document and title of the SOP. “Audit responses” was changed to “CAPA Plan” throughout the document. Removed the Dean and Executive Dean for Research from section 4.2.1. Added the Essential Documents for Quality Review document to sections 4.2.1 and 7. Replaced HSRO personnel with the HSRO mailbox in section 4.2.2. Minor edits were made throughout.

02 Apr 2019  H. Miletic  Removed Audit and Advisory Services from section 2. Modified section 4.2 to add the Director Clinical research Services and remove the BPEI mailbox when notifying the PI. Step 4.2.2.1 was added for Focused Quality Reviews. Steps within section 4.2 were renumbered. Removed the HSRO notification and the Quality.Determination@miami.edu mailbox in step 4.2.3. Changed the Associate Vice Provost for Human Subject Research to the Executive Director for Human Subject Research, throughout the SOP. Updated step 4.3 to remove reference to studies initiated prior to 2008. Clarified step 4.5.2 regarding focused reviews and the calculation for sampling of subjects. Updated step 4.7 to notify the Executive Director for Human Subject Research of IRB observations. Updated step 4.12 to clarify that an IRB determination letter will not be issued if no observations were identified. Removed the HSRO Quality Review Notification from section 7. Minor revisions to text were made throughout.

9. SIGNATURES

Signature on file  
Prepared by: ________________________________  Date: ____________
Helen Miletic, MA, CHRC, RQAP-GCP
Director, GxP Compliance, RCQA

Signature on file  
Approved by: ________________________________  Date: ____________
Johanna Stamates, RN, MA, CCRC, CHRC
Executive Director, RCQA