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3.8 **Investigators’ Input to the HSPP**
### 3.1 Policies, Procedures, and Resources Available to Investigators and Research Staff

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<th>AAHRPP Std./Element</th>
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<td>I.1.D</td>
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The Human Subjects Protection Program Office (HSPPO) has primary responsibility for ensuring the HSPP Policy Manual and related materials are available to the entire University of Louisville research community, including:

- Investigators
- Research staff
- IRB staff, HSPPO staff
- IRB members and Chairs
- Employees
- Affiliated hospital staff
- Students

The HSPPO maintains the [Human Subjects Protection Program](#) website which provides access to:

- IRB Review Lifecycle Information (Before you begin, Initial Submission, Continuation Review, Event Reporting, and Study Closure);
- The HRPP Policy Manual;
- [About the IRB](#): A list of the current Chairs and Vice Chairs for the two University of Louisville IRBs; IRB Membership Rosters (and Past Rosters, as required by sponsors); current FWA for the University and its’ affiliated HRPP components;
- Information for Research participants;
- Links to pertinent governmental regulations and guidelines;
- Links to University of Louisville policies (including the [University of Louisville Research Handbook](#));
- Guidance on various topics such as special protections for vulnerable populations;
- Access to the electronic IRB submission system along with instructions and information on how to apply;
- Human subject determination information and forms to assist investigators in identifying which protocols involve human subject research requiring IRB review. For example, the following might not be research under 45 CFR 46, or 21 CFR 50, 56: QA/QI, pilot projects, research practicum, case studies (up to 5 individuals), and oral histories. See Guide 025 - Is My Project “Research”?
- News and Announcement alerts highlighting the posting of new information or changes in existing policies and procedures;
- IRB member and investigator educational presentations.

The IRB staff is readily available by telephone and in-person meetings to assist investigators and research staff on human subject research matters, particularly IRB applications and review questions.

IRB member and staff education is provided at most convened IRB meetings. At the beginning of the meeting the IRB staff provides a brief educational presentation on a specific topic, policy or procedures governing human subject research. Most education presentations are available to all IRB members on the Human Subjects Protection Program website.
The IRB staff regularly gives presentations, often to large research groups, and accepts invitations to attend classes and departmental meetings to provide information and guidance to the University of Louisville research community on IRB policies and procedures governing human subject research.

Within the HSPPO, the IRB staff is responsible for identifying new information involving human research participant protection such as new organizational policies, or emerging ethical and scientific issues. Information about new or modified laws might also be identified by legal counsel. New information is posted on the Human Subjects Protection Program website and is disseminated to the IRB staff, IRB members and the University of Louisville research community via other distribution sources as noted above.

3.2 Investigator Conflicts of Interest (COI)

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<td>I.6.B</td>
<td>The University of Louisville has and follows written policies and procedures to identify, manage, and minimize or eliminate individual financial conflicts of interest of Researchers and Research Staff that could influence the conduct of the research or the integrity of the Human Research Protection Program. The Organization works with the Institutional Review Board in ensuring that financial conflicts of interest are managed and minimized or eliminated, when appropriate.</td>
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**Covered Individual** shall mean all University employees. It also includes other individuals with responsibility for the design, performance, or reporting of Institution research, regardless of pay or enrollment status. It also includes individuals conducting research at the University of Louisville, or using University of Louisville researchers, or using University of Louisville facilities or resources.

**Individual Conflict of Interest Policies**

Covered individuals at the University of Louisville must comply with Board of Trustees Policy: Individual Conflict of Interest and all applicable federal and state laws and contractual terms related to conflict of interest. This procedure covers academic, business, clinical and research and scholarly activities conducted under the auspices of and / or for the benefit of the University of Louisville.

The University of Louisville has the following policies regarding individual conflict of interest:

- **Individual Conflict of Interest Policy** – Board of Trustees
- **Addressing Potential Individual Conflict of Interest Policy** – COI Office
- **Guidelines for External Activities** – Red Book Sec. 4.3.3 – Faculty Work Outside the University
- **Guidelines for External Activities** – HR Policy PER 1.12 – Staff Work Outside the University
- **Guidelines for External Activities** – Red Book Sec. 5.6 – Staff Work Outside the University
- **Commitment of Effort** – Red Book Sec. 4.3.1 - Annual Work Plan and Presence at the University

**Disclosure of Financial Interests**

Covered individuals must disclose on an annual basis all financial relationships that reasonably appear to be related to their institutional responsibilities. This is done through University of Louisville’s Attestation and Disclosure Form (ADF). In addition, as faculty enter into changed or new financial relationships related to their institutional responsibilities, they can access their ADF to update previously reported activities or financial relationships, or to enter new activities.

Disclosure must be made by each investigator for him or herself and his or her immediate family. “Immediate family” means the investigator’s spouse or domestic partner and dependent children (as defined by the IRS).
Before a study application can be submitted to the IRB, the PI, faculty listed on the protocol, and any others identified as presenting a potential conflict of interest must complete and submit an Attestation and Disclosure Form.

Potential conflict disclosure in the informed consent process may be an important part of the management strategy, but will not necessarily be the only strategy used. It is the responsibility of the Conflict of Interest Office, in conjunction with the Conflict Review Board (CRB) to determine what strategy or strategies are appropriate to eliminate, mitigate, or manage conflict that has the potential to harm subjects or compromise the objectivity of the research, or are likely to be perceived as having that potential.

### 3.3 Role of the IRB

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#### Review of potential conflicts of interest with initial approval

When a potential conflict of interest has been identified, the IRB communicates closely with the appropriate COI point of contact and the investigator throughout the protocol review process. When appropriate, a plan or strategy to adequately eliminate, mitigate, or manage the conflict must be determined by the Conflict of Interest Program, in conjunction with the Conflict Review Board and accepted by the IRB. The IRB has the final authority to decide whether the potential conflict of interest and its management, if any, allows the research to be approved.

- When there are non-substantive outstanding COI matters, a protocol may be approved contingent upon the matters being resolved (e.g., requiring that the investigator modify the informed consent document to include verbatim language).
- When there are substantive outstanding COI matters, a protocol will either be tabled or precluded from possible approval until matters are resolved.

Only when COI matters are completely resolved is the study Final Approval Letter generated.

#### Review of conflicts of interest disclosed after IRB approval of research

When a potential conflict of interest arises and the investigator discloses it after the IRB has reviewed and approved a protocol, the investigator should immediately notify the IRB of the potential conflict and notify the IRB that enrollment and protocol procedures will stop until the conflict of interest has been reviewed and resolved by the Conflict Review Board as described above. The determination by the CRB is forwarded to the IRB.

When a known potential conflict of interest is discovered after the IRB review and approval, the IRB will ask the PI to file a conflict of interest disclosure as described above, and may, among other possible actions, ask the investigator to disclose the relationship to research participants. The IRB will assess whether any action should be taken in accordance with Non-Compliance with HRPP Requirements in Chapter 3.7.

#### Recordkeeping

Records on all disclosures of financial interests and all decisions to manage, reduce, or eliminate conflicts of interest are maintained within the iRIS electronic submission system. This information will be made available to DHHS upon request, while maintaining the confidentiality of all records of financial interest.
3.4 Institutional Conflict of Interest

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The University of Louisville has the following policies regarding institutional conflict of interest:

- Institutional Conflict of Interest Policy – Board of Trustees
- Addressing Potential Institutional Conflict of Interest Policy – COI Office

An institutional conflict of interest (ICOI) is created if an investigator at University of Louisville undertakes human subjects research on a drug, device, biologic or other item on which University of Louisville has a patent, has licensed the intellectual property, or receives royalties or other fees.

All new human subjects research protocols submitted for IRB review must indicate the source(s) of all funding to be used in supporting the research, including unrestricted school, department or individual accounts, as well as the name of the manufacturer when applicable. In addition, the investigators are required to answer questions about the relationship of their research to their administrative duties. When a protocol lists a manufacturer, or when other information indicates a potential conflict, the issues are handled as outlined in Addressing Potential Institutional Conflict of Interest Policy.

Decisions are communicated to the IRB, to the relevant offices within the University, and to the relevant dean or associate dean so that the recommendations can be implemented at the level of the individual schools as appropriate.

3.5 Non-Compliance

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<td>I.5.D</td>
<td>The University of Louisville has and follows written policies and procedures for addressing allegations and findings of non-compliance with Human Research Protection Program requirements, and works with the Institutional Review Board, when appropriate, to ensure that participants are protected when non-compliance occurs. Such policies and procedures include reporting these actions, when appropriate.</td>
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Any situation of perceived or actual serious or continuing non-compliance jeopardizes the University of Louisville commitment to human subject research protection. Receiving information about possible non-compliance is essential for accountability and education purposes, correcting non-compliance, deterring it from occurring again, and attempting to mitigate any adverse effects on research participants.

Definitions and Examples

**Allegation of non-compliance**: A report of non-compliance that represents an unproven assertion.
Continuing non-compliance: A pattern of non-compliance that indicates a deficiency likely to result in further non-compliance (e.g., a pattern that indicates lack of attention to or knowledge or understanding about regulations or ethics) or a circumstance in which an investigator fails to cooperate with investigating or correcting non-compliance. Continuing non-compliance includes repeated failures to complete the continuation review process prior to study expiration.

Finding of non-compliance: Non-compliance that is true, or an allegation of non-compliance that is determined to be true based on a preponderance of the evidence.

Non-compliance: An action or activity in human subject research at variance with the approved IRB protocol, other requirements and determinations of the IRB, the HRPP Policy Manual and other applicable policies of University of Louisville or relevant state or federal laws. Non-compliance actions may range from minor to serious, be unintentional or willful, and may occur once or several times. The degree of non-compliance is evaluated on a case-by-case basis and will take into account whether subjects were harmed or placed at an increased risk and willfulness of the non-compliance.

Examples of non-compliance include, but are not limited to:

1. Failure to obtain IRB approval;
2. Inadequate or non-existent procedures for the informed consent process;
3. Inadequate supervision;
4. Failure to follow recommendations made by the IRB;
5. Failure to report adverse events or protocol changes;
6. Failure to provide ongoing progress reports prior to study expiration; or

Serious non-compliance: Non-compliance that affects the rights or welfare of human subject research participants.

Examples of serious non-compliance include, but are not limited to:

1. Conducting non-exempt research without IRB approval;
2. Enrollment of subjects that fail to meet the protocol enrollment criteria and increase subject risk; or
3. Enrollment of research subjects while study approval has lapsed; or
4. Serious protocol deviations that may place subjects at risk from the research.

Review of Allegations or Findings of Non-Compliance

Findings and allegations of non-compliance can come from a number of different sources, including investigators, members of the research team, study sponsors, regulatory bodies (OHRP, FDA), subjects and their families, institutional personnel or committees, the media, the public, or anonymous sources. Additionally, the IRB can identify non-compliance during the review of research studies.

All reports of non-compliance are initially evaluated by the Compliance Auditors. The Compliance Auditors, in conjunction with the Director or Assistant Director, HSPPO, or the IRB Chair may consult with other institutional units or committees (such as the Research Integrity Program, the Privacy Office, Institutional Compliance Office or the IBC) concerning the reported non-compliance. A report will either be designated as not requiring further action, or will be escalated for review by the Director, HSPPO, IRB Chair or to the convened IRB.

The Director or Assistant Director, HSPPO, the IRB Chair or their delegate ensures that immediate action is taken as necessary to prevent unacceptable risk to research participants.

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If the instance of non-compliance involves research conducted without prior IRB approval, the Director, HSPPO, or the IRB Chair will order all research activities to stop. The Compliance Auditors will be requested to investigate and present findings to the convened IRB.

If Non-compliance is not found
A report requires no further action if the non-compliance is:
1. A factual assertion of non-compliance (generally self-reported by the investigators);
2. Neither serious nor continuing; and
3. Addressed by the investigator through a corrective action plan to remedy the problem.

If a report of non-compliance does not require further action, the incident and corrective action plan will be documented in writing and stored in appropriate files. Findings of possible serious or continuing non-compliance are referred to the IRB for review.

Investigation of Non-compliance
The Director or Assistant Director, HSPPO or the Compliance Monitor(s) review the report of non-compliance and chooses one of the following courses of action in investigating the allegation:

- Conducts the review alone;
- Conducts the initial review in coordination with the IRB Chair;
- Delegates some of the review to IRB staff;
- Delegates all of the review to IRB staff;
- Empanels a reviewing subcommittee of the IRB;
- Requests that legal counsel provide advice and conduct the review;
- Requests that the Research Integrity Program provide advice and conduct the review;
- Requests assistance from others at University of Louisville or outside consults as necessary.

The individual(s) or subcommittee conducting the investigation may take any of the following actions necessary to determine whether allegations are true, and to determine the seriousness or number of occurrences of the actions:

- Reviewing written materials;
- Interviewing knowledgeable sources;
- Collecting relevant documentation.

During the fact-finding process, the Director, HSPPO, an IRB Chair or delegate communicates as appropriate with the PI or representative about the progress of the review and investigation. A factual and objective written record of findings and evidence is made and stored in the appropriate files.

Allegations which, in the opinion of the Director, HSPPO, the IRB Chair and/or the Compliance Monitor(s), are supported by the preponderance of evidence are determined to be findings of non-compliance. Findings of non-compliance are assessed by the Director, HSPPO, or delegate and the IRB Chair as to whether they are either serious or continuing.

If the non-compliance is neither serious nor continuing, the Director, HSPPO, or delegate, alone or with the IRB Chair, examines whether the PI understands the non-compliance and has an adequate corrective action plan. If so, the decision and corrective action plan are documented and filed. Otherwise the report is referred to the IRB (the convened IRB, the IRB Chair, or their delegate) for review.
Non-compliance Finding for Lapse in IRB Approval
If an investigator has failed to provide continuing review information to the IRB by the required date, and the research has expired before the annual review approval has been issued by the IRB, all research activities must stop. This includes recruitment, research interventions or interactions, data sharing/reporting, data collection and analysis of identifiable data, and no new subjects may be enrolled. The investigator and study contacts (if named) will be sent a notice that the research has expired and that no human subjects activity, including enrollment or recruitment, may take place on or after the expiration date. The investigator will have 10 working days from the date of expiration to obtain continuing review approval for the research, or it will be administratively closed by the IRB and the Dean/department chair, facility, and Clinical Contracts Division (if applicable) will be notified of the non-compliance.

If the study is closed by the IRB, the investigator has five working days to contact the IRB office and request re-opening of the study. The request to the IRB must include the following information:

- the circumstances that led to the protocol closure;
- reasons why the investigator feels the research should be re-opened;
- corrective action the investigator has taken in order to avoid study expiration and closure in the future.

Once the request has been reviewed by a Research Compliance Monitor, the PI will have two working days to submit the continuing review. If the review is not submitted within two days the study will be closed permanently by the IRB.

If the request to re-open is greater than 7 days after closure, the investigator must submit a new project application via the electronic submission system for IRB review and approval. The new submission must reference the study that was closed by the IRB due to non-compliance. If applicable, the new application will also require the IRB Initial Review fee to be paid.

A lapse in approval represents serious non-compliance whether it occurs once in a single study, more than once in study, or once in more than one study conducted by the same Principal Investigator. The latter two events could also constitute continuing noncompliance. Serious and/or continuing noncompliance must be reported and is referred to the Research Compliance Monitors for determination of serious or continuing non-compliance. Such a determination may be brought before the convened IRB and reported to the Federal Office of Human Research Protections per 45 CFR 46.103(a), (b)(5) and may be reportable, if applicable, to the NIH, Department of Health and Human Services (DHHS), Food and Drug Administration (FDA) study sponsors, and other oversight agencies. In addition institutional officials may be notified. The Research Compliance Monitors may also conduct audits on lapsed research to determine if there was any study activity conducted within the lapsed period. The Research Compliance Monitors maintain a list of studies that were Closed by the IRB.

If a study was re-opened at the request of the investigator, following the process outlined above, and is allowed to lapse a second time, the Research Compliance Monitors will forward a finding of continued non-compliance to the IRB Chair or to the convened IRB. (See Possible IRB Actions for Serious or Continuing Non-Compliance).

Consequential Actions for lapse in IRB Approval
If the Principal Investigator has two or more interventional studies closed in a period of 18 months the investigator will be required to meet with an IRB Chair(s) and a Compliance Monitor to discuss the seriousness and ramifications of allowing the study to lapse. The Compliance Monitor will notify the PI and research team that they cannot submit a new study to the IRB until they meet with an IRB chair. Outcomes of these meetings will be reported to the IRB on quarterly meeting.
Safety of Subjects During a Lapse in Approval
During a lapse in approval, research activity may continue for currently enrolled subjects only if the IRB finds that it is in the best interest of individual subjects to continue participating in the research. In order for the IRB to make this determination, the principal investigator must submit to the IRB a written list of research subjects for whom stopping the research would cause harm, and the reason. An IRB Chair will review and determine who may continue in the research, and which procedures will be allowed to continue.

Serious or Continuing Non-Compliance Referred to the IRB
Non-compliance that is believed to be serious or continuing is referred for review by the convened IRB. The report with other relevant portions of the protocol is available to the reviewer(s). As a result of this review, the following actions may be taken:

- The IRB determines that additional information is needed and requests that such information be obtained before further action is taken.
- The IRB determines that non-compliance did not occur or that non-compliance occurred but was neither serious nor continuing, and either takes no action or requires or recommends an appropriate corrective action plan.
- The IRB determines that non-compliance occurred and that it was serious or continuing. The IRB:
  - Takes action appropriate to the situation
  - Follows the internal reporting procedure required in Chapter 3.6 concerning determinations of serious or continuing non-compliance.

IRB determinations and actions are recorded, and communicated as appropriate to the relevant, involved individual(s), normally including the PI. IRB determinations of serious or continuing non-compliance are reported internally and externally as described in Chapter 3.6.

Possible IRB Actions for Serious or Continuing Non-Compliance
In considering actions for serious or continuing non-compliance, the IRB seeks to:

- Correct the non-compliance;
- Deter it from occurring again (e.g., hold the relevant individuals accountable for their actions and provide education on how to comply); and
- Attempt to mitigate any adverse effects on participants.

The IRB must consider:

- Suspension or termination of the protocol.
- Notification of current participants (required when such information may relate to participants’ willingness to continue to take part in the research).
- Other possible IRB actions include but are not limited to the following:
  - Monitoring of the research
  - Monitoring of the consent process
  - Referral to other organizational entities (e.g., legal counsel, risk management, institutional official)
  - Modification of the research protocol
  - Modification of the information disclosed during the consent process
- Provision of additional information to past participants
- Requiring re-consent of current participants to continued participation
- Modification of the continuing review schedule
- Participation by research team members in additional training or education
- When appropriate, applying any corrective action to all similar protocols.

If the IRB action will affect participants in the protocol (e.g., requires withdrawal of participants), the IRB utilizes a process that takes into account the impact on their health and safety.

**Suspension or Termination of Previously Approved Research**

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<td>The IRB has and follows written policies and procedures for suspending or terminating IRB approval of research, if warranted, and for reporting these actions, when appropriate.</td>
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The University of Louisville IRB has the authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB’s requirements, or that has been associated with unexpected serious harm to subjects or others. Any suspension or termination of approval shall include a statement of the reasons for the IRB’s action, and shall be reported promptly to the investigator, appropriate institutional officials, and the department or agency head.

**Definitions:**

**Convened Meeting**: A meeting at which a majority of the members of the IRB is present, including at least one member whose primary concerns are in nonscientific areas. In order for an action to be approved, it shall receive the approval of a majority of those members present at the meeting.

**Key Personnel**: Participants in a research team who contribute in a substantive way to the scientific development or execution of a project, including the principal investigator.

**Principal Investigator**: A qualified person who directs a research project or program, may write the protocol, and oversees the scientific, technical and day-to-day management of the research. For the purpose of this policy, investigator may refer to the principal investigator, sub or co-investigator.

**Suspension**: The temporary closing of a human research project or discontinuing an investigator’s or key personnel’s privilege to conduct or to participate in the conduct of human research at the University of Louisville. The suspension may be partial in that certain activities may continue while others may stop or it may be complete in that no activity related to the human research or related to the privilege to conduct or participate in the conduct of human research may proceed. The IRB will make this determination.

**Termination**: The permanent closing of all activities related to a human research project or an investigator’s or key personnel’s privilege to conduct or to participate in the conduct of human research at the University of Louisville except the continuation of follow-up activities necessary to protect subject safety.

The Director or Assistant Director, HSPPO, the IRB Chair or their delegate ensures that immediate action is taken as necessary to prevent unacceptable risk to research participants.
Before ordering a suspension or termination of research, the convened IRB, IRB chair, HSPPO Director, or person ordering the suspension or termination must consider the effect of the suspension or termination on the rights and welfare of current participants, and consider whether procedures for withdrawal of current participants takes into account their rights and welfare such as:

a. Making arrangements for medical care outside of the research study;
b. Requiring follow-up by the current investigator;
c. Transferring responsibility for the protocol to another principal investigator;
d. Arranging for follow-up with another physician;
e. Arranging for the participant to stay on the study at another institution;
f. Informing current participants of the termination or suspension;
g. Submitting all reportable adverse events or outcomes to the IRB.

If a termination or suspension involves the withdrawal of current participants from the research, the investigator and key personnel must:

a. Respond immediately to any requests from the IRB for additional information;
b. Notify subjects that their enrollment in the study has been terminated and inform the subjects why their enrollment has been terminated. The reasons given will be those reasons determined to be appropriate by the IRB. The notice given may be oral but will also be in writing and copied to the IRB;
c. Inform the subjects of any actions the investigator and key personnel will take to ensure their safety;
d. Subjects should be requested to report any adverse events or unanticipated problems involving risks to them or others to the PI. Such reports will be reported to the IRB and others as required by the protocol and the University’s policies and procedures.

The Director, HSPPO, will inform the Executive Vice President for Research, the Principal Investigator, and key personnel of the suspension or termination determined by the IRB chair or Director, HSPP, as they occur, and by the convened IRB immediately after the meeting in which they occur.

The Director, HSPPO, will notify the PI when a human research protocol on which he/she is the PI has been suspended or terminated. If the Director, HSPPO cannot contact the investigator, the Director, HSPPO will inform the department chair, who will be responsible for taking further action to notify the PI, key personnel and participants.

Reporting of suspensions or terminations will be done in accordance with Chapter 3.6.

### 3.6 Internal and External Report of Findings

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<td>The IRB has and follows written policies and procedures for suspending or terminating IRB approval of research, if warranted, and for reporting these actions, when appropriate.</td>
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Event Reporting to the IRB
Events and information that must be reported to the IRB, along with the timelines for reporting, are listed in the Chapter 15.2 and in Guide-023 Events that Require Prompt Reporting to the IRB. They should be reported to the IRB using the appropriate online IRB Form in the electronic submission system.

Suspensions and termination of research ordered by someone other than the IRB (e.g. the study sponsor, federal agency, etc...) must be reported to the IRB within 5 working days of site awareness through the ESS. The submission should include all pertinent information related to the suspension or termination. Once received by the HSPPO office, the information will be reviewed by the IRB Chair/Vice Chair, HSPPO Director, convened IRB (when necessary), and/or specific institutional officials (as necessary).

Reportable Determinations, Distribution, and Reporting to Regulatory Agencies
If the convened IRB determines that:
• serious or continuing noncompliance has occurred as specified in Chapter 3.5; or
• an unanticipated problem involving risks to participants or others (UP) or some other reportable event has occurred as specified in Chapter 15.2; or
• suspends or terminates the approval of a protocol as specified in Chapter 3.5; then the following reporting process will be followed.

The Director or Assistant Director, HSPPO, in conjunction with the Compliance Monitors, and/or the IRB Chair, will prepare a draft report promptly after the IRB meeting at which the determination occurred.

The report will contain:

a. A summary of the event,
b. The findings of the organization,
c. Actions taken by the organization or IRB,
d. Reasons for the organization’s or IRB’s actions, and
e. Plans for continued investigation or action,
f. Project title,
g. Principal Investigator,
h. Federal Support, if any.

The Director, HSPPO, in consultation with the IRB chair and the EVPRI will finalize the report within ten (10) working days after the IRB meeting at which the final determination occurred. The EVPRI will send the report to the following, as determined by the IRB:

a. The IRB (as a information item with the agenda),
b. OHRP*,
c. FDA* (whenever the research is subject to FDA regulation),
d. Other Federal Agencies* that are a signatory to “The Common Rule” who conduct or oversee the research,
e. Investigator,
f. Department Chair/Division Chief/Program Director/Unit Head,
g. Dean/Research Dean
h. Other organizations involved with the research,
i. The sponsor,
j. The funding agency,
k. The Office of Sponsored Program Administration and the Clinical Contracts Division, as applicable.

Suspensions and terminations of IRB approval are promptly reported (within 30 days) to OHRP and/or FDA (if research is FDA regulated).

*Reporting is not required if the agency has already been made aware of the event through other mechanisms, such as reporting by the investigator, sponsor, or another organization.

For multicenter research projects, only the institution at which the reportable event occurred must report the event to the supporting agency head (or designee) and OHRP (45 CFR 46.103(b)(5)).

### 3.7 Research Compliance Monitoring Program Activities

<table>
<thead>
<tr>
<th>AAHRPP Std./Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.5.A</td>
<td>The Organization conducts audits or surveys or uses other methods to assess compliance with organizational policies and procedures and applicable laws, regulations, codes, and guidance. The Organization makes improvements to increase compliance, when necessary.</td>
</tr>
<tr>
<td>I.5.B</td>
<td>The Organization conducts audits or surveys or uses other methods to assess the quality, efficiency, and effectiveness of the Human Research Protection Program. The Organization identifies strengths and weaknesses of the Human Research Protection Program and makes improvements, when necessary, to increase the quality, efficiency, and effectiveness of the program.</td>
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</table>

The Post Approval Monitoring Program and Research Compliance Monitors of the Human Subjects Protection Program Office (HSPP) is designed to:

- Evaluate and monitor the effectiveness of the HSPP;
- Assess compliance with HSPP policies and procedures;
- Prepare and execute For-Cause assessments;
- Prepare and execute Not-For-Cause assessments;
- Identify areas and implement measures for improvement.

This is accomplished by working with the various components of the HSPP to design, recommend and implement improvements to promote the protection of human subject research participants.

**Compliance Monitoring**

HSPP Compliance Monitors conduct periodic compliance reviews and for-cause assessments to evaluate adherence to applicable federal regulations, state and local laws and University of Louisville policies and procedures, and to verify that research is conducted in accordance with the IRB approved protocols.

- **For-cause Assessments:** The HSPPO Director may direct the Research Compliance Monitors to conduct an assessment in response to a particular concern. Concerns that may prompt a for-cause assessment include but are not limited to:
  - Failure of routine reviews;
  - Complaints or concerns initiated by a research participant, family member, or research team/workforce member;
- Irregular receipt of required reports (Continuation Review reports, data safety monitoring reports, sponsor monitor reports, etc.);
- Reviews studies closed due to investigator failure to complete the continuation process prior to study expiration;
- Reports of serious or repeated non-compliance.

- **Not-For-Cause Assessments**: Research Compliance Monitors regularly conduct reviews using systematic methods to assess the conduct of research studies to ensure compliance with federal regulations, state and local laws, and University of Louisville policies and procedures. Such not for cause assessments include but are not limited to:
  - Examinations of executed informed consent forms;
  - Observations of the informed consent process;
  - Review of training approvals for investigators and study personnel at initial submission and continuation review.

- **Periodic Compliance Reviews**: Periodic compliance reviews are conducted using systematic methods to assess IRB compliance with federal regulations, state and local laws, and University of Louisville policies and procedures. Periodic compliance reviews include but are not limited to:
  - Reviews of IRB meeting minutes;
  - Detailed examinations of protocol files;
  - Review of determinations made for vulnerable populations;
  - Review of Exempt and Not Human Subjects Research determinations made by the IRB Chairs;
  - Review of turnaround times for IRB staff; and
  - Review of administrative approvals made by the IRB Staff.

**Reporting of Compliance Monitoring Results**
Results of compliance monitoring activities are documented and reported to the Director, HSPPO, the IRB, Institutional Officials and other units within University of Louisville, as appropriate. These results, supplemented by other review results when available, provide a quantitative and qualitative measurement of compliance with the HSPP.

**Other Review Activities**
Depending on the results of annual risk assessments, the University’s Office of Audit Services may conduct additional reviews of the IRBs and the various schools and departments within the institution that conduct or review human subject research activities.

**Research Community Feedback**
Research Compliance Monitors are asked to track and share comments, questions and issues received from the University of Louisville investigators and participants to identify areas for potential improvement in the effectiveness of HRPP policies and procedures and for ensuring the protection of human subject research participants. The Principal Investigator and key study personnel receive a request to respond to a survey after approval of each event by the IRB. A customer service survey and submission form for questions, complaints, or concerns is available on the HSPPO Website.

Additionally, [proposed policy and procedure changes](#) are typically posted as drafts for 14-30 days to get feedback from HSPPO staff, Investigators, IRB members, coordinators and others as applicable.

**IRB Performance Metrics**
The Director and Assistant Director, HSPPO, review periodic metrics and analysis of the IRB operations and functions, including detailed measurements of activity volume.
Based on the results of the aforementioned assessments and feedback received from the communities served by the HSPPO, the HSPPO staff may partner with other components of the University of Louisville to identify root causes of problems, recommend action plans to correct issues, and provide education, tools and outreach to promote effectiveness of improvements.

### 3.8 Investigators' Input to the HSPP

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<tr>
<td>I.5.C</td>
<td>University of Louisville has and follows written policies and procedures so that Researchers and Research Staff may bring forward concerns or suggestions regarding the Human Research Protection Program, including the ethics review process.</td>
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There are a variety of mechanisms available for contacting relevant individuals to bring concerns and suggestions, including:

- Reporting possible non-compliance as described in HSPP Chapter 3.6;
- Reporting possible unanticipated problems as described in HSPP Chapter 15.2;
- Making general comments and suggestions and expressing concerns about other matters, issues or processes involving the HRPP, including IRB review and operations to any person in the HSPPO or to the Associate Vice President for Research and Innovation.
- Reporting of any financial irregularities to the Office of Audit Services.

The Director, HSPPO, receives and evaluates the input from any of these sources, with review by other individuals, as needed.