Office of Research Oversight (ORO)

Policy and Education Workgroup

Guidance for Research Compliance Officers (RCOs) and Research Review Committees (RRCs) on Reporting and Reviewing All Audit Results

1. Background

Per VHA Directive 1058.01, RCOs must report all audit results (regardless of findings) to the Research and Development Committee (R&DC) and other appropriate RRCs, whether operated by a VA medical facility or another entity. The goal of this policy provision is to facilitate the informing of RRCs with regard to exercising of their responsibilities to provide continuing oversight of the research. Even audit results with no findings provide pertinent information regarding the quality of a study team's conduct of the research and are informative for committees that are providing continuing oversight.

This document provides RCOs with guidance that will assist in updating RCO Audit Plans/Standard Operating Procedures (SOPs) specifically for reporting audit results (with and without findings) to research review committees (RRCs), including external RRCs. This document also provides RRCs with guidance on how to receive and review RCO audit results, regardless of findings. It also provides related policy and guidance references.

2. Reporting Audit Findings to RRCs

VHA Directive 1058.01 requires RCOs to report all audit results (regardless of findings) to the R&DC and other appropriate RRCs, whether operated by a VA medical facility or another entity. Such results shall be reported using processes mutually agreed upon by the RCO and RRCs. RCOs may provide audit results directly to the appropriate RRC in writing through an electronic platform account or other secure system. For information about using IRBNet/VAIRRS, *see* https://dvagov.sharepoint.com/sites/VHAORPPE/VAIRRS. This must be done within the timeframes specified in VHA Directive 1058.01 or local policy (if local timeframes are shorter than that specified in Directive 1058.01) except as described in the NOTE below. In addition to providing reports in writing, the RCO or other individual may present findings at RRC meetings, by invitation of a committee or as specified by local research committee or RCO SOPs.

Alternatively, RCOs may provide the audit results to a study Principal Investigator (PI) or the RRC coordinator or point of contact for upload to the applicable electronic platform, for example, if the RCO does not have access to that platform. When using this reporting method, the RCO must verify that the report has been submitted by the PI and received by the applicable RRC within the timeframes required by VHA Directive 1058.01 or local policies. There are pros and cons to this approach, as it provides the RCO more flexibility, but alternatively may be more labor intensive for the RCO to verify submission. RCOs are not expected to be listed on the Study Team's electronic platform account.

Regardless of which method is used, the RCO Audit Plan or RCO SOP must describe the process for submitting audit results to each RRC and verifying that the RRC received the reports, if such reports are not provided directly to the RRC by the RCO. The RCO's role, if any, in reporting to other entities should also be described in SOPs (e.g., RCO role in drafting reports to ORO). Individual RRCs may have timelines that are shorter than those in VHA Directive 1058.01; the RCO audit plan should reflect any such shorter

local timeframes. ***NOTE:*** *If the procedures of a non-VA operated committee differ from, or the timeframes exceed those of, VHA Directive 1058.01, the medical facility Director must consult with the VHA Office of Research & Development (ORD) and the appropriate ORO workgroup (as specified on ORO's website) as to the adequacy of those procedures to protect the interests of VA and those involved in VA research. Consultation with ORO and ORD should occur when requesting formal permission to rely upon the non-VA RRC, or upon learning that a non-VA RRC's SOPs have changed such that the procedures and/or timeframes no longer comport with VHA Directive 1058.01.*

Special Considerations for reporting to external Institutional Review Boards (IRBs):

VA facilities must establish a Memorandum of Understanding (MOU) or IRB Authorization/IRB Reliance Agreement with other VA facilities or external organization(s) providing IRB services. Some IRB reliance agreements are established for use nationwide with an ORD Master Service Agreement or national MOU. National agreements have been established for IRBs such as the National Cancer Institute IRB, the NIH All of Us IRB, and the Advarra, WCG-WIRB and Sterling commercial IRBs. Each facility will also have a local IRB agreement and supplemental SOP that must be available to the RCOs for each IRB.

RCOs may establish accounts within the commercial IRB platforms in order to provide audit results that are reportable under VHA Directive 1058.01 directly to the commercial IRB. Each VA medical facility has provided one or more administrative contact persons in the research program to the commercial IRB and to ORD for the IRBs for easier communication. RCOs are encouraged to work with the facility contact(s) to establish direct reporting.

For IRB reliance agreements not established nationally, RCOs should work with VA-operated IRBs, academically affiliated IRBs, other academic or Federal IRBs to discuss and establish the processes preferred by the IRB for the reporting of RCO audit results. RCOs and IRB contact(s) should specifically discuss whether different processes for reporting of audit results should be utilized depending on whether or not there are audit findings.

As noted above, VHA Directive 1058.01 provides added flexibility for reviewing and reporting requirements for situations where a VA medical facility relies upon a research review committee that is not operated by a VA entity. Any such differences approved by ORO/ORD must be described in the IRB reliance agreement and SOPs.

3. **Apparent Serious or Continuing Noncompliance and Unanticipated Problems Involving Risks to Subjects or Others (UPIRTSOs)**

Per VHA Directive 1058.01, apparent serious or continuing noncompliance or apparent UPIRTSOs identified by an RCO through the course of conducting study audits or by other means must be reported to the appropriate RRC within 5 business days of becoming aware of such apparent noncompliance or apparent UPIRTSO. However, prior to concluding that an audit result or other event represents apparent serious or continuing noncompliance or apparent UPIRTSO (that then must be reported as such to the appropriate RRC(s)), an RCO should exercise due diligence to ensure that there is a reasonable basis upon which to conclude that the result or event in question represents apparent serious or continuing noncompliance with applicable research requirements or an apparent UPIRTSO as defined in VHA Directive 1058.01. In some cases, such due diligence may involve consulting with the research team or RRC to seek clarification and/or confirm the results. For example, if while conducting a

review of a study file the RCO identifies that an informed consent document (ICD) is not in the file, rather than quickly concluding that informed consent was not obtained and notifying the IRB that apparent serious noncompliance has occurred (i.e., failure to obtain required informed consent), the RCO should first reach out to the study team for an explanation (e.g., an incomplete file was inadvertently provided to the RCO or the ICD was misfiled) and to ascertain whether the missing ICD can readily be provided.

4. Other Events Reportable Under VHA Directive 1058.01

VHA Directive 1058.01 also requires the reporting of any apparent serious accident, injury, illness or exposure of a human (not involving a death) that may be the result of working with, caring for, or having other contact with research animals or otherwise may be the result of a research activity (1) in a VA research laboratory or dedicated VA research area (e.g., research specimen storage area), (2) in a research laboratory or dedicated research area owned or operated by a non-VA entity, or (3) that requires research laboratory safety events to be reported under applicable federal requirements, including Occupational Safety and Health Administration (OSHA) and relevant VHA policy requirements. (VHA Directive 1058.01 §9.b. & §10.b). Please consult VHA Directive 1058.01 for details on these reporting requirements.

5. Documentation of Reporting Audit Results to RRCs

There must be documentation that the RRC members were made aware of RCO audit results (including the result that no findings of noncompliance were identified during the study audit). Although the RRC members would not necessarily need to review the RCO's audit report for an audit that did not have any findings or had findings that are not required to be reported within a specified timeframe under VHA Directive 1058.01, the RRC members would need to be informed of the audit result.

When the subcommittee coordinator gets an email notification that the RCO has uploaded audit results into VAIRRS, this notification may not reveal the nature of the audit results. Further, even if the notification provided the nature of the audit results to the coordinator, but not the RRC members, such a process would not meet the requirement of VHA Directive 1058.01 that such results be provided to the RRC - the coordinator is not the committee. The audit results need to be provided to the committee members and this should be documented in some way. The timeframe and process for reporting audit results with no findings or findings not required to be reported within a specified timeframe by VHA policy should be described in local SOPs, as agreed upon with the RRC.

For audit results with findings that are required to be reported within a specified timeframe under VHA Directive 1058.01, the audit results should be placed on the agenda for review at the next convened meeting of the RRC, but no later than 30 days after the notification of the audit results.

For audits that did not have any findings or had findings that are not required to be reported within a specified timeframe under VHA Directive 1058.01, reporting could be accomplished in a variety of ways; for example, the RCO or the chair or coordinator could make an announcement at a meeting indicating the study protocol title(s) audited and that there were no findings. ORO suggests that audit reports/summaries be included as action items on the meeting agenda and documented in committee minutes. Another option is listing the completed audits in the meeting minutes or agenda or as an attachment prepared by the RCO so as not to burden the committee coordinator. RCOs who identify an

issue that is not immediately reportable nor apparent serious and/or continuing noncompliance, but in their opinion requires review by the RRC, will submit the report with a request for review of the specific issue.

6. Review of Audit Results Reported to RRCs

For audit results with findings that are required to be reported within a specified timeframe under VHA Directive 1058.01, the audit results must be reviewed at the next convened meeting of the RRC, but no later than 30 days after the notification of the audit results. The RRC then has 60 calendar days to determine whether or not serious or continuing noncompliance actually occurred, or whether an actual systemic deficiency exists that could substantially compromise the VA medical facility's research protection programs or information security processes, or whether or not an animal research event reportable to NIH-OLAW involving VA research has occurred, as applicable; and, if so, what, if any, actions are needed to remediate present noncompliance or prevent future noncompliance; or for systemic deficiencies what, if any, remedial actions are needed to ensure the effectiveness of research protection programs or information security processes; or, for animal research events reportable to NIH-OLAW, what, if any, protocol or programmatic changes are warranted. See VHA Directive 1058.01 and https://www.va.gov/ORO/Docs/Guidance/Reporting_of_Systemic_Deficiencies_and_Noncompliance_in_VA_Research.pdf for more details. The RRC has 30 calendar days to determine whether or not unanticipated problems or accident, injury, illness or exposure in VA research occurred. See Reporting_Human_Deaths_Unanticipated_Problems_and_Accident_Injury_Illness_and_Exposure_in_VA_Research.pdf for more details.

For audits results with no findings, or with findings that are not required to be reported within a specified timeframe under VHA Directive 1058.01, as noted above, the individual RRC members would not necessarily need to review such RCO audit results, but members must be informed that audits on particular protocols revealed no findings or be informed of any findings that are not required to be reported within a specified timeframe under VHA Directive 1058.01.

The timeframe and process for reporting audit results with no findings or findings not required to be reported within a specified timeframe by VHA policy must be described in RCO SOPs, as agreed upon with the RRC. Most commercial IRBs will accept a summary of audit reports with no findings (or those findings not required to be reported within a specified timeframe by VHA policy). Regardless of which procedures are used, timeframes and processes for reporting to each research review committee must be described in the RCO audit plan.

References

VHA Directive 1058.01 §5.g.(2). "Each VA medical facility Director whose VA medical facility has a research program is responsible for: … Ensuring that documents (e.g., standard operating procedures (SOPs) or memoranda of understanding (MOUs)) establishing the role of a non-VA operated research review committee in the oversight of a VA medical facility's research address the non-VA operated committee's procedures for the review and reporting (including to VA medical facility personnel) of events described in this directive, including timeframes. If the procedures of the non-VA operated committee differ from, or the timeframes exceed those of, this Directive, the Director must consult with the VHA Office of Research & Development (ORD) and the appropriate ORO workgroup (as specified on ORO's website) as to the adequacy of those procedures to protect the interests of VA and those involved

in VA research. ***NOTE:*** *In the event that a non-VA operated research review committee is unable or unwilling to review an event required to be reviewed under this directive, the VA medical facility's R&DC will either review the event or designate another applicable VA research review committee to review the event as would otherwise occur if the event were subject to review by a VA-operated research review committee under the requirements of this directive.*"

VHA Directive 1058.01 §5.i. "The RCO is appointed by the VA medical facility Director and is responsible for: (1) Auditing VA medical facility research projects including performing annual informed consent and triennial regulatory audits of approved study protocols and other post-approval monitoring activities as specified by ORO. RCO audits must be conducted in accordance with a written audit plan or SOP that describes the RCO's auditing process, including procedures for planning and conducting audits, procedures for soliciting study investigators' responses to preliminary audit findings and timelines for providing all audit results (**regardless of findings**) to the relevant research review committees, including the R&DC…. (2) Informing the VA medical facility Director and applicable research review committees about research compliance concerns (emphasis added)."

VHA Directive 1058.01 §7.b. "Apparent UPIRTSO in VA Non-Exempt Human Subjects Research. VA personnel must ensure written notification is provided to the appropriate IRB of Record within five (5) business days after becoming aware of an apparent UPIRTSO involving a VA non-exempt human subjects research study. ***NOTE:*** *In accordance with paragraph 3.q [of VHA Directive 1058.01], an apparent UPIRTSO is an apparent incident, experience or outcome that is: unexpected and related or possibly related to participation in the research and indicative of the research placing subjects or others at substantively greater risk of harm than was previously known or recognized. For purposes of this directive, an apparent unexpected SAE that is related or possibly related to participation in human subjects research constitutes an apparent UPIRTSO*."

VHA Directive 1058.01 §7.c. "Apparent Serious or Continuing Noncompliance Involving VA Non-Exempt Human Subjects Research. VA personnel must ensure that the appropriate IRB of Record is notified, in writing, within five (5) business days after becoming aware of any apparent serious or continuing noncompliance with applicable laws, regulations, policies, and agreements pertaining to non-exempt human subjects research. This includes, but is not limited to, serious or continuing noncompliance with the Common Rule, local VA medical facility policies and SOPs related to human subjects research, if developed, IRB-approved protocols, and the requirements or determinations of the IRB…"

For further information about which IRBs are allowed by VHA Policy, see VHA Directive 1200.05(2) §5.

Please see the RCO SOP Checklist for details of other elements to include in RCO Audit SOPs.