



**WASHINGTON STATE**  
U N I V E R S I T Y

**Human Research Protection Program Policies and  
Procedures Manual**

**September 1, 2023**

Human Research Protection Program (HRPP) - Office of Research Assurances  
PO Box 643143 Neill Hall 427 Pullman, WA 99164-3143  
Email: [irb@wsu.edu](mailto:irb@wsu.edu) Web site: [www.irb.wsu.edu](http://www.irb.wsu.edu)

# Introduction

The Washington State University (WSU) Human Research Protection Program (HRPP) Policies and Procedures Manual (PPM) complements the WSU Policy “Research Involving Human Subjects” (BPPM 45.50) and details the written procedures, notably those required under 45CFR46.108(3) and 21CFR56.108, that WSU will follow to ensure compliance with applicable regulatory requirements (e.g., HHS, FDA, WAC), ethical principles for the conduct of human participant research (e.g., Belmont report), and to fulfill the commitment WSU has made to the Department of Health and Human Services (HHS) via the WSU Federal wide Assurance (FWA) statement. When reviewing research that is not federally funded, WSU applies equivalent protections to those cited above.

Human research participant protection is a constantly evolving field, as such, sections of the manual require occasional revisions. Changes may not be immediately reflected in the pdf version of the manual, when this is the case changes will be communicated to faculty and staff prior to implementation and will be reflected as soon as practicable in the online version of this manual found on the WSU Institutional Review Board (IRB) web page ([irb.wsu.edu](http://irb.wsu.edu)). Please contact the IRB/HRPP office with any questions related to policies and procedures.

The review of non-exempt human participant research performed by WSU faculty, staff, students, or volunteers (anyone acting as an agent of WSU) is conducted by the IRB. The IRB is part of the Human Research Protection Program (HRPP) within the Office of Research Assurances (ORA), which provides administrative support to all WSU IRBs. The HRPP conducts pre-reviews to ensure applications are complete, provides support to researchers via consultation and educational outreach, and is responsible for determining if a project requires IRB review or if it is exempt (see 45CFR46.104).

Each IRB is comprised of faculty representatives from various academic disciplines and campuses at WSU as well as staff from various WSU departments who serve as subject matter experts (e.g., Information Technology and Security, Regulatory Compliance, Legal). IRB membership includes but may not be limited to physicians, researchers, scientific members, non-scientific members and community representatives (who are not otherwise affiliated with the University). All WSU IRBs are registered with the Food and Drug Administration (FDA) as required under 21CFR56.106, as well as the Office of Human Research Protections (OHRP) within the HHS.

Effective January 1, 2019, the WSU HRPP transitioned to the revised common rule (2018). All new federally funded research is reviewed under the 2018 requirements. Any ongoing research that was originally reviewed under the pre-2018 requirements will be re-reviewed under the 2018 requirements during continuing review, with the transition date documented. For any project reviewed under the pre-2018 requirements that cannot be transitioned, the basis for not transitioning will be documented during continuing review.

# Table of Contents

Introduction .....	1
Table of Contents .....	2
1. Human Research Protection Program (HRPP) .....	13
1.1 Mission .....	13
1.2 Institutional Authority .....	13
1.3 Definitions .....	13
1.4 Ethical Principles .....	15
1.5 Regulatory Compliance .....	15
1.6 Federalwide Assurance (FWA) .....	15
1.7 Research Covered by the HRPP .....	16
1.8 Written Policies and Procedures .....	16
1.9 HRPP Organization .....	16
1.9.1 Institutional Official .....	17
1.9.2 Director and Assistant Director Office of Research Assurances .....	17
1.9.3 Institutional Review Board (IRB) .....	18
1.9.4 Investigator .....	18
1.9.5 Attorney General's Office, WSU Division (AGO) .....	18
1.9.6 Office of Research (OR), Office of Research Support and Operations (ORSO) .....	19
1.9.7 Information Technology Services (ITS) .....	19
1.9.8 Compliance and Risk Management .....	19
1.9.9 Relationship Among Components .....	19
1.10 HRPP Operations .....	20
1.10.1 HRPP Office .....	20
1.10.2 Director and Assistant Director of the Office of Research Assurances .....	20
1.10.3 Selection, Supervision, and Evaluation of HRPP Supporting Staff .....	20
1.11 HRPP Resources .....	20
1.12 Conduct of Quality Assurance/Quality Improvement Activities .....	20
1.12.1 Investigator Audits and Compliance Reviews .....	21
1.12.2 External Site Audits and Compliance Reviews .....	21

1.12.3 Disposition of Quality Assurance Reports .....	21
1.12.4 HRPP Internal Compliance Reviews .....	22
1.12.5 Quality Improvement .....	22
1.12.6 Examples of Quality Improvement and Quality Assessment Activities ..	22
1.13 Collaborative Research Projects .....	23
<b>2. Institutional Review Board.....</b>	<b>24</b>
2.1 IRB Authority and Independence .....	24
2.2 Number of IRBs.....	25
2.3 IRB Membership .....	25
2.4 Composition of the IRB .....	25
2.5 IRB Coordinators and Compliance Analysts/Specialists .....	26
2.5.1 Qualifications.....	26
2.5.2 Responsibilities .....	27
2.5.3 Evaluation .....	27
2.6 Chair, Co-Chair and Vice Chair of the IRB .....	27
2.6.1 Appointment.....	27
2.6.2 Qualifications.....	28
2.6.3 Responsibilities .....	28
2.6.4 Evaluation .....	28
2.7 IRB Members .....	28
2.7.1 Appointment.....	28
2.7.2 Qualifications.....	29
2.7.3 Responsibilities .....	29
2.7.4 Alternate Members.....	29
2.7.3 Evaluation .....	30
2.8 IRB Member Conflict of Interest .....	30
2.9 Use of Consultants.....	31
2.10 Training and Continuing Education of Chair and IRB Members .....	32
2.10.1 Orientation.....	32
2.10.2 Initial Education.....	32
2.10.3 Continuing Education .....	32
2.11 Liability Coverage for IRB Members.....	33
2.12 Reporting and Investigating Allegations of Undue Influence .....	33

3. IRB Review Processes.....	33
3.1 Definitions .....	33
3.2 Human Subjects Research Determination .....	34
3.3 Exempt Determinations .....	34
3.3.1 Limited IRB Review .....	35
3.3.2 Limitations on Exemptions .....	35
3.3.3 Categories of Exempt Research .....	36
3.3.4 Unused Exemption Categories.....	38
3.3.4 FDA Exemptions .....	38
3.3.5 Procedures for Exemption Determination.....	39
3.4 Expedited Review .....	39
3.4.1 Categories of Research Currently Authorized by HHS as Eligible for Expedited Review .....	40
3.4.2 Additional Categories Eligible for Expedited Review (Flexibility Criterion) .....	43
3.4.3 Continuing Review and Annual Status Report .....	43
3.4.4 Informing the IRB .....	43
3.5 Convened IRB Meetings .....	44
3.5.1 IRB Meeting Schedule .....	44
3.5.2 Preliminary Review .....	44
3.5.3 Primary and Secondary Reviewers .....	44
3.5.4 Availability of Documents Before a Meeting .....	45
3.5.5 Materials Reviewed by the IRB .....	45
3.5.6 Quorum .....	46
3.5.7 Meeting Procedures .....	46
3.5.8 Guests.....	47
3.6 Criteria for IRB Approval of Research .....	47
3.6.1 Required determinations .....	47
3.6.2 Additional considerations for vulnerable subjects.....	48
3.6.3 Risk-Benefit Assessment .....	48
3.6.4 Assessment of Scientific Merit .....	49
3.6.5 Equitable Selection of Subjects.....	49
3.6.6 Informed Consent.....	50
3.6.7 Safety Monitoring .....	50
3.6.8 Privacy and Confidentiality .....	51

3.6.9 Vulnerable Populations .....	52
3.7 Additional Considerations During IRB Review and Approval of Research ....	53
3.7.1 Approval Period.....	53
3.7.2 Independent Verification That No Material Changes Have Occurred.....	54
3.7.3 Consent Monitoring .....	54
3.7.4 Investigator Conflicts of Interest.....	55
3.7.5 Significant New Findings.....	55
3.7.6 Advertisements and Recruitment Materials.....	55
3.7.7 Payment to Research Subjects .....	56
3.7.8 Compliance with Applicable State and Local Laws and Laws of Foreign Countries.....	57
3.7.9 IRB Review of Grant Applications .....	58
3.8 Possible IRB Actions .....	58
3.9 Suspension, Termination, and Investigator Hold .....	59
3.9.1 Suspension and Termination.....	59
3.9.2 Investigator Hold .....	60
3.10 Continuing Review and Status Reports.....	61
3.10.1 Ongoing research that presents greater than minimal risk.....	61
3.10.2 When continuing review is not required.....	61
3.10.3 Approval Period.....	62
3.10.4 Local Implementation (January 2019, Full transition effective January 1, 2022).....	62
3.10.5 When Continuing Review Might be Required.....	63
3.10.6 Continuing Review Process .....	63
3.10.7 Lapse in Continuing Review .....	64
3.11 Amendment of an Approved Protocol.....	65
3.11.1 Expedited Review of Protocol Modifications.....	65
3.11.2 Review of Protocol Modifications at Convened Meeting .....	66
3.12 Closure of Protocols .....	66
3.13 Reporting IRB Actions .....	67
3.14 Review and Reconsideration of IRB Decisions .....	67
3.15 Use of Other IRBs .....	67
3.15.1 Situations in which use of another IRB would be appropriate: .....	68
3.15.2 WSU responsibilities prior to accepting oversight for a study by an external IRB .....	68

3.15.3 WSU and IRB responsibilities after approval.....	69
3.16 Posting of Clinical Trial Consent Forms .....	69
3.17 Multisite Studies .....	69
3.17.1 Role of the Lead Investigator .....	70
3.17.2 Study sites.....	70
3.17.3 Site approvals .....	70
3.17.4 Communication among sites .....	70
4. Documentation and Records.....	70
4.1 IRB Records .....	70
4.2 IRB Study Files .....	71
4.3 Documentation of Expedited Reviews.....	72
4.4 IRB Minutes.....	72
4.5 IRB Membership Roster .....	74
4.6 Access to IRB Records .....	75
4.7 Record Retention .....	75
5. Informed Consent.....	75
5.1 Definitions .....	76
5.2 Basic Requirements .....	76
5.3 General Requirements for Informed Consent.....	77
5.4 Basic Elements of Informed Consent .....	78
5.4.1 FDA regulated studies.....	79
5.4.2 Additional elements of informed consent .....	79
5.4.3 General Data Protection Regulation (GDPR) .....	80
5.5 Broad Consent .....	80
5.6 Documentation of Consent.....	82
5.7 Special Consent Circumstances .....	82
5.7.1 Non-English-Speaking Subjects.....	82
5.7.2 Use of interpreters in the consent process.....	83
5.7.3 Oral Consent .....	83
5.8 Consent Monitoring .....	84
5.9 Subject Withdrawal or Termination .....	84
5.10 Waiver or Alteration of Informed Consent .....	86
5.10.1 General Waiver or Alteration of Consent.....	86

5.10.2 Waiver or Alteration of Consent in Research Involving Public Benefit and Service Programs.....	87
5.11 Screening, Recruiting, or Determining Eligibility.....	87
5.12 Waiver of Documentation of Informed Consent.....	88
5.13 Informed Consent, Assent and Parental Permission.....	89
<b>6. Vulnerable Subjects in Research .....</b>	<b>89</b>
6.1 Involvement of Vulnerable Populations .....	89
6.2 Responsibilities .....	90
6.3 Procedures.....	90
6.3.1 Initial Review of Research Proposal.....	90
6.4 Research Involving Pregnant Women, Human Fetuses, and Neonates.....	91
6.4.1 Research Involving Pregnant Women or Fetuses .....	91
6.4.2 Research Involving Neonates .....	93
6.4.3 Research Involving, After Delivery, the Placenta, the Dead Fetus or Fetal Material .....	93
6.5 Research Involving Prisoners.....	93
6.5.1 Applicability .....	93
6.5.2 Composition of the IRB and Role of the Prisoner Representative.....	94
6.5.3 Use of Expedited Review Procedures.....	95
6.5.4 Exempt Determinations .....	96
6.5.5 When a Participant Becomes a Prisoner.....	96
6.5.6 Additional Duties of the IRB when prisoners are involved.....	96
6.6 Research Involving Children .....	99
6.6.1 Allowable Categories .....	99
6.6.2 Parental Permission and Child Assent .....	100
6.7 Persons with Impaired Decision-Making Capacity .....	102
6.7.1 IRB Composition .....	103
6.7.2 Determination of Decision-Making Capacity.....	103
6.7.3 Informed Consent and Assent.....	105
6.8 Cultural Context and Informed Consent, Assent and Permission.....	105
<b>7. FDA Regulated Research .....</b>	<b>105</b>
7.1 Definitions .....	106
7.2 Procedures.....	106
7.3 Investigational Drugs and Devices .....	107



7.4 IND Exemption .....	107
7.5 Medical Devices .....	108
7.5.1 IDE Requirements .....	108
7.5.2 Exempted IDE Investigations .....	109
7.6 Responsibilities .....	109
7.6.1 Principal Investigator .....	109
7.6.2 IRB .....	111
8. Reportable Events, Non-Reportable Events and Unanticipated Problems Involving Risks to Subjects or Others.....	112
8.1 Definitions .....	112
8.2 Reportable Event Procedures .....	113
8.2.1 Reporting by Investigator .....	113
8.2.2 Submission of Reports by Investigator .....	114
8.2.3 Processing Reports of Possible Unanticipated Problems .....	114
8.3 Reporting Other Events.....	117
9. Protocol Exceptions & Deviations .....	117
9.1 Exceptions.....	117
9.2 Deviations .....	118
9.3 Reporting & Review.....	118
10. Complaints, Concerns and Non-Compliance .....	118
10.1 Definitions .....	119
10.2 Complaints .....	120
10.3 Noncompliance .....	120
10.3.1 Review of Allegations of Noncompliance .....	121
10.3.2 Review of Findings of Noncompliance .....	122
10.3.3 Inquiry Procedures .....	123
10.3.4 Final Review.....	123
11. Reporting to Institutional Officials, Regulatory Agencies, and AAHRPP .....	124
11.1 Reporting Triggers.....	124
11.2 Preparation of Report.....	124
11.3 Recipients of Report.....	125

11.4 Reporting to AAHRPP .....	126
12. Investigator Responsibilities.....	126
12.1 Investigators.....	126
12.1.1 Principal Investigators .....	126
12.1.2 Student Investigators .....	126
12.1.3 Research Team.....	127
12.2 Responsibilities .....	127
12.3 Training and Ongoing Education of Investigators and Research Team ....	128
12.3.1 Initial Education .....	128
12.3.2 Waiver of Initial Education.....	128
12.3.3 Continuing Education and Recertification.....	129
12.4 Investigator Concerns .....	129
13. Sponsored Research .....	129
13.1 Definitions .....	130
13.2 Contracts.....	130
14. [This section will undergo revision pending the outcome of WSU COI policy development, in progress as of 10/1/2022.] Financial Conflicts of Interest in Human Subjects Research .....	131
14.1 Definition of Financial Conflict of Interest .....	131
14.2 Training in Financial Conflict of Interest .....	132
14.3 Personnel Who Must Disclose (also called Key Personnel or Participating Faculty/Staff).....	132
14.4 Individual Conflicts of Interest .....	133
14.4.1 Disclosure and Evaluation of Investigator Financial Interests in Research .....	133
14.4.2 Management of COI .....	133
14.5 Institutional Conflict of Interest .....	134
14.5.1 Responsibilities .....	134
14.5.2 Management of Conflict of Interest .....	134
15. Community Outreach .....	135
15.1 HRPP Outreach Activities .....	136
15.2 University Outreach Activities.....	136

15.3 Evaluation .....	136
16. Health Insurance Portability and Accountability Act (HIPAA).....	136
16.1 Definitions .....	137
16.2 Research Under HIPAA .....	138
16.2.1 Waiver of Authorization for Use or Disclosure of Protected Health Information in Research .....	138
16.2.2 Review Preparatory to Research .....	139
16.2.3 Research on Protected Health Information of Decedents .....	141
16.2.4 Limited Data Sets with a Data Use Agreement .....	141
16.3 HIPAA and Documentation Requirements .....	143
16.4 Patient Rights and Research.....	143
16.5 HIPAA and Existing Studies .....	143
16.6 Waivers to HIPAA Authorization Form .....	143
17. Special Topics .....	143
17.1 Certificate of Confidentiality (CoC) .....	143
17.1.1 Statutory Basis for Protection.....	144
17.1.2 Usage.....	144
17.1.3 Limitations .....	145
17.1.4 Application Procedures .....	146
17.2 Mandatory Reporting.....	146
17.3 WSU Students and Employees as Subjects.....	146
17.4 Student Research.....	147
17.4.1 Human Subjects Research and Course Projects .....	147
17.4.2 Individual Research Projects Conducted by Students.....	147
17.4.3 Theses and Dissertations.....	148
17.5 Pilot Studies .....	148
17.6 Case Reports Requiring IRB Review .....	148
17.7 International Research .....	149
17.7.1 Monitoring of Approved International Research .....	150
17.8 Community-Based Research (CBR).....	151
17.9 State and Local Laws [Reserved].....	153
18 Additional Requirements of Federal Agencies .....	153
18.1 Environmental Protection Agency (EPA).....	153

18.1.1 Exposure to Substances; Protections for Pregnant Women, Children, and Others .....	153
18.1.2 Children in Observational Research Greater than Minimal Risk but with Prospect of Direct Benefit .....	154
18.2 Department of Energy .....	154
18.2.1 Department of Energy (DOE) Requirements:.....	154
18.3 Department of Education (ED) .....	155
18.3.1 Department of Education (ED) Requirements .....	156
18.3.2 Releasing Records Without Consent .....	156
18.3.3 Protection of Students .....	156
18.3.4 For research not funded by the US Department of Education.....	157
18.3.5 Protection of Pupil Rights .....	158
18.3.6 Access to Instructional Material Used In Research .....	158
18.3.7 Other Department of Education Requirements that are Congruent with Current HRPP Policies .....	158
18.4 Department of Defense (DOD)/Department of the Navy (DON).....	158
18.4.1 International Research .....	159
18.4.2 Reporting – by Researchers, Institution .....	159
18.4.3 Monitors .....	160
18.4.4 Provision for research-related injury.....	161
18.4.5 Research involving surveys.....	161
18.4.6 DoD Personnel as participants.....	161
18.4.7 Research Involving a Human Being as an Experimental Subject.....	162
18.4.8 Waivers of Informed Consent.....	164
18.4.9 Other DoD and DON Requirements that are Congruent with Current HRPP Policies.....	165
18.5 Department of Justice (DOJ)/National Institute of Justice (NIJ) .....	166
18.5.1 For detailed requirements refer to the regulatory links provided here:	166
18.5.2 National Institute of Justice (NIJ) funded research Requirements:.....	167
18.5.3 For research conducted with the Bureau of Prisons:.....	167
18.5.4 Informed Consent Requirements .....	168
18.6 [Publicly Available Data and Specimens] .....	169
19. Definitions .....	169
A –	169
B –	170

C – 170  
D - 171  
E – 171  
F – 172  
G – 172  
H – 172  
I – 173  
J – 174  
K – 174  
L – 174  
M – 174  
N – 174  
O – 175  
P – 175  
Q – 176  
R – 176  
S – 178  
T – 179  
U – 180  
V – 180  
W – 180  
X – 180  
Y – 180  
Z – 180

# **1. Human Research Protection Program (HRPP)**

Washington State University (WSU) fosters a research environment that promotes respect for the rights and welfare of individuals participating in research conducted at or under the auspices of WSU. In reviewing and conducting research, WSU will be guided by the principles of respect for persons, beneficence, and justice set forth in the Ethical Principles and Guidelines for the Protection of Human Subjects of Research. In addition, WSU will be guided by the idea of respect for the community as well. The actions of WSU will also conform to all applicable federal, state, and local laws and regulations. WSU has established a Human Research Protections Program (HRPP) to fulfill this commitment.

## **1.1 Mission**

The mission of the HRPP is to:

1. Safeguard and promote the health and welfare of human research participants by ensuring that their rights, safety and well-being are protected.
2. Provide timely and high-quality education, review and monitoring of human research projects; and
3. Facilitate excellence in human participant research by assisting investigators in conducting ethical research which complies with all relevant Federal, State and local regulations.

The HRPP includes mechanisms to:

1. Establish a formal process to monitor, evaluate, and continually improve the protection of human research participants.
2. Dedicate resources sufficient to do so.
3. Exercise effective oversight of research.
4. Educate investigators and research staff about their ethical responsibility to protect research participants.
5. When appropriate, intervene in research and respond directly to the concerns of research participants.

## **1.2 Institutional Authority**

The WSU HRPP operates under the authority of the WSU policy: "Research Involving Human Subjects", BPPM 45.50 (HSR Policy). As stated in that policy, this document contains the detailed policies and procedures governing IRB review and oversight of human participant research at WSU. The HSR Policy and these operating procedures are made available to all WSU investigators and research staff and are posted on the HRPP website.

## **1.3 Definitions**

**Common Rule** –The Common Rule refers to the “Federal Policy for the Protection of Human Subjects” adopted by a number of federal agencies. Although the Common Rule is codified by each agency separately, the text is identical to DHHS regulations in 45 CFR 46 Subpart A. For the purposes of this document, references to the Common Rule will cite the DHHS regulations.

The provisions of the revised Common Rule, which was implemented in January 2018 but delayed until January 1, 2019, have been adopted by WSU. WSU may elect to apply Common Rule requirements or to apply equivalent protections to research that is not federally funded.

**Engagement** – Institutions are considered “engaged” in a research project when the involvement of their employees or agents in that project includes any of the following:

1. Intervention for research purposes with any human subjects of the research by performing invasive or noninvasive procedures.
2. Intervention for research purposes with any human subject of the research by manipulating the environment.
3. Interaction for research purposes with any human subject of the research.
4. Obtaining the informed consent of human subjects for the research.
5. Obtaining for research purposes identifiable private information or identifiable biological specimens from any source for the research. In general, obtaining identifiable private information or identifiable specimens includes, but is not limited to
  - a. observing or recording private behavior;
  - b. using, studying, or analyzing for research purposes identifiable private information or identifiable specimens provided by another institution; and
  - c. using, studying, or analyzing for research purposes identifiable private information or identifiable specimens already in the possession of the investigators.

**Human subject** – means a living individual about whom an investigator (whether professional or student) conducting research:

1. Obtains information or biospecimen through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or
2. Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimen.

For research covered by FDA regulations (21 CFR 50 and 56), “human subject” means an individual who is or becomes a participant in a clinical investigation (as defined below), either as a recipient of the test article or as a control. A subject may be in normal health or may have a medical condition or disease. In the case of a medical device, a human subject/participant also includes any individual on whose tissue specimen an investigational device is used or tested.

Note: The terms “subject” and “participant” are used interchangeably in this document and have the same meaning.

**Human Subjects Research** – means any activity that meets the definition of “research” and

involves “human subjects” as defined by either the Common Rule or FDA regulations.

**Research** – The Common Rule defines research as a systematic investigation, including research development, testing, and evaluation that is designed to develop or contribute to generalized knowledge.

For the purposes of this policy, a “systematic investigation” is an activity that involves a prospective study plan that incorporates data collection, either quantitative or qualitative, and data analysis to answer a study question. Investigations designed to develop or contribute to generalizable knowledge are those designed to draw general conclusions (i.e., knowledge gained from a study may be applied to populations outside of the specific study population), inform policy, or generalize findings.

**Additional Definitions:** [Section 19](#).

## 1.4 Ethical Principles

Washington State University is committed to conducting research with the highest regard for the welfare of human subjects. It upholds and adheres to the principles of The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects in Research by the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research (1979). These principles include:

**Respect for Persons**, which is ensured by obtaining informed consent, consideration of privacy, confidentiality, and additional protections for vulnerable populations.

**Beneficence**, which is assured by ensuring that possible benefits are maximized, and possible risks are minimized.

**Justice**, which is the equitable selection of subjects.

## 1.5 Regulatory Compliance

The HRPP is responsible for ensuring compliance with federal regulations, state law, and institutional policies. All human subjects research at WSU is conducted in accordance with federal regulations 45 CFR 46 and 21 CFR 50 and 56. The actions of WSU will also conform to all other applicable federal, state, and local laws and regulations.

WSU voluntarily applies the International Conference on Harmonization (ICH) Good Clinical Practices (GCP) Guidelines (sometimes referred to as ICH-GCP or E6) to certain types of human subject’s research conducted under its HRPP only to the extent that they are compatible with FDA and DHHS regulations.

## 1.6 Federalwide Assurance (FWA)



Federal regulations require that federally funded human subjects research only be conducted at facilities covered by Federal wide Assurance (FWA) approved by the DHHS Office for Human Research Protections (OHRP). WSU has an OHRP-approved Federal wide Assurance. The FWA designates the Institutional Review Board that will review and oversee the research, specifies the ethical principles under which the research will be conducted, and names the individuals who will be responsible for the proper conduct of the research.

In its FWA, WSU has opted to limit the application of the FWA to research funded by DHHS or federal agencies that have adopted the Common Rule.

WSU reserves the right to apply “equivalent protections” to research that is not funded or otherwise subject to oversight by an agency that has adopted the Common Rule.

## **1.7 Research Covered by the HRPP**

The WSU Human Research Protection Program covers all research involving human subjects that is conducted by agents of WSU or conducted under the auspices of WSU, regardless of funding.

## **1.8 Written Policies and Procedures**

The WSU Human Research Protection Program Policies and Procedures Manual details the policies and regulations governing research with human subjects and the requirements for submitting research proposals for review by the WSU IRB. The Director and/or Assistant Director of the Office of Research Assurances (DRA/ADRA) is responsible for implementing changes in procedures necessary to comply with changes in federal or state regulations as well as other changes dictated by the IRB or institutional policy. The policies and procedures are reviewed every 3 years or more often as needed to respond to required changes. The Institutional Official (IO) will approve all revisions of the policies and procedures or will delegate this responsibility to the DRA and/or ADRA.

The ADRA will keep the Washington State University research community apprised on the IRB website and through campus electronic newsletters of new information that may affect the HRPP, including laws, regulations, policies, procedures, and emerging ethical and scientific issues. The policies and procedures will be available on the WSU IRB website.

## **1.9 HRPP Organization**

The HRPP is a comprehensive system to ensure the protection of human subjects participating in research. It consists of various individuals and committees, such as the IO, the DRA/ADRA, the IRB, other committees or subcommittees addressing human subject protection (e.g., Biosafety, Radiation Safety, Conflict of Interest), investigators, IRB staff, research staff, and health and safety staff (e.g., Biosafety Officer, Radiation Safety Officer). The objective of this system is

to assist the institution in meeting ethical principles and regulatory requirements for the protection of human subjects in research.

The following officials, administrative units, and individuals have primary responsibilities for implementing the HRPP.

### ***1.9.1 Institutional Official***

The ultimate responsibility of the HRPP resides with the Vice President for Research (VPR), who serves as the Institutional Official (IO) of the HRPP. The IO is responsible for ensuring the WSU HRPP has the resources and support necessary to comply with institutional policies, federal regulations, and state laws that govern human subjects research. The IO is legally authorized to represent WSU, is the signatory of the FWA, and assumes the obligations of the FWA.

The IO also holds ultimate responsibility for:

1. oversight of the Institutional Review Board (IRB);
2. oversight over the conduct of research conducted by all WSU investigators;
3. assuring that IRB members are appropriately trained to review research in accordance with ethical standards and applicable regulations;
4. assuring that all investigators are appropriately trained to conduct research in accordance with ethical standards and applicable regulations.

The IO may delegate authority to qualified individuals within the HRPP, including the Director of the Office of Research Assurances and Assistant Director of the Office of Research Assurances who oversees day to day operations of the HRPP. When authority is delegated, it will be documented in writing.

### ***1.9.2 Director and Assistant Director Office of Research Assurances***

The Director of the Office of Research Assurances is appointed by and reports to the IO. The Director appoints the Assistant Director who oversees day-to-day operations of the HRPP and is responsible for:

1. Developing, managing and evaluating policies and procedures that ensure compliance with all state and federal regulations governing research. This includes monitoring changes in regulations and policies that relate to human research protection and overseeing all aspects of the HRPP program.
2. Advising the IO on key matters regarding research at WSU.
3. Implementing the institution's HRPP policy and standard operating procedures.
4. Submitting, implementing, and maintaining an approved FWA through the VPR and the Department of Health and Human Services Office of Human Research Protection (OHRP).
5. Submits reports to AAHRPP to support accreditation when applicable.
6. Managing the budget of the WSU HRPP.
7. Assisting investigators in their efforts to carry out Washington State University's research

mission.

8. Developing and implementing needed improvements and ensuring follow-up of actions, as appropriate, for the purpose of managing risk in the research program.
9. Developing and implementing educational plans for IRB members, staff, and investigators.
10. Developing training requirements as mandated and appropriate for investigators, subcommittee members, and research staff, and ensuring that training is completed on a timely basis.
11. Exercising day-to-day responsibility for the operation of the HRPP office, including supervision of HRPP staff.
12. Responding to questions from faculty, students, and staff.
13. Working closely with the Chair(s) of the IRB(s) and on the development of policy and procedures as well as organizing and documenting the review process.

These responsibilities are facilitated operationally through the Assistant Director for the HRPP in the Office of Research Assurances.

### ***1.9.3 Institutional Review Board (IRB)***

IRB members are appointed by the IO. While appointment authority ultimately resides with the President, this appointment authority is normally delegated in writing to the VPR who serves as the IO. The IRB prospectively reviews and makes decisions concerning all human subjects research conducted at WSU facilities and/or by its employees or agents or under its auspices, regardless of location. The IRB is responsible for protecting the rights and welfare of human research subjects at WSU. It discharges this duty by complying with the requirements of the Common Rule, state regulations, the FWA, and institutional policies (see [Section 2](#) for a detailed discussion of the IRB).

### ***1.9.4 Investigator***

The investigator is the ultimate protector of the human subjects who participate in research. The investigator must abide by the highest ethical standards and must follow a protocol that incorporates the principles of the Belmont Report. The investigator is expected to conduct research in accordance with the approved research protocol and to oversee all aspects of the research by providing supervision of support staff, including oversight of the informed consent process. All subjects must give informed consent (unless this condition is explicitly waived by the IRB), and the investigator must establish and maintain an open line of communication with all research subjects within his/her responsibility. In addition to complying with all the policies and standards of the governing regulatory bodies, the investigator must comply with institutional and administrative requirements for conducting research. The investigator is responsible for ensuring that all research staff complete appropriate training and must obtain all required approvals prior to initiating research. When investigational drugs or devices are used, the investigator is responsible for developing and following written procedures for their storage, security, dispensing, and disposal.

### ***1.9.5 Attorney General's Office, WSU Division (AGO)***

The WSU HRPP relies on the Washington State Attorney General's Office, WSU Division (AGO) for the interpretations and applications of Washington law and the laws of any other jurisdiction where research is conducted as they apply to human subjects research.

#### ***1.9.6 Office of Research (OR), Office of Research Support and Operations (ORSO)***

Staff of the Office of Research Support and Operations within the Office of Research review all research agreements with federal and state sponsors, and research agreements from foundation or non-profit sponsors. This institutional review ensures that all terms of the award compliance with institutional policies. Only designated senior individuals within OR/ORSO have the authority to approve research proposals and to execute research agreements on behalf of the institution. As a further control, internal documents retained by the ORSO as part of the application process for extramural funding include a copy of the proposal submitted to the external agency, the proposed budget, the financial disclosure statement, and the internal transmittal document.

When the grant or contract agreement includes activities that will be conducted by investigators who are not employees or agents of WSU, and where funding will be provided to the collaborating institution, a subcontract is executed between WSU and the collaborating institution. If human subject research is involved, the subcontract includes the requirement for the collaborating institution to assure compliance with federal regulations for the protection of human subjects in research, including any training requirements for personnel. The collaborating institution must maintain documentation of compliance fulfillment of all federal, sponsor, and institutional requirements and provide it to WSU upon request.

#### ***1.9.7 Information Technology Services (ITS)***

The HRPP has established a very close working relationship with the Information Technology Services. ITS personnel have ex-officio appointments to the IRB, actively participate in protocol review when needed; offer technical assistance to investigators developing applications to conduct research involving human subjects; and offer educational presentations for the board. The HRPP corresponds with Area Technology Officers (ATOs) within Colleges and Departments to assist PIs in complying with WSU IT Policies.

#### ***1.9.8 Compliance and Risk Management***

The IRB consults Compliance & Risk Management when questions arise about liability insurance coverage for investigators conducting research in other states or countries and for consultation on other issues that arise which may represent a risk to the University, University agents or the WSU community.

#### ***1.9.9 Relationship Among Components***

The IRB functions independently of, but in coordination with, other institutional regulatory committees. The IRB, however, makes its independent determination whether to approve, require

modifications in order to secure approval, or disapprove a protocol based upon whether human subjects are adequately protected. The institution may disapprove research that has been approved by the IRB but may not approve any research for which the IRB has withheld approval.

## **1.10 HRPP Operations**

### ***1.10.1 HRPP Office***

Operation of the office is the responsibility of the Director and Assistant Director assisted by HRPP staff in the Office of Research Assurances.

### ***1.10.2 Director and Assistant Director of the Office of Research Assurances***

The Director of the Office of Research Assurances (DRA) is responsible for all aspects of the IRB throughout the review process of a research proposal involving human subjects. This responsibility is delegated to the Assistant Director (ADRA) and includes the initial review of documents and screening of research proposals prior to their review by the convened IRB as well as serving as the liaison, if needed, between the investigators and the IRB. The ADRA reviews the IRB minutes for accuracy and ensures proper documentation of discussions, including controverted issues discussed and actions taken by the IRB during its convened meetings.

### ***1.10.3 Selection, Supervision, and Evaluation of HRPP Supporting Staff***

All staff who support the IRB and HRPP are selected by the ADRA and/or DRA of the Office of Research Assurances according to WSU Human Resources policies and procedures.

## **1.11 HRPP Resources**

The HRPP Office is in Neill Hall and has the necessary office, meeting, and storage space and equipment to perform the functions required by the HRPP. The adequacy of personnel and non-personnel resources of the HRPP program is assessed annually by the ADRA and DRA in consultation with HRPP staff.

The WSU IO provides resources to the IRB and HRPP Office, including adequate meeting and office space, and staff for conducting IRB business. Office equipment and supplies, including technical support, file cabinets, computers, internet access, and copy machines, are made available to the IRB and staff. Resources provided for the IRB and HRPP Office are reviewed by the ADRA/DRA and IO during the annual budget review process.

## **1.12 Conduct of Quality Assurance/Quality Improvement Activities**

The objective of Washington State University's HRPP Quality Assurance / Quality Improvement Plan is to measure and improve human research protection effectiveness, efficacy, and compliance with organizational policies and procedures and applicable federal, state, and local

laws. The Quality Assurance / Quality Improvement Plan will be managed and implemented by ADRA.

### ***1.12.1 Investigator Audits and Compliance Reviews***

Directed (“for cause”) audits and periodic (“not for cause”) compliance reviews will be conducted to assess investigator compliance with federal, state, and local laws as well as Washington State University policies; identify areas for improvement; and suggest process improvements. Directed audits of IRB-approved research studies are authorized by the IRB Chair and/or ADRA in response to identified concerns. Periodic compliance reviews are conducted using a systematic method to review IRB- approved research on a regular basis. The results are reported to the IO and the IRB Chair via ADRA.

Activities of auditors during directed audits and periodic compliance reviews may include, but are not limited to:

1. Requesting progress reports from researchers;
2. Evaluating the integrity of data security;
3. Examining investigator-held research records;
4. Contacting research subjects;
5. Observing research sites where research involving human research subjects and/or the informed consent process is being conducted;
6. Evaluating advertisements and other recruiting materials as deemed appropriate by the IRB;
7. Reviewing projects to verify from sources other than the researcher that no unapproved changes have occurred since previous review;
8. Monitoring conflict of interest concerns to assure the consent documents include the appropriate information and disclosures;
9. Monitoring HIPAA or FERPA authorizations and implementation of COI management plans;
10. Conducting other monitoring or auditing activities as deemed appropriate by the IRB.

### ***1.12.2 External Site Audits and Compliance Reviews***

External directed audits and periodic compliance reviews will be conducted, as needed, at non-Washington State University sites, where the WSU IRB serves as the “IRB of Record,” to assess compliance with federal, state, and local law; research subject safety; and IRB policies and procedures. These reviews may include items listed in [Section 1.12.1](#) above. Operational deficiencies are discussed with the IRB Chair(s) and remediation plans are developed.

### ***1.12.3 Disposition of Quality Assurance Reports***

The results of all quality assurance activities are reported to the ADRA/DRA and to the IRB Chair(s) as needed. Any noncompliance will be handled according to the procedures in [Section 10](#). If an audit or review finds that subjects in a research project have been exposed to unexpected

serious risk, the reviewer will promptly report such findings to the ADRA and/or DRA and the IRB Chair for immediate action.

#### ***1.12.4 HRPP Internal Compliance Reviews***

Internal directed audits and random internal compliance reviews will be conducted. The results may impact current practices, may require additional educational activities, and will be reported in summary form to the VPR/IO. The ADRA, DRA or designee will:

1. Review the IRB minutes to determine that adequate documentation of the meeting discussion has occurred. This review will include:
  - assessing the documentation surrounding the discussion for protections of vulnerable populations as well as;
  - other risk/benefit ratio and consent issues that are included in the criteria for approval; and assess the IRB minutes to assure that a quorum was met and maintained;
2. Assess the current adverse-event reporting process;
3. Assess privacy provisions, according to HIPAA, have been adequately reviewed, discussed, and documented in the IRB minutes;
4. Evaluate the continuing review discussions to ensure they are substantive and meaningful and that no lapse has occurred since the previous IRB review;
5. Observe IRB meetings or other related activities;
6. Review IRB files to ensure retention of appropriate documentation and consistent organization of the IRB file according to current policies and procedures;
7. Review the IRB database to ensure tasks are completed accurately;
8. Verify that reviews are completed;
9. Verify IRB approvals for collaborating institutions or external performance sites;
10. Review the appropriate metrics (e.g., time from submission to first review) to evaluate the quality, efficiency, and effectiveness of the IRB review process;
11. Review the workload of IRB staff to evaluate appropriate staffing level;
12. Perform other monitoring or auditing activities deemed appropriate by the IRB.

The IO will review the results of internal compliance reviews with the DRA and/or ADRA. If any deficiencies are noted in the review, a corrective action plan will be developed by the ADRA and approved by the IO. The ADRA will be responsible for implementing the corrective action plan, the results of which will be evaluated by the DRA and/or IO.

#### ***1.12.5 Quality Improvement***

All quality assurance reports, both research-related and HRPP-related, will be reviewed by the ADRA, DRA and/or the IO to determine if systemic changes are required in the HRPP to prevent re-occurrence of noncompliance. If so, a corrective action plan will be developed, implemented, and evaluated by the ADRA, DRA and/or IO.

#### ***1.12.6 Examples of Quality Improvement and Quality Assessment Activities***

An example of an objective to achieve or maintain compliance would be determining whether IRB minutes meet standards listed at [Section 4.4](#) of these SOPs. The measure of compliance is the percentage of required elements that are consistently present in the minutes. The method to assess compliance is to use a checklist based on the required elements (at [Section 4.4](#) of these SOPs) and evaluate minutes usually covering a 6-month block of time.

An example of efficiency of IRB operations is timely review of protocols using exemption determinations, expedited review procedures and review at convened meetings. Efficiency is measured by the time it takes to complete a review of a protocol. The efficiency is assessed by comparing WSU data to data published by AAHRPP for similar institutions as well as timeliness of reviews when compared to prior periods.

## **1.13 Collaborative Research Projects**

In the conduct of collaborative research projects, WSU acknowledges that each institution is responsible for safeguarding the rights and welfare of human subjects and for complying with applicable federal regulations. When WSU is engaged in only part of a cooperative research project, the WSU IRB only needs to approve the part(s) of the research in which the WSU investigator is engaged. For example, if WSU is operating the statistical center for a multicenter trial that receives identifiable private information from multiple other institutions, the WSU IRB reviews and approves the research activities related to the receipt and processing of the identifiable private information by the statistical center.

When a cooperative agreement exists, WSU may enter into a joint review arrangement, rely on the review of another qualified IRB, or make similar arrangements for avoiding duplication of effort. A formal relationship must be established between Washington State University and the other institutions through a Cooperative Agreement, Reliance Agreement or a Memorandum of Understanding. This relationship must be formalized before Washington State University accepts any human research proposals from the other institution or relies on the review of the other institution. When cooperative agreements exist but the research is determined to be exempt, the relationship may or may not be formally documented, however any decision to rely on another institution's exemption determination will be documented. The ADRA will normally determine the acceptability of exemption determinations made by other institutions, however these decisions may be delegated to qualified HRPP staff.

It is the policy of WSU to assure that all facilities participating in a human subject's study receive adequate documentation about the study to protect the interests of study participants. It is the responsibility of the PI to ensure each research site/facility has adequate information to ensure that the approved protocol is followed by all research staff. Before a study can begin, it must be approved by the IRBs of record for each participating facility and, where appropriate, the IRB of record for the coordinating facility.

For collaborative research, the PI must identify all institutions participating in the research, the responsible IRB(s), and the procedures for dissemination of protocol information (e.g., IRB initial and continuing approvals, relevant reports of unanticipated problems, protocol modifications, and



interim reports) among all participating institutions.

When WSU relies on another IRB, the ADRA, DRA or designee will review the standing of the institution/IRBs registration with OHRP, current FWA (if applicable) and/or policies and procedures of the IRB to ensure that they meet WSU standards. If the other IRB is part of an accredited HRPP, then it will be assumed that adequate protections are in place to protect human subjects.

## **2. Institutional Review Board**

Note: In the following section and in the remainder of this document, reference to the Institutional Review Board (singular) is meant to refer to all Institutional Review Boards registered to WSU and noted on the most current version of the WSU IRB Registration(s) approved by the Office of Human Research Protections. The membership of each board, the meeting schedule for each board, and, if appropriate, the special areas of review of each board, will be described in separate documents.

WSU has established a Human Research protection Program (HRPP) and Institutional Review Board (IRB) to ensure the protection of participants in human subjects research conducted under the auspices of Washington State University. All Exempt research involving human participants must be reviewed by the HRPP, all non-exempt human subjects research conducted under the auspices of Washington State University must be reviewed and approved by the WSU IRB prior to the initiation of the research.

### **2.1 IRB Authority and Independence**

The IRB derives its authority from the WSU HSR policy. Under the federal regulations, this authority includes:

- To approve, require modifications to secure approval, or disapprove all research activities overseen and conducted under the auspices of the WSU;
- To suspend or terminate approval of research not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to participants;
- To observe, or have a third party observe, the consent process; and
- To observe, or have a third party observe, the conduct of the research.

Under certain conditions, detailed in [Section 1.13](#), the Institutional Official or designee may authorize other IRBs to carry out these functions.

Research that has been reviewed and approved by the IRB may be subject to further review and approval or disapproval by officials of the institution. However, those officials may NOT approve research if it has not been approved by the IRB. WSU officials may strengthen requirements

and/or conditions or add other modifications to secure WSU approval or approval by another WSU committee. Previously approved research proposals and/or consent forms must be re-approved by the IRB before the changes or modifications may be initiated.

## **2.2 Number of IRBs**

The number of active IRBs registered to WSU is specified in the FWA. The IO, the DRA and ADRA, and the Chair(s) of the IRB(s) will review the activity of the (on-site) IRB on at least an annual basis and determine the appropriate number of IRBs that are needed for the institution.

As of June 2020 WSU has two separately constituted and registered IRBs:

- IRB1 meets during the academic year and may convene during the summer months when IRB 2 will not convene (OHRP registration # IRB00000449)
- IRB2 meets either during the summer months or to review emergency/disaster research or both (OHRP registration # IRB00011272)

Because the two IRBs have significantly overlapping membership and function within a single continuous review system, protocols presented to one board may be reviewed by the other board.

## **2.3 IRB Membership**

The structure and composition of each IRB is appropriate to the amount and nature of the research that is reviewed. Every effort is made to have members that understand the areas of specialty that encompass most of the research performed at the WSU.

The IRB will include members who are knowledgeable about and experienced working with vulnerable populations that typically participate in WSU research.

Members of the boards are drawn from colleges that submit most of the protocols: Liberal Arts and Social Sciences; Education and Human Services; Health Professions; and Medicine. In recognition of the increasing importance of data security in research, the information technology directors of the various colleges have been appointed as ex-officio members of the IRB.

No one from the WSU Office of Sponsored Programs Services, the Office of Research Support and Operations, or any other WSU office with the authority to accept research revenue or financial contributions to the University, shall serve as members of the IRB or carry out day-to-day operations of the review process. Individuals from these offices may provide information to the IRB and attend IRB meetings as guests.

## **2.4 Composition of the IRB**

The IRB will have at least five members with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the institution.

In addition to possessing the professional competence necessary to review specific research activities, the IRB will be able to ascertain the acceptability of proposed research in terms of institutional policies and regulations, applicable law, data security, and standards of professional conduct and practice. The IRB will therefore include people knowledgeable in these areas.

No IRB has members who are all males or all females. The IRB shall not consist entirely of members of one discipline or profession.

The IRB includes at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas.

The IRB includes at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution.

The IRB includes at least one member who represents the general perspective of participants. One member may satisfy more than one membership category.

Staff of the WSU HRPP Office may be voting members of the IRB.

Per institutional policy, the WSU Privacy Officer may serve on the IRB as an ex-officio voting or non-voting member.

Representatives from the AGO serve on the IRB in a consultant capacity and are typically listed as ex-officio, non-voting members.

On an annual or more frequent basis, the IRB Chairs and the ADRA or DRA shall review the membership and composition of the IRB to determine if they continue to meet regulatory and Institutional requirements.

## **2.5 IRB Coordinators and Compliance Analysts/Specialists**

### ***2.5.1 Qualifications***

IRB Coordinators, Compliance Analysts and Compliance Specialists are expected to be knowledgeable about regulations pertaining to human subjects research protections and be a resource for investigators and their research teams, especially those who may be inexperienced in research, about IRB requirements and human subjects protections training. Certification as either CIM or CIP, either at time of hiring or within 5 years of hiring, is an expectation for this position. In lieu of obtaining certification, individuals in these positions must demonstrate acceptable progress towards obtaining the expertise required to attain certification as evidenced by documented continuing education.

Note: HRPP Review Coordinators, IRB Review Coordinators, IRB Coordinators, Program Coordinators and Program Specialists whose primary function is to support/coordinate IRB

operations are collectively referred to as IRB Coordinators. Compliance positions may also have different official designations but share common working titles of “analyst” or “specialist” depending on qualifications and duties assigned.

### **2.5.2 Responsibilities**

The Coordinator is responsible for receiving and docketing new protocol applications and revisions and applications for continuing review; assigning reviewers for new and continuing applications; preparing correspondence on behalf of the IRB; developing agendas for convened meetings; and maintaining the IRB document management system. The Coordinator may also delegate some of these activities to HRPP support staff (e.g. Program Coordinators, Graduate Assistants). The Coordinator is a member of the IRB and they may review and approve protocols, amendments or other submissions under the same criteria as any other IRB member.

Compliance Analysts and Specialists are tasked with higher level activities of the HRPP including development of reliance agreements, metrics used for program evaluation, conducting for cause and not for cause audits (e.g., Compliance reviews and investigations, Post Approval Review/Post Approval Monitoring) and participating in University wide education and outreach.

### **2.5.3 Evaluation**

The performance of all HRPP staff is evaluated on an ongoing basis and documented in annual reviews by the ADRA, with input from various sources, including the IRB Chair(s), the DRA and the staff members themselves. An integral part of the evaluation process is giving constructive feedback to address any performance areas that are deficient or should be improved. If necessary, formal improvement plans are developed, implemented and reviewed at pre-specified intervals.

## **2.6 Chair, Co-Chair and Vice Chair of the IRB**

### **2.6.1 Appointment**

The WSU IO, in consultation the DRA/ADRA (who in turn may consult with the IRB Chairs(s) and members), appoints a Chair and Co-Chair or Vice Chair for each IRB to serve for renewable terms of up to three years. Any change in appointment, including reappointment or removal, requires written notification.

Nominations are also sought directly from colleges and departments by contacting Deans, ADRs/VCRs (Associate Deans for Research or Vice Chancellors for Research) and Chairs. These nominations are vetted by the ADRA or DRA, normally in consultation with the IRB Chair(s), prior to being presented to the VPR for consideration.

The Vice Chair serves as the Chair of the IRB in the absence of the Chair and will have the same qualifications, authority, and duties as Chair. When an IRB has two Co-Chairs, the Co-Chairs may alternate in fulfillment of the responsibilities, including leading convened meetings based on

factors such as availability and/or individual expertise suited to the protocols to be reviewed. In the event of any dispute between Co-Chairs that cannot be resolved by a vote of the convened IRB, the ADRA will facilitate agreement, with the final decision of any unresolved dispute to be determined by the IO.

### **2.6.2 Qualifications**

The IRB Chair/Vice Chair should be a highly-respected individual, from within Washington State University, capable of managing the IRB and the matters brought before it with fairness and impartiality. The task of making the IRB a respected part of the institutional community will fall primarily on the Chair. The IRB must be perceived to be fair, impartial, and immune to pressure by the institution's administration, the investigators whose protocols are brought before it, and other professional and nonprofessional sources.

### **2.6.3 Responsibilities**

The IRB Chair/Vice Chair is responsible for:

- conducting the meetings;
- designating other IRB members (e.g., the Vice Chair) to perform duties, as appropriate, for review, and other IRB functions or;
- delegating responsibilities to IRB members or HRPP staff as appropriate;
- advising the IO and the DRA/ADRA about IRB member performance and competence.

### **2.6.4 Evaluation**

The performance of IRB Chair/Vice Chair will be reviewed annually by the DRA/ADRA. Feedback from this evaluation will be provided to the Chair. If the Chair is not acting in accordance with the IRB's mission, following these policies and procedures, has an undue number of absences, or is not fulfilling the responsibilities of the Chair, he/she may be removed by the IO.

## **2.7 IRB Members**

### **2.7.1 Appointment**

The IRB Chair, Vice Chair, and/or the ADRA identifies a need for a new, replacement, or alternate member. The ADRA, on behalf of the IO, solicits nominations from Deans, Associate Deans for Research (ADRs), Chairs and other members of the research community and sends the names of the nominees to the IOIO for final consideration and appointment. Department Chairs and others may forward nominations directly to the IO, to the HRPP Office, or the IRB Chair. The final decision in selecting a new member is made by the IO in consultation with the IRB Chair and the ADRA/DRA. Appointments are made for an initial one to three-year term. Subsequent appointments may be made for a period of service of up to three years, and may be renewed. The appointment letter explicitly states performance expectations and members explicitly

acknowledge the expectations in signing their agreement to serve.

Any change in appointment, including reappointment or removal, requires written notification. Members may resign by written notification (e.g., e-mail) to the Chair or ADRA. The IRB Chair and the ADRA review membership and composition of the IRB at least annually to determine if they continue to meet regulatory and institutional requirements.

### **2.7.2 Qualifications**

Required qualifications are willingness to commit to serve on board and attend meetings; completion of required initial and training and continuing education; take active part in discussions before the board; evaluate protocols assigned for expedited review; and present assigned protocols at convened meetings.

The process for identifying potential unaffiliated members is informal and has been operated by the ADRA reaching out to members of the communities near WSU campuses, including Pullman and Spokane, either directly or through WSU staff intermediates.

### **2.7.3 Responsibilities**

The agenda, submission materials, protocols, proposed informed consent forms, and other appropriate documents are made available to members approximately one week prior to the convened meetings at which the research is scheduled to be discussed. Members review the materials before each meeting in order to participate fully in the review of each proposed project. IRB members will treat specific details regarding research proposals, protocols, and supporting data confidentially and sign a non-disclosure agreement as part of initial member training.

Members should attend all scheduled meetings. If a member is unable to attend a scheduled meeting, he/she should inform the IRB Chair, Vice Chair, or an HRPP Office staff member.

If an IRB member is to be absent for an extended time, such as for a sabbatical, he/she must notify the IRB at least 30 days in advance so that an appropriate replacement can be obtained. If the member has a designated alternate the alternate can serve during the primary member's absence.

### **2.7.4 Alternate Members**

The appointment, qualifications, and responsibilities of alternate members are the same as those of primary IRB members. Alternate members' expertise and perspective are comparable to those of the primary members with whom they are paired. A single alternate may be paired with more than one primary member and more than one alternate member may be paired with a single primary member.

WSU faculty consider the term "alternate" as indicating a lower level of membership with lower expectations and less credit for university service. Therefore, we have developed a separate

nomenclature to describe a rotating voting member system in which:

- All appointments to the board are as undifferentiated “members”;
- Rosters filed with OHRP do indicate primary and alternate members;
- Members are grouped according to subject area (e.g., medicine, psychology, education, information technology) and may rotate responsibilities for serving as either a voting member at convened meetings or an expedited reviewer;
- All members are encouraged to attend as many meetings as possible, even when they are not designated voting members for particular meetings; and
- All members receive the same training.

The role of the alternate member is to serve as a voting member of the IRB when the regular member is unavailable to attend a convened meeting. The IRB roster identifies the primary member(s) for whom each alternate member may substitute.

An alternate member may attend convened meetings but will not be counted as a voting member unless the primary member is absent or recuses. The IRB minutes will document when an alternate member replaces a primary member at a convened meeting.

To ensure a quorum at a convened meeting, the IRB coordinator and/or the HRPP Program Coordinator determine approximately 1 week in advance which members will be present and which will serve as voting members. Voting members – whether primary or designated alternates – are announced at the beginning of each meeting and noted in the minutes.

Any experienced members may conduct expedited reviews.

The ADRA is responsible for maintaining current rosters of IRB primary and alternates.

### **2.7.3 Evaluation**

Members are evaluated on their ability to conduct expedited and full board reviews accurately and in a timely manner. If requested, a report of the members’ times to complete assigned reviews will be provided. If needed, the ADRA and IRB Chair or designee will discuss any issues that might negatively affect a members’ ability to complete reviews in a timely manner.

Evaluation is an integral part of the HRPP Quality Assurance and Quality Improvement Programs, as such the results of HRPP QA/QI audits will be utilized for evaluating the effectiveness of protocol reviews. The results of QA/QI audits may be shared with the IRB Chair, the ADRA/DRA, the IO or the full IRB or discussed with individual members of the IRB as appropriate.

## **2.8 IRB Member Conflict of Interest**

An IRB Member Conflict of Interest is a situation in which a member’s financial interest, scientific activities, or personal relationships are inconsistent with the member’s ability to evaluate an application to the IRB without prejudice or prejudgment.

In compliance with federal regulations and guidance, no member may participate in the review (initial, continuing, or modification) of any research project in which the member has a conflict of interest (COI), except to provide information as requested. It is the responsibility of each IRB voting member to disclose any COI in a study submitted for review and recuse him/herself from the deliberations and vote by leaving the room.

When first appointed and upon each successive re-appointment, all members of the IRB will complete a conflict of interest disclosure, which will be consistent with the forms used in connection with WSU's Conflicts of Interest Policies. If a member discloses a potential financial conflict, the Conflict of Interest Committee (COIC) and/or the DRA and Associate VPR are notified, and coordinate development of a conflict of interest management plan.

Committee members may find themselves in any of the following conflicts of interest when reviewing research:

1. Where the member is involved in the design, conduct, and reporting of the research.
2. Where an immediate family member of the member or consultant is involved in the design, conduct, and reporting of the research.
3. Where the member holds significant financial interests related to the research being reviewed. (See [Section 14.1](#) for a definition of significant financial interests.)
4. Any other situation where an IRB member believes that another interest conflicts with his/her ability to deliberate objectively on a protocol.

The IRB Chair polls members at each convened meeting to determine if a COI exists regarding any protocols to be considered during the meeting and reminds members that they should recuse themselves by leaving the room during the discussion and vote of the specific protocol. Members with conflicting interest(s) are excluded from being counted towards quorum, and all recusals are noted in the minutes.

If the Conflict of Interest status of an IRB member changes during the course of a study, the IRB member is required to declare this to the IRB Chair or the ADRA.

## **2.9 Use of Consultants**

The IRB Chair or the ADRA may solicit individuals with competence in special areas to assist in the review of issues or protocols that require appropriate scientific or scholarly expertise beyond or in addition to that available on the IRB. The need for an external reviewer is determined in advance of the meeting by the ADRA or the IRB Chair by reviewing the protocols scheduled to be reviewed at the convened meeting. The HRPP Office will ensure that all relevant materials are provided to the external reviewer prior to the convened meeting.

Written statements of consultants will be kept in IRB records, and key information provided by consultants at meetings will be documented in the minutes.



The ADRA or designee reviews the conflict of interest policy with consultants, and consultants must sign a COI disclosure form and non-disclosure agreement prior to conducting a review. Individuals who have a conflicting interest or whose family members have a conflicting interest in the sponsor of the research will generally not be invited to provide consultation.

The consultant's findings will be presented to the full board or the member serving as an expedited reviewer for consideration either in person or in writing. If in attendance at a convened meeting, these individuals will provide consultation but may not participate in or observe the vote.

Ad hoc or informal consultations requested by individual members (rather than the full board) must be requested in a manner that protects the researcher's confidentiality and complies with the IRB conflict of interest policy (unless the question raised is generic enough to protect the identity of the particular PI and the title or specific details of the research protocol).

## **2.10 Training and Continuing Education of Chair and IRB Members**

A vital component of a comprehensive Human Research Protection Program is an education program for IRB Chairs and IRB members. WSU is committed to providing training and an on-going educational process for IRB members and the staff of the HRPP Office related to ethical concerns and regulatory and institutional requirements for the protection of human subjects.

### ***2.10.1 Orientation***

New IRB members, including alternate members will meet with the IRB Coordinator (or IRB Chair or the ADRA) for an orientation session. At the session, the new member will receive access to or electronic copies of the following documents:

- The Belmont Report;
- WSU Policies and procedures for the review and oversight of human subject research; and
- Federal regulations for protection of human subjects.

### ***2.10.2 Initial Education***

Prior to serving as primary or independent reviewers, new members are required to complete the Initial Education requirement for IRB members including CITI training; orientation to review procedures with the IRB Coordinator, ADRA and/or IRB Chair; orientation with the IRB Coordinator or HRPP staff on the use of the electronic management system for conducting reviews; and work with an experienced IRB member to conduct expedited reviews.

### ***2.10.3 Continuing Education***

To ensure that oversight of human research is ethically grounded and the decisions made by the IRB are consistent with current regulatory and policy requirements, training is continuous for IRB

members throughout their service on the IRB. Educational activities include, but are not limited to,

- In-service training at IRB meetings;
- Training workshops;
- Copies of appropriate publications.

Identification and dissemination by the ADRA of new information that might affect the Human Research Protection Program, including laws, regulations, policies, procedures, and emerging ethical and scientific issues to IRB members via email, mail, or during IRB meetings.

## **2.11 Liability Coverage for IRB Members**

Washington State University's insurance coverage applies to employees and any other person, including members of the IRB, authorized to act on behalf of Washington State University within the scope of their employment or authorized activity.

## **2.12 Reporting and Investigating Allegations of Undue Influence**

If an IRB chair, member, or staff person feels that the IRB has been unduly influenced by any party, they shall make a confidential report to the IO, depending on the circumstances. Issues or concerns involving the IO will be reported to the Provost or President, and other appropriate institutional official(s) or the WSU compliance hotline (509-335-1289 or [or.hotline@wsu.edu](mailto:or.hotline@wsu.edu)). The IO or other official receiving the report will conduct an investigation, and if necessary, prescribe corrective action to prevent additional occurrences.

# **3. IRB Review Processes**

All human subjects research conducted under the auspices of WSU must meet the criteria for one of the following methods for review:

- Exempt Review
- Expedited Review
- Review at Convened Meeting (Full Board Review)

The IRB will ensure that the research meets all required ethical and regulatory criteria for initial and continuing review as well as any modifications of approved research.

## **3.1 Definitions**

**Minimal Risk** – The probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

**Minor Change** – A change that, in the judgment of the IRB reviewer or IRB/HRPP coordinator, makes no substantial alteration in the level of risks or a decrease in benefit or unfavorable change to the risk/benefit ratio to subjects. For example:

1. the research design or methodology (Note: Adding procedures that are not eligible for expedited review (see [Section 3.4](#)) would not be considered a minor change;
2. the number of subjects enrolled in the research (if research is greater than minimal risk, no greater than 10% of the total requested);
3. the qualifications of the research team;
4. the facilities available to support safe conduct of the research; and
5. any other factor that would warrant review of the proposed changes by the convened IRB.

**Quorum** – A simple majority of the voting membership, including at least one member whose primary concern is in a non-scientific area.

**Suspension of IRB approval** – A directive of the convened IRB or an authorized individual to temporarily stop some or all previously approved research activities. Suspended protocols remain open and require continuing review.

**Termination of IRB approval** – A directive of the convened IRB to stop permanently all activities in a previously approved research protocol. Terminated protocols are considered closed and no longer require continuing review.

## 3.2 Human Subjects Research Determination

The investigator is responsible for initial determination of whether an activity constitutes human subject research. The investigator should make this determination based on the definitions of “human subject” and “research” in [Section 19](#). Since Washington State University will hold them responsible if the determination is not correct, investigators are urged to request confirmation that an activity does not constitute human subjects research from the HRPP Office.

Determinations as to whether an activity constitutes human subjects research will be made according to the definitions in [Section 19](#) using either the Human Subject Research Determination form, or via the electronic submission system. Determinations regarding activities that either clearly are or clearly are not human subjects research may be made by experienced HRPP staff, the ADRA or the Chair. Determinations regarding less clear activities will be referred to the ADRA and/or IRB Chair, who may make the determination or refer the matter to the convened IRB.

Documentation of all determinations made through the HRPP Office will be recorded and maintained in the IRB document management system. Formal submissions will be responded to in writing and a copy of the submitted materials and determination letter/email will be kept on file.

## 3.3 Exempt Determinations

Determinations regarding whether research involving human subjects qualifies for exempt status will be made by the ADRA or IRB Chair. The ADRA or Chair may designate qualified IRB members and HRPP staff to make exemption determinations and conduct exemption reviews. Individuals will be determined to be qualified through completion of training in the conduct of exempt reviews. As indicated by OHRP guidance, exemption determinations may not be made solely by the researcher or by someone with a conflict of interest in the research.

Although exempt research is not covered by the federal regulations, it is not exempt from the ethical guidelines of the Belmont Report, nor can it be considered exempt from the regulations until an exempt determination has been documented by a qualified individual within the HRPP. The individual making the determination of exemption will determine whether to require additional protections for subjects in keeping with the guidance of the Belmont Report.

### ***3.3.1 Limited IRB Review***

Certain types of exempt research, typically involving sensitive data, may require limited IRB review. When the research requires limited IRB review, the review will be conducted by the IRB Chair or a designated member of the IRB (including appropriately qualified non-voting members) and may be conducted using expedited review procedures limited to and focused on criteria 7 (45 CFR 46.111). As with all other research subject to IRB review requirements, when conducting limited IRB review the IRB has the authority to approve, require modifications in (to secure approval), or disapprove all research activities.

Proposed modifications to the aspects of research subject to limited IRB review must be submitted to, and approved by, the IRB prior to implementation, except when necessary to eliminate apparent immediate hazards to the subject(s), in which case the change must be promptly reported to the IRB (within 5 business days if possible).

Continuing review is generally not required for research determined to be exempt, even when that research is subject to limited IRB review. However, the IRB or HRPP may determine that continuing review is required for a particular study subject to limited IRB review, in which case it shall document the reasons for its determination in the IRB record and communicate the requirement to the investigator in the determination letter.

### ***3.3.2 Limitations on Exemptions***

**Children:** Exemption #2(i) and (ii) for research involving survey or interview procedures or observations of public behavior does NOT apply to research in children, except for research involving observations of public behavior when the investigator does not participate in the activities being observed. Exemption #2(iii), where identifiable information is obtained and the IRB conducts a limited IRB review, is NOT applicable to research in children. Exemption #3 does NOT apply to research involving children.

**Prisoners:** Exemptions do not apply EXCEPT for research aimed at involving a broader subject population that only incidentally includes prisoners.

### **3.3.3 Categories of Exempt Research**

Unless otherwise required by law or a federal agency or department, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from the additional requirements of the revised Common Rule, except as specified.

Note: Other than exempt category 6, these categories do not apply to research that is also FDA-regulated.

1. Research, conducted in established or commonly accepted educational settings, that specifically involves normal educational practices that are not likely to adversely impact students' opportunity to learn required educational content or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.
2. Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
  - i. The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;
  - ii. Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or
  - iii. The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7): "When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data."
3. Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met:
  - i. The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;
  - ii. Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or
  - iii. The information obtained is recorded by the investigator in such a manner that the

identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7): “When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.”

For the purpose of this provision, benign behavioral interventions are brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing.

Provided all such criteria are met, examples of such benign behavioral interventions would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else.

If the research involves deceiving the subjects regarding the nature or purposes of the research, this exemption is not applicable unless the subject authorizes the deception through a prospective agreement to participate in research in circumstances in which the subject is informed that he or she will be unaware of or misled regarding the nature or purposes of the research.

4. Secondary research for which consent is not required: Secondary research use of identifiable private information or identifiable biospecimens, if at least one of the following criteria is met:
  - i. The identifiable private information or identifiable biospecimens are publicly available;
  - ii. Information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects;
  - iii. The research involves only information collection and analysis involving the investigator’s use of identifiable health information when that use is regulated under 45 CFR parts 160 and 164 [‘HIPAA’], subparts A and E, for the purposes of “health care operations” or “research” as those terms are defined at 45 CFR 164.501 or for “public health activities and purposes” as described under 45 CFR 164.512(b); or
  - iv. The research is conducted by, or on behalf of, a Federal department or agency using government-generated or government-collected information obtained for non-research activities, if the research generates identifiable private information that is or will be maintained on information technology that is subject to and in compliance with section 208(b) of the E-Government Act of 2002, 44 U.S.C. 3501 note, if all of the identifiable private information collected, used, or generated as part of the activity will be maintained in systems of records subject to the Privacy

Act of 1974, 5 U.S.C. 552a, and, if applicable, the information used in the research was collected subject to the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 et seq.

5. Research and demonstration projects that are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated authority to conduct the research and demonstration projects), and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants. Exempt projects also include waivers of otherwise mandatory requirements using authorities such as sections 1115 and 1115A of the Social Security Act, as amended.
  - I. Each Federal department or agency conducting or supporting the research and demonstration projects must establish, on a publicly accessible Federal Web site or in such other manner as the department or agency head may determine, a list of the research and demonstration projects that the Federal department or agency conducts or supports under this provision. The research or demonstration project must be published on this list prior to commencing the research involving human subjects.
6. Taste and food quality evaluation and consumer acceptance studies:
  - i. If wholesome foods without additives are consumed, or
  - ii. If a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

### ***3.3.4 Unused Exemption Categories***

The WSU HRPP has determined that exempt categories 7 and 8 are not used, even though allowed by regulation. Protocols involving broad consent for future use of identified data or biospecimens will be reviewed by expedited processes or at a convened meeting.

### ***3.3.4 FDA Exemptions***

The following categories of clinical investigations are exempt from the requirements of IRB review:

1. Emergency use of a test article. WSU IRB does not currently oversee emergency use of investigational or unlicensed test articles. In the event this type of research is submitted to the WSU IRB for review, it will normally be sent to a commercial IRB with which WSU has established a master services agreement.
2. Taste and food quality evaluations and consumer acceptance studies, if wholesome foods

without additives are consumed or if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe; or agricultural, chemical, or environmental contaminant at or below the level found to be safe by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture [21 CFR 56.104(d)].

### **3.3.5 Procedures for Exemption Determination**

In order to obtain an exemption determination, investigators should submit

1. a completed IRB Application to Conduct Exempt Research;
2. all recruitment materials (e.g., letter of invitation, recruitment script, flyer), consent form (when appropriate), or a consent script or justification for waiving informed consent (or documentation of consent) when a consent form will not be used
3. all surveys, questionnaires, instruments, etc.;
4. letter(s) of permission from each non-Washington State University site of performance (if letters are not available at time of submission, the investigator is responsible for obtaining them prior to initiation of research activity and should provide a copy to the IRB when available);
5. if sponsored, one copy of the grant application(s) and/or contract (at a minimum, the investigator must provide the ORSO # for reference);
6. verification of current human research protection training for all key members of the research team, including the faculty advisor. When the protocol involves non-WSU personnel, the PI at the corresponding site will be responsible for ensuring completion and documentation of appropriate training.

Investigators will be given feedback by email as to the qualification of the application for exempt status. Once institutional review is completed, IRB staff or the ADRA will send an email notification to the PI of the results of the review. Documentation will include the specific categories justifying the exemption.

Approval periods: Exemptions will have no default termination date unless otherwise specified, however status checks to confirm that the project is still active may be required.

Collaborative research exemption determinations: For multi-site/multi-institution exempt research, please see [Section 3.17](#) "Multi-site studies" for information regarding WSU reliance/acceptance of other IRBs/HRPPs exemption determinations and for the procedures to request formal or informal reliance on WSU HRPP exemption determination by external sites, institutions or independent researchers.

## **3.4 Expedited Review**

Research that presents minimal risk to research subjects may be reviewed by expedited procedures. If the research is funded or supported by an agency that subscribes to the Common Rule, then the research must fall in one of the categories described below in [Section 3.4.1](#).



Otherwise, all other minimal risk research is eligible for expedited review (See [Section 3.4.2](#))

Expedited review may be carried out by the IRB Chair or by one or more reviewers designated by the Chair from among members of the IRB. As HRPP staff are often in the best position to determine reviewer availability and workload, the IRB Chair may designate in writing the authority to assign members to conduct expedited reviews to well qualified members of the HRPP. The designated reviewers must be qualified voting or non-voting members of the IRB (having successfully completed introductory training sessions in IRB procedures and carried out at least one expedited review under the guidance of an experienced member). HRPP Staff will maintain a list of members qualified to conduct independent expedited reviews and the Chair(s) or designated HRPP staff will select expedited reviewers from that list. Selected reviewers will have the qualifications, experience, and knowledge in the content of the protocol to be reviewed as well as be knowledgeable of the requirements to approve research under expedited review. IRB members with a conflict of interest in the research (see [Section 2.8](#)) will not be selected.

When reviewing research under an expedited review procedure, the IRB Chair or designated IRB member(s) will have access to all documentation associated with the protocol. The reviewer(s) conducting initial or continuing review will determine whether the research meets the regulatory criteria for approval by expedited review. If the research does not meet the criteria for expedited review, then the reviewer will indicate that the research requires full review by the convened IRB, and the protocol will be placed on the next agenda for an IRB meeting.

In reviewing the research, the reviewers will follow the Review Procedures described in [Section 3.7](#) and [Section 3.8](#) below and may exercise all of the authorities of the IRB except that the reviewers may not disapprove the research. A research activity may be disapproved only after review in accordance with the non-expedited procedure described in [Section 3.8](#).

Reviewers will document approval, required modifications, or requirement for convened board review. If modifications are required, the IRB Office staff will inform the investigator by e-mail. If expedited review is carried out by more than one IRB member and the expedited reviewers cannot agree, the IRB Chair may make a final determination or refer the matter to the convened IRB.

### ***3.4.1 Categories of Research Currently Authorized by HHS as Eligible for Expedited Review***

The activities listed below should not be deemed to be of minimal risk simply because they are included on this list. Inclusion on this list merely means that the activity is eligible for review through the expedited review procedure when the specific circumstances of the proposed research involve no more than minimal risk to human subjects.

The categories in this list apply regardless of the age of subjects, except as previously noted.

The expedited review procedure may not be used where identification of the subjects and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, insurability, reputation, or be stigmatizing, unless

reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.

The expedited review procedure may not be used for classified research involving human subjects.

Research Categories one (1) through seven (7) pertain to both initial and continuing IRB review:

1. Clinical studies of drugs and medical devices only when condition (a) or (b) is met.
  - a. Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.)
  - b. Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.
2. Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:
  - a. from healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8-week period and collection may not occur more frequently than 2 times per week; or
  - b. from other adults and children [2], considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8-week period and collection may not occur more frequently than 2 times per week.
3. Prospective collection of biological specimens for research purposes by noninvasive means. Examples: (a) hair and nail clippings in a non-disfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.
4. Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.)

Examples: (a) physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject's privacy; (b) weighing or testing sensory acuity; (c) magnetic resonance imaging; (d) electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography; (e) moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

5. Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis). (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(4). This listing refers only to research that is not exempt.)
6. Collection of data from voice, video, digital, or image recordings made for research purposes.
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.)

Note 1: The WSU IRB has determined that research involving brief episodes of intense exercise, such as that involved in maximum oxygen uptake testing, is eligible for inclusion in this category under example (e) provided that the subject population meets the following criteria: non-pregnant; 18-45 years of age; in good health, with no medical indication(s) that would otherwise preclude them from engaging in vigorous exercise.

8. Continuing review of research previously approved by the convened IRB as follows:
  - a. where (i) the research is permanently closed to the enrollment of new subjects; (ii) all subjects have completed all research-related interventions; and (iii) the research remains active only for long-term follow-up of subjects; or
  - b. where no subjects have been enrolled and no additional risks have been identified; or
  - c. where the remaining research activities are limited to data analysis.
  - d. Where the convened board approved the protocol and made a determination that the protocol involves minimal risk only, subsequent reviews will be eligible for expedited procedure unless the convened board specifically notes that continuing review before the convened Board is required.
9. Continuing review of research not conducted under an investigational new drug application or investigational device exemption where categories two (2) through eight (8) do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

Limited IRB Review. The limited IRB review that is required for certain exempt research (categories 2(iii) and 3(iii)) (See [Section 3.3](#)) may be conducted using expedited review

procedures.

### ***3.4.2 Additional Categories Eligible for Expedited Review (Flexibility Criterion)***

The WSU IRB has determined that certain categories of research, beyond those described in [Section 3.4.1](#) present minimal risk to subjects and can be reviewed by expedited procedures, provided the research is not supported or regulated by a Common Rule agency.

Flex 1. Research involving low levels of ionizing radiation (not to exceed 0.1 mSv per exposure) qualifies for expedited review if the following conditions are met: (i) subjects are 18 years of age or over; (ii) subjects are not pregnant; (iii) the use of multiple exposures is justified as being necessary to evaluate a study hypothesis, and the exposures are separated by a reasonable interval of time considered sufficient for hypothesis testing.

Flex 2. Any research that the IRB Chair or convened IRB determines to present minimal risk to subjects may be reviewed by expedited procedures.

### ***3.4.3 Continuing Review and Annual Status Report***

Continuing review of research is not required for research that qualifies for expedited review unless the IRB determines that it is required and documents the rationale within the IRB record. As noted in [Section 3.4.1](#) (8d), for any minimal risk research originally reviewed by the convened Board, but that was determined by the Board to involve no more than minimal risk and where the board does not specifically request continuing review by the convened Board, that research will be eligible for review by expedited procedure (e.g., for continuing review, amendment reviews).

Note: some federal agencies that do not follow, or partially follow, the common rule may require continuing review (e.g., DOJ/NIJ, see DOJ addendum for more).

Research that was approved by expedited process prior to implementation of the revised Common Rule by the WSU IRB in January 2018 will be evaluated on a case-by-case basis to determine whether continuing review will be required. Whenever possible, these projects will be reviewed under the revised common rule and further continuing review will only be required when indicated by the IRB or expedited reviewer and the basis for continuing review documented.

Investigators conducting research approved by expedited process that does not require continuing review must submit annual status reports. If the PI, after multiple attempts to contact them, fails to submit an annual status report, the protocol will be deactivated by HRPP staff.

### ***3.4.4 Informing the IRB***

All members of the IRB will be apprised of all expedited review approvals by means of a list in the agenda for each scheduled meeting. Any IRB member can request access to the complete protocol file by contacting the IRB Office.

## **3.5 Convened IRB Meetings**

Except when an expedited review procedure is used, the IRB will conduct initial and continuing reviews of all non-exempt research at convened meetings at which a quorum (defined below) of the members is present.

### ***3.5.1 IRB Meeting Schedule***

The IRB usually meets at least once per month during the academic year and summer. The schedule for IRB meetings and deadlines for submitting applications is posted on the HRPP website. Special meetings may be called at any time by the IRB Chair or the ADRA.

### ***3.5.2 Preliminary Review***

The IRB Coordinator or other appropriately trained HRPP staff will perform a preliminary review of all protocol materials submitted to the HRPP Office for determination of completeness and accuracy. Only complete submissions will be placed on the IRB agenda for review. The investigator will be informed either by e-mail, phone, or in person of missing materials and the necessary date of receipt for inclusion on that agenda.

Individualized IRB consultations can be arranged for investigators who are submitting protocols for the first time or for investigators who may not be well-versed in the protocol submission procedures. Specific questions about the IRB policies and procedures, determination of whether a particular protocol is human research or not, and what particular forms are required for a particular study can be submitted to the HRPP for information and/or clarification.

### ***3.5.3 Primary and Secondary Reviewers***

After determining that the protocol submission is complete, designated HRPP staff, in consultation with the IRB Chair, will assign protocols for review taking account of the scientific content of the protocol, the potential reviewer's area of expertise, and representation for vulnerable populations involved in the research. At least one reviewer will be assigned to each protocol, normally two reviewers will be assigned to full board to ensure that at least one reviewer can present the protocol in person at a convened meeting.

Reviewers are assigned to all protocols requiring initial review, continuing review, and modifications. When the IRB is presented with a protocol that may be outside of the knowledge base or representative capacity of any of the IRB members, a consultant will be sought (see [Section 2.9](#)). Protocols for which appropriate expertise cannot be obtained for a given meeting will be deferred to another meeting when appropriate expertise can be achieved.

The primary and secondary reviewers are responsible for:

1. Having a thorough knowledge of the details of the proposed research.
2. Performing an in-depth review of the proposed research.
3. Leading the discussion of the proposed research at the convened meeting, presenting

both positive and negative aspects of the research.

4. Making suggestions for changes to the proposed research, where applicable.
5. Completion and submission of applicable IRB reviewer forms or comments prior to a convened meeting.

If both the primary and secondary reviewer are absent from the meeting, a new reviewer may be assigned, provided they have reviewed the materials prior to the meeting. Additionally, an absent reviewer can submit written comments for presentation at the convened meeting, as long as another reviewer present at the convened meeting can serve as the primary reviewer and present the materials on their behalf. All IRB members have access to, and are expected to review, all proposed studies.

#### ***3.5.4 Availability of Documents Before a Meeting***

Investigators must submit all required materials (in full) according to the schedule posted to the HRPP web page (typically 7-10 business days) before the convened meeting for inclusion on the next IRB agenda. The meeting agenda will be prepared by the ADRA or IRB Coordinator and made available to the IRB members prior to the meeting. All IRB members receive access to their review materials which include the IRB agenda, prior month's meeting minutes, applicable business items and audits, appropriate continuing education materials and protocol review materials no later than 5 business days before the scheduled meeting to allow sufficient time for review, however materials containing minor revisions/updates may be provided at any time up to 24 hours prior to a convened meeting.

#### ***3.5.5 Materials Reviewed by the IRB***

Each IRB member has access to the following documentation, as applicable, for all protocols on the agenda:

1. Complete Protocol Application form
2. Proposed Consent / Parental Permission / Assent Form(s)
3. Recruitment materials / subject information
4. Data collection instruments (including all surveys and questionnaires)

At least one primary reviewer must receive and review the following (when they exist): any grant applications (when relevant); the sponsor's protocol, the investigator's brochure, the DHHS-approved sample informed consent document, the complete DHHS-approved protocol.

Any IRB member may request access to any of the material provided to the primary and secondary reviewers by contacting the IRB Office, however these materials are usually made available to all members via normal operational procedures (e.g., IRB SharePoint folders).

Protocol reviewers will complete a Reviewer Checklist, or equivalent electronic record, to document their review.

### **3.5.6 Quorum**

A quorum consists of a simple majority (more than half) of the voting membership, including at least one member whose primary concern is in a non-scientific area. The IRB Chair, with the assistance of the IRB staff, will confirm that an appropriate quorum is present before calling the meeting to order. The IRB Chair will be responsible for ensuring that the meetings remain appropriately convened.

At meetings of the IRB, a quorum must be established and maintained for the deliberation and vote on all matters requiring a vote. If a quorum is not maintained, the pending action item must be deferred or the meeting terminated. The IRB staff will note the arrival and departure of all IRB members during the meeting and notify the IRB Chair when quorum is lost.

It is generally expected that at least one unaffiliated member and at least one member who represents the general perspective of participants (the same individual can serve in both capacities) will be present at all IRB meetings. Although the IRB may, on occasion, meet without this representation, individuals serving in these roles should be present for at least 80% of the IRB meetings.

An attendance sheet is completed by the IRB staff to determine and document whether an IRB meeting is appropriately convened and maintained. A sign-in sheet is maintained for any meeting convened in person.

IRB members are considered present and participating at a duly convened IRB meeting when they are either physically present or participating through electronic means (e.g., tele/video-conferencing) that permits them to listen to and speak during IRB deliberations and voting. When not physically present, the IRB member must have access to all pertinent materials prior to the meeting and must be able to participate actively and equally in discussions.

Opinions of absent members may be considered by the attending IRB members but will not be counted in any vote.

### **3.5.7 Meeting Procedures**

The IRB Chair, or Vice-Chair in the event that the IRB Chair is absent, will:

- Call the meeting to order once it has been determined that a quorum is established;
- With the assistance of HRPP staff, identify which of the members present will occupy voting seats and which of the members will not be voting;
- Remind IRB members to recuse themselves from the discussion and vote by leaving the room where they have a conflict of interest;
- Indicate any non-IRB member individuals in attendance including: HRPP staff members (only those who are not also members of the IRB), consultants, and guests.

The IRB will review and discuss the IRB minutes from the prior meeting and determine if there

are any revisions/corrections to be made. If there are no changes to be made, the minutes will be accepted as presented and considered final. Minutes may be accepted by consensus or by vote. If it is determined that revisions/corrections are necessary, the minutes will be amended. Once accepted by the IRB, minutes may not be altered, however in the event an error is detected at a later time (e.g., via quality assurance audit), an administrative note will be attached to the approved minutes and signed by the ADRA and/or Chair.

The IRB reviews all submissions for initial and continuing review, as well as requests for modifications. The Primary and Secondary Reviewer each present an overview of the research. The chair leads the IRB through consideration of the regulatory criteria for approval (e.g., “111 criteria”). For the research to be approved, it must receive the approval of a majority of those voting members present at the meeting.

It is the responsibility of the ADRA to ensure that HRPP staff record the proceedings of the session and take minutes at each IRB meeting. Audio or video recordings may be utilized for quality assurance purposes. When this is done, the recordings will be maintained only until the minutes have been approved by the IRB and then will be deleted as soon as practicable.

### **3.5.8 Guests**

At the discretion of the IRB Chair or ADRA, the Principal Investigator will be invited to the IRB meeting to answer questions about proposed or ongoing research. The Principal Investigator should not be present for the discussion or vote on the proposal.

Other guests may be permitted to attend IRB meetings at the discretion of the IRB Chair and the ADRA; they may not speak unless requested by the IRB Chair and will be asked to sign a confidentiality agreement and/or to not be present during deliberations and voting. When guests attend electronically or via phone, they are placed on hold or in a virtual waiting room during deliberations or voting.

## **3.6 Criteria for IRB Approval of Research**

### **3.6.1 Required determinations**

For the IRB to approve human subjects research, either through expedited review or by review at a convened meeting, it must determine that the following criteria are satisfied:

1. Risks to subjects are minimized (i) by using procedures that are consistent with sound research design and that do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.
2. Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result. In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would



receive even if not participating in the research). The IRB should not consider possible long- range effects of applying knowledge gained in the research (for example, the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.

3. Selection of subjects is equitable. In making this assessment the IRB should take into account the purposes of the research and the setting in which the research will be conducted and should be particularly cognizant of the special problems of research that involves a category of subjects who are vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons.
4. Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with and to the extent required by the federal regulations.
5. Informed consent will be appropriately documented, in accordance with and to the extent required by the federal regulations.
6. When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects.
7. When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

### ***3.6.2 Additional considerations for vulnerable subjects***

When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects.

While pregnant women are no longer described as vulnerable within the above criteria, the IRB shall continue to apply Subpart B “Additional Protections for Pregnant Women, Human Fetuses and Neonates.” The revised Common Rule does not eliminate or modify Subpart B.

These criteria must be satisfied for each review (initial, continuing, and modifications) for both expedited review and review by the convened IRB.

### ***3.6.3 Risk-Benefit Assessment***

The goal of the assessment is to ensure that the risks to research subjects posed by participation in the research are reasonable in relation to the anticipated benefits to the subjects or society.

Toward that end, the IRB must:

1. judge whether the anticipated benefit, either of new knowledge or of improved health for the research subjects, justifies asking any person to undertake the risks;
2. disapprove research in which the risks are judged unreasonable in relation to the anticipated benefits.

The assessment of the risks and benefits of proposed research involves a series of steps:

1. identify the risks associated with the research, as distinguished from the risks of therapies the subjects would receive even if not participating in research;
2. determine whether the risks will be minimized to the extent possible;
3. identify the probable benefits to be derived from the research;
4. determine whether the risks are reasonable in relation to the benefits to subjects, if any, and assess the importance of the knowledge to be gained;
5. ensure that potential subjects will be provided with an accurate and fair description of the risks or discomforts and the anticipated benefits;

### ***3.6.4 Assessment of Scientific Merit***

To assess the risks and benefits of the proposed research, the IRB must determine that the knowledge expected to result from this research is sufficiently important to justify the risk.

In making this determination, IRB reviewers may draw on their own knowledge and disciplinary expertise, or they may draw on the knowledge and disciplinary expertise of others, such as reviews by a funding agency or consultants. When scientific review is conducted by an individual or entity external to the IRB, documentation that the above questions were considered must be provided to the IRB for review and consideration.

When scientific review is conducted by an individual or entity external to the IRB, the Investigator may provide documentation that the above questions were considered to the IRB for review and consideration. For example, when a protocol is the subject of a masters or doctoral thesis, evidence of scientific merit may be provided in the form of a statement of approval from the advisory committee. When a protocol is reviewed for scientific merit as part of an internal funding application, evidence of the review may be provided to the IRB.

### ***3.6.5 Equitable Selection of Subjects***

The IRB will determine by viewing the application, protocol, and other research project materials that the selection of subjects is equitable with respect to sex, gender, age, socioeconomic status, and other characteristics of groups considered vulnerable or qualified for special protections under state or federal law.

The IRB will not approve a study that does not provide adequately for the equitable selection of subjects, given the research topic, or has not provided an appropriate scientific and ethical justification for excluding classes of persons who might benefit from the research. In making this determination, the IRB evaluates the purposes of the research; the setting in which the research occurs; scientific and ethical justification for including vulnerable populations such as children, prisoners, decisionally-impaired persons, economically or educationally disadvantaged persons or individuals determined by the IRB to be situationally vulnerable (e.g. students); the scientific and ethical justification for excluding classes of persons who might benefit from the research; and the inclusion/exclusion criteria.

The IRB will not approve a study that proposes to recruit subjects because they are disadvantaged economically and would be likely to participate solely in response to economic inducements.

The investigator will provide the IRB with all recruiting materials to be used in identifying participants, including recruitment methods, advertisements, and payment arrangements (see [Section 3.7.6](#) for discussion of IRB review of advertisements and [Section 3.7.7](#) for discussion of IRB review of payments).

### **3.6.6 Informed Consent**

The IRB will ensure that informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by [45 CFR 46.116](#) and 21 CFR 50.20. In addition, the board will ensure that informed consent will be appropriately documented in accordance with, and to the extent required by [45 CFR 46.117](#) and [21 CFR 50.27](#) (see [Section 5](#) below for detailed policies on informed consent).

### **3.6.7 Safety Monitoring**

The elements of a safety monitoring plan may vary depending on the risks, complexity, and nature of the research. Monitoring may be conducted in various ways or by various individuals or groups, depending on the size and scope of the research effort. These exist on a continuum from monitoring by the principal investigator in a small, low-risk study to the establishment of an independent data- and safety-monitoring board for a large phase III clinical trial.

The factors the IRB will consider in determining whether the safety monitoring plan is adequate for the research are as follows:

1. Monitoring is commensurate with the nature, complexity, size, and risk involved.
2. Monitoring is timely with a determined frequency commensurate with risk. Results are reported to the IRB.
3. For low-risk studies, continuous, close monitoring by the study investigator or other individual may be adequate and appropriate, with prompt reporting of problems to the IRB, sponsor, and regulatory bodies as appropriate.
4. For an individual Safety Monitor, the plan must include;
  - a. Parameters to be assessed.
  - b. Mechanism to assess the critical efficacy endpoints at intervals to determine when to continue, modify, or stop a study.
  - c. Frequency of monitoring.
  - d. Procedures for reporting to the IRB.
5. For a Data Safety Monitoring Board (DSMB), the plan must include;
  - a. The name of the DSMB.
  - b. When appropriate, the DSMB must be independent from the sponsor
  - c. Availability of written reports
  - d. Composition of the monitoring group (if a group is to be used). Experts in all scientific

- disciplines needed to interpret the data and ensure patient safety. Clinical trial experts, biostatisticians, bioethicists, and clinicians knowledgeable about the disease and treatment under study should be part of the monitoring group or be available if warranted.
- e. Frequency and content of meeting reports.
  - f. Frequency and character of monitoring meetings (e.g., open or closed, public or private). In general, it is desirable for a DSMB to be established by the study sponsor for research that is blinded, involves multiple sites, involves vulnerable subjects, or employs high-risk interventions. The IRB has the authority to require a DSMB as a condition for approval of research when it determines that such monitoring is needed. When DSMBs are utilized, the IRB conducting continuing review of research may rely on a current statement from the DSMB indicating that it has and will continue to review study-wide Adverse Events, interim findings, and any recent literature that may be relevant to the research, in lieu of requiring that this information be submitted directly to the IRB.

### **3.6.8 Privacy and Confidentiality**

The IRB will determine whether adequate procedures are in place to protect the privacy of subjects and to maintain the confidentiality of the data.

#### **3.6.8.1 Privacy**

Privacy is defined as having control over the extent, timing, and circumstances of sharing oneself physically, behaviorally, or intellectually with others.

To determine that adequate procedures are in place to protect the privacy of subjects, the IRB must obtain information regarding how the investigators obtain access to subjects or subjects' private, identifiable information and the subjects' expectations of privacy in the situation. Investigators must have appropriate authorization to access the subjects or the subjects' information.

In developing strategies for the protection of subjects' privacy, consideration should be given to:

1. Methods used to identify and contact potential participants.
2. Settings in which an individual will be interacting with an investigator.
3. Appropriateness of all personnel present for research activities.
4. Methods used to obtain information about participants and the nature of the requested information.
5. Information that is obtained about individuals other than the "target participants" and whether such individuals meet the regulatory definition of "human participant" (e.g., a subject provides information about a family member for a survey).
6. That access will be limited to the minimum amount of information necessary to complete the study.

### **3.6.8.2 Confidentiality**

Confidentiality refers to the methods used to ensure that information obtained by researchers about research subjects is not improperly divulged.

The level of confidentiality protection should be commensurate with the potential of harm from inappropriate disclosure. Confidentiality and anonymity are not the same. If anyone, including the investigator, can readily ascertain the identity of the subjects from the data, then the research is not anonymous, and the IRB must determine if appropriate protections are in place to minimize the likelihood that the information will be inappropriately divulged.

### **3.6.8.3 Review of measures to protect privacy and confidentiality**

At the time of initial review, the IRB ensures that the privacy and confidentiality of research subjects is protected. The IRB assesses whether there are adequate provisions to protect subject privacy and maintain confidentiality. The IRB does this through the evaluation of the methods used to obtain information about:

1. subjects,
2. individuals who may be recruited to participate in studies,
3. the use of personally identifiable records, and
4. the methods to protect the confidentiality of research data.

The PI will provide the information regarding the privacy and confidentiality of research subjects at the time of initial review through the completion of the application, any necessary HIPAA Forms, research protocol, and/or other submitted, applicable materials. The IRB will review all information received from the PI and determine whether the privacy and confidentiality of research subjects are sufficiently protected. In some cases, the IRB may also require that a Certificate of Confidentiality be obtained to additionally protect research data (see [Section 17.1](#)).

In reviewing confidentiality protections, the IRB will consider the nature, probability, and magnitude of harms that would be likely to result from a disclosure of collected information outside the research. It will evaluate the effectiveness of proposed de-identification techniques, coding systems, encryption methods, storage facilities, access limitations, and other relevant factors in determining the adequacy of confidentiality protections.

As necessary, the IRB will draw on the expertise of the office of Information Technology Services (ITS) to assess plans for data security.

### **3.6.9 Vulnerable Populations**

At the time of initial review, the IRB will consider the scientific and ethical reasons for including vulnerable subjects in research. The IRB may determine and require that, when appropriate, additional safeguards be put into place for vulnerable subjects.

For an extensive discussion about the IRB's review and approval process for individual populations of vulnerable subjects, please refer to [Section 6](#).

## **3.7 Additional Considerations During IRB Review and Approval of Research**

### **3.7.1 Approval Period**

At the time of initial review and at continuing review, the IRB will determine the frequency of review of the research protocols. All protocols will be reviewed by the IRB at intervals appropriate to the degree of risk. The meeting minutes will reflect the IRB's determination regarding review frequency. The default approval period is one year unless documented otherwise. For research approved via expedited review, approval periods are considered to be one year and will require either a full continuing review or an annual status check. Protocols determined to require status checks only will not be assigned an expiration date but must notify the HRPP if they will continue beyond one year to avoid deactivation.

Unless specifically waived by the IRB, research that meets any of the following criteria will require review more often than annually:

1. Significant risk to research subjects (e.g., death, permanent or long-lasting disability or morbidity, severe toxicity) without the possibility of direct benefit to the subjects.
2. The involvement of populations likely to be subject to undue influence.
3. A history of serious or continuing non-compliance on the part of the PI.

The following factors will also be considered when determining which studies require review more frequently than annually:

1. The probability and magnitude of anticipated risks to subjects.
2. The likely medical condition of the proposed subjects.
3. The overall qualifications of the PI and other members of the research team.
4. The experience of the Principal Investigator and other members of the research team in conducting similar research.
5. The nature and frequency of adverse events observed in similar research at this and other institutions.
6. The novelty of the research making unanticipated Adverse Events more likely.
7. Any other factors that the IRB deems relevant.

In specifying an approval period of less than one year, the IRB may define the period with either a time interval or a maximum number of subjects either studied or enrolled. If a maximum number of subjects studied or enrolled is used to define the approval period, it is understood that the approval period in no case can exceed one year and that the number of subjects studied or enrolled determines the approval period only when that number of subjects is studied or enrolled in less than one year. If an approval period of less than one year is specified by the IRB, the reason for more frequent review must be documented in the minutes.

### ***3.7.2 Independent Verification That No Material Changes Have Occurred***

The IRB recognizes that protecting the rights and welfare of subjects sometimes requires independent verification from sources other than the investigator that no material changes occurred during the IRB-designated approval period.

The IRB will determine the need for independent verification on a case-by-case basis and according to the following criteria:

1. Protocols where concern about possible changes occurring without IRB approval have been raised based on information provided in continuing review reports or from other sources.
2. Protocols conducted by PIs who have previously failed to comply with federal regulations and/or the requirements or determinations of the IRB Protocols subject to internal audit.
3. Whenever else the IRB deems verification from outside sources relevant.

The following factors will also be considered when determining which studies require independent verification:

1. The probability and magnitude of anticipated risks to subjects.
2. The likely medical condition of the proposed subjects.
3. The probable nature and frequency of changes that may ordinarily be expected in the type of research proposed.

In making determinations about independent verification, the IRB may require on initial review that such verification take place at predetermined intervals during the approval period or may require such verification at the time of continuing review and review of amendments and/or unanticipated problems.

If any material changes have occurred without IRB review and approval, the IRB will decide the corrective action to be taken (see [Section 10.3](#)).

### ***3.7.3 Consent Monitoring***

In reviewing the adequacy of informed consent procedures for proposed research, the IRB may determine that special monitoring of the consent process by an impartial observer (consent monitor) is required to reduce the possibility of coercion and undue influence. Such monitoring may be particularly warranted when the research presents significant risks to subjects or if subjects are likely to have difficulty understanding the information provided.

Monitoring may also be appropriate as a corrective action where the IRB has identified problems associated with a particular investigator or a research project (see [Section 5.8](#) for further discussion of consent monitoring).

### **3.7.4 Investigator Conflicts of Interest**

The research application asks protocol-specific questions regarding conflict of interest for the investigators and key personnel. If a conflict of interest exists, final IRB approval of a protocol cannot be given until an approved conflict management plan that adequately protects the human subjects in the protocol is in place (see [Section 14](#) for a detailed discussion of Conflict of Interest).

### **3.7.5 Significant New Findings**

During the course of research, significant new knowledge or findings may develop about the treatment or test article and/or the condition under study. The PI must report any significant new findings to the IRB and the IRB will review them with regard to the impact on the subjects' rights and welfare. Since the new knowledge or findings may affect the risks or benefits to subjects or subjects' willingness to continue in the research, the IRB may require, during the ongoing review process, that the PI contact the currently enrolled subjects to inform them of the new information. The IRB will communicate this to the PI. The informed consent should be updated and the IRB may require that the currently enrolled subjects be re-consented, acknowledging receipt of this new information and affirming their continued participation.

### **3.7.6 Advertisements and Recruitment Materials**

The IRB/HRPP must approve all advertisements and recruitment materials prior to posting and/or distribution for studies that are conducted under the purview of the WSU IRB. The IRB will review:

1. The information contained in the advertisement.
2. The mode of its communication.
3. The final copy of printed advertisements.
4. The final audio/video-taped advertisements.

This information should be submitted to the IRB with the initial application.

#### **3.7.6.1 General Considerations**

Any advertisement to recruit subjects should be limited to the information the prospective subjects need to determine their eligibility and interest. When appropriately worded, the following items may be included:

1. The name and address of the investigator and/or research facility.
2. The condition being studied and/or the purpose of the research.
3. In summary form, the criteria that will be used to determine eligibility for the study.
4. The time or other commitment required of the subjects.
5. The location of the research and the person or office to contact for further information.
6. A clear statement that this is research and not treatment.
7. A brief list of potential benefits (e.g., no cost for a health exam).



### **3.7.6.2 Additional Considerations Relevant to Biomedical Research**

The IRB reviews the material to assure that it is accurate and is not coercive or unduly optimistic, creating undue influence to the subject to participate, which includes but is not limited to:

1. Statements implying a certainty of favorable outcome or other benefits beyond what was outlined in the consent document and the protocol.
2. Claims, either explicit or implicit, that the drug, biologic, or device is safe or effective for the purposes under investigation.
3. Claims, either explicit or implicit, that the test article was known to be equivalent or superior to any other drug, biologic, or device.
4. Using terms like “new treatment,” “new medication,” or “new drug” without explaining that the test article is investigational.
5. Promising “free medical treatment” when the intent is only to say participants will not be charged for taking part in the investigation.
6. Emphasis on payment or the amount to be paid, such as bold type or larger font on printed media.
7. The inclusion of exculpatory language.

Coupons. Advertisements may not include compensation for participation in a trial offered by a sponsor to involve a coupon good for a discount on the purchase price of the product once it has been approved for marketing.

Once approved by the IRB, an advertisement or recruitment notice cannot be altered or manipulated in any way without prior IRB approval.

### **3.7.7 Payment to Research Subjects**

Payment to research subjects may be an incentive for participation or a way to reimburse a subject for travel and other expenses incurred due to participation. However, payment for participation is not considered a research benefit. Regardless of the form of remuneration, investigators must take care to avoid coercing or unduly influencing research subjects.

Investigators who wish to pay research subjects must indicate in their research project application the justification for such payment. Such justification should:

1. demonstrate that proposed payments are reasonable and commensurate with the expected contributions of the subject;
2. state the terms of the subject participation agreement and the amount of payment in the informed consent form; and
3. demonstrate that subject payments are fair and appropriate and that they do not constitute (or appear to constitute) undue pressure on the participant to volunteer for the research study.

The IRB must review both the amount of payment and the proposed method of disbursement to

ensure that neither entails a problem of coercion or undue influence. Payments to participants must be in compliance with WSU policies, including but not limited to BPPM 45.56.

#### **3.7.7.1 Partial Payment**

Credit for payment should accrue and not be contingent upon the participant completing the entire study (note: this is not usually applicable to single session studies). The IRB does not normally allow the entire payment to be contingent upon completion of all parts of a multipart study. Any amount paid as bonus for completion of the entire study should not be so great that it becomes unduly influential.

The consent form must describe the terms of payment and the conditions under which subjects would receive partial payment or no payment (e.g., if they withdraw from the study before their participation is completed).

#### **3.7.7.2 Lotteries**

Incentives in the form of entering a research subject's name in a lottery are permitted and must conform to the terms of Washington Lottery Laws (e.g., RCW 67.70):

1. The informed consent document must include a description of the lottery/raffle process
2. If the amount of any prize is valued at/above \$600, participants must be informed that the prize may be subject to income tax requirements.

#### **3.7.7.3 WSU Business Practices**

It is the investigator's responsibility to comply with the policy of the appropriate WSU business office for processing payments to research subjects. Investigators are encouraged to seek guidance on internal procedures from the appropriate WSU business office during the initial planning stages of the research project. Investigators who wish to have WSU issue compensation payments directly to research subjects should seek guidance from their departmental offices and/or the WSU Accounts Payable.

Investigators who wish to be reimbursed for compensation payments made directly to research subjects should contact the WSU Payroll office.

#### ***3.7.8 Compliance with Applicable State and Local Laws and Laws of Foreign Countries***

The HRPP and the IRB rely on the Attorney General's Office, WSU Division (AGO) for the interpretation and application of Washington State law and the laws of any other jurisdiction where research is conducted as they apply to human subject research.

All research practices and consent forms must be consistent with applicable state and local laws. International research must observe the laws of the country in which the research takes place.

### **3.7.9 IRB Review of Grant Applications**

Although the revised Common Rule removes the requirement that the IRB review Federal grant applications or proposals, the WSU HRPP will continue to review grant and contract proposals submitted to internal and external funding programs to ensure congruency upon request by Office of Research or Office of Research Support and Operations.

## **3.8 Possible IRB Actions**

**Approval:** The study is approved as submitted.

**Conditional Approval:** The protocol, supporting materials and/or consent form require minor revisions, such as wording changes, with replacement language provided. The required changes must be specific or directed as described in relevant Office of Human Research Protections guidance. For protocols reviewed at a convened IRB meeting, the needed revisions are agreed upon at the IRB meeting and the board votes to approve the protocol subject to satisfactorily responding to the stipulation. To make this approval, the Board must be able to determine that the criteria for approval at 45CFR46.111 will have been satisfied once the required changes are implemented. Depending on the stipulations and expertise required to confirm them, the changes may be reviewed by the Chair, designated member(s) or by IRB staff member(s) or any combination of these that the IRB determines to be sufficient in expertise.

A conditional approval may also be used to approve the initiation of some, but not all, activities within a protocol, when this occurs the approval date and the expiration date for the protocol is calculated based on the date of conditional approval and NOT on the final approval date. In all other cases, the approval and expiration dates will be calculated like a deferral for minor modifications, based on the date that all stipulations have been addressed to the satisfaction of the assigned reviewer(s) or Chair.

Note 2: Conditional approval is NOT used by the WSU IRB when an application is reviewed by expedited procedures.

**Deferred for minor revisions** is similar to a conditional approval except that the revisions may require some clarification and that the approval date/expiration date are based on the date of full approval rather than the date that minor revisions were required. If the required changes are specific and/or directed, the Board will determine who may review the changes which may include returning response to the Convened Board, review by the Chair or IRB member(s) or by IRB staff member(s) or any combination of these determined by the Board to be sufficient in expertise.

**Deferred for substantive revisions** regarding the protocol and/or consent form that must be addressed. This action is taken if substantial modification or clarification is required or there is insufficient information to judge the application adequately (e.g., the risks and benefits cannot be assessed with the information provided).

To receive approval for a protocol deferred for substantive issues,

1. For review at convened meeting, IRB members will have access to the investigator's response package. The item is placed on the agenda for re-review at the next meeting.
2. For expedited, the investigator's response package is assigned to the same reviewer(s) for re-review (if possible).
3. The outcome of the IRB's deliberations is communicated to the investigator in writing.

The IRB's determination concerning the subsequent revised submission will be documented in the minutes of the IRB meeting or in the file for expedited review.

Note: Failure to submit a response to IRB-stipulated changes or inquiries related to deferred protocols within 60 days of the IRB date of determination will result in administrative closure of the IRB file. The PI will receive notification of the closure of the IRB file, including an explanation for this action. An extension beyond 60 days may be granted by the IRB Chair and/or ADRA if the PI provides an adequate justification.

**Disapproved:** The IRB has determined that the research cannot be conducted at the WSU or by employees or agents of WSU or otherwise under the auspices of WSU.

Note: A protocol reviewed by expedited procedures cannot be disapproved. The matter must be referred for consideration at a convened meeting. The institution may not approve any research that has been disapproved by the IRB but may disapprove research that has been approved by the IRB.

## **3.9 Suspension, Termination, and Investigator Hold**

### ***3.9.1 Suspension and Termination***

IRB approval may be suspended or terminated if research is not being conducted in accordance with IRB or regulatory requirements or has been associated with unexpected problems or serious harm to subjects (see [Section 8](#) for a discussion of unexpected problems and [Section 10](#) for a discussion of noncompliance).

Hold (Temporary halt) Research may be temporarily halted by the IRB Chair, or designees of the IO including the ADRA/DRA, in order to ensure safety of participants or others while gathering information or investigating adverse events, unanticipated problems or potential non-compliance that may pose risks to participants or others if continued. If a halt to research activities is requested and the PI does not agree, then a project may be suspended by written directive of the convened IRB, IRB Chair, ADRA/DRA as described below. An Investigator may also place a temporary hold on research activity as described in [section 3.9.2](#) below.

**Suspension** of IRB approval is a directive of the convened IRB, the IRB Chair, or the ADRA/DRA to temporarily stop some or all previously approved research activities short of stopping them

permanently. Suspension directives made by the IRB Chair or ADRA/DRA must be reported to a meeting of the convened IRB. Suspended protocols remain open and require continuing review.

**Termination** of IRB approval is a directive of the convened IRB to stop permanently all activities in a previously approved research protocol. Terminated protocols are considered closed and no longer require continuing review. Terminations of protocols approved under expedited review must be made by the convened IRB.

The IRB shall notify the PI in writing of such suspensions or terminations and shall include a statement of the reasons for the IRB's actions. The terms and conditions of the suspension must be explicit. The investigator shall be provided with an opportunity to respond in person or in writing.

When study approval is suspended or terminated, in addition to stopping all research activities, the HRPP will notify any subjects currently participating that the study has been suspended or terminated. The HRPP will consider whether procedures for withdrawal of enrolled subjects are necessary to protect their rights and welfare of subjects, such as: transferring participants to another investigator; making arrangements for care or follow-up outside the research; allowing continuation of some research activities under the supervision of an independent monitor; or requiring or permitting follow-up of participants for safety reasons.

If follow-up of subjects for safety reasons is permitted/required by the HRPP, subjects will be informed, and any adverse events/outcomes will be reported to the IRB and the sponsor.

Investigator **MUST** continue to provide reports on adverse events and unanticipated problems to both the IRB and sponsor just as if there had never been a suspension (i.e., all events that need to be reported during a study need to continue to be reported during the suspension period.)

Suspension or termination of research conducted under protocols approved by the IRB can be issued by WSU officials acting outside of and unrelated to the HRPP. Such action can be taken by the President, Provost, and Deans, and can be made for any reason in furtherance of the Institution's interest provided. The affected investigator is entitled to all rights and procedures afforded to him/her under the relevant grievance policy(ies) of the university. The PI must report any suspension or termination of the conduct of research by WSU officials to the IRB. The IRB will then determine if suspension or termination of the IRB approval protocol is warranted.

### ***3.9.2 Investigator Hold***

An investigator may initiate an Investigator Hold to temporarily or permanently stop some or all approved research activities. Investigator Holds are not suspensions or terminations.

Investigators must notify the IRB in writing of the following:

1. They are voluntarily placing a study on Investigator Hold.
2. A description of the research activities that will be stopped

3. Proposed actions to be taken to protect current participants.
4. Actions that will be taken prior to IRB approval of proposed changes in order to eliminate apparent immediate harm.

Upon receipt of written notification of the investigator, the IRB staff places the research on the agenda for review.

The IRB Chair and/or ADRA, in consultation with the investigators, determine whether any additional procedures need to be followed to protect the rights and welfare of current participants as described in “Protection of Currently Enrolled Participants” below.

The IRB Chair and/or ADRA, in consultation with the investigators, determine how and when currently enrolled participants will be notified of the Investigator Hold.

Investigators must notify the IRB before removing an Investigator Hold.

### **3.10 Continuing Review and Status Reports**

#### ***3.10.1 Ongoing research that presents greater than minimal risk***

The IRB will conduct continuing review of ongoing research that presents greater than minimal risk to subjects at intervals that are appropriate to the level of risk for each research protocol but not less than once per year.

#### ***3.10.2 When continuing review is not required***

The revised Common Rule modifies when continuing review is required. Unless WSU IRB determines otherwise, continuing review of research is not required for research subject to the revised Common Rule in the following circumstances:

1. Research eligible for expedited review in accordance with §46.110; and research eligible for expedited review under flexibility criteria listed in [Section 3.4.2](#).
2. Exempt research reviewed by the IRB in accordance with limited IRB review as described in [Section 3.3](#);
3. Research that has progressed to the point that it involves only one or both of the following, which are part of the IRB-approved study:
  - a. Data analysis, including analysis of identifiable private information or identifiable biospecimens, or
  - b. Accessing follow-up clinical data from procedures that subjects would undergo as part of clinical care

Note: When either of these conditions apply to a protocol approved by the convened board and determined to be more than minimal risk, the board must make a determination and document the justification for no longer requiring continuing review.

**Exceptions to continuing review requirements:** please see DOJ and other agency specific addenda for minimal risk protocols for which continuing review must be conducted no less than once per year.

If continuing review is not required, periodic status reports must be submitted to the IRB Office for the protocol to remain active. If the PI fails to notify the IRB that a project remains active, HRPP staff will deactivate 30 days after sending a final notice.

### ***3.10.3 Approval Period***

Determination of the approval period and the need for additional supervision is made by the IRB on a protocol-by-protocol basis. Approval period of less than one year might be warranted if the research is particularly risky; research by an investigator who has recently had a protocol suspended by the IRB due to regulatory concerns, an on-site review by a subcommittee of the IRB might occur or approval might be subject to an audit of study performance after a few months of enrollment or after enrollment of the first several subjects. For each initial or continuing approval, the IRB will indicate an approval period with an approval expiration date specified. IRB approval lapses on the expiration date of the approval. For a study approved by the convened IRB, the approval period starts on the date that the IRB conducts its final review of the study, that is, the date that the convened IRB approved the research or the date the convened IRB gave conditional approval. For a study approved by expedited review procedures, the approval period begins on the date HRPP staff gives final approval to the protocol after receiving the completed review from the assigned reviewer with a recommendation to approve.

The approval date and approval expiration date (when applicable) are clearly noted on all IRB certifications sent to the PI and must be strictly adhered to. Investigators should allow sufficient time for development and review of renewal submissions.

Review of a change in a protocol ordinarily does not alter the date by which continuing review must occur, the sole exception would be when an amendment and continuing review are conducted simultaneously.

The regulations make no provision for any grace period extending the conduct of research beyond the expiration date of IRB approval. Therefore, continuing review and re-approval of research must occur by midnight of the date when IRB approval expires. If the IRB performs continuing review within 30 days before the IRB approval period expires, the IRB may retain the anniversary date as the date by which the continuing review must occur.

### ***3.10.4 Local Implementation (January 2019, Full transition effective January 1, 2022)***

In most cases in accordance with the new final rule, continuing review will no longer be required. Reviewers will note whether continuing review is required and if yes, will justify the need for continuing review.

Status Report. For research that meets criteria listed in [Section 3.10.2](#), the WSU IRB will require a yearly Status Report indicating the project is still active and affirming that there have been no changes in procedures that have not been approved by the IRB. For research projects involving vulnerable subjects or supported by internal or external grants or contracts, the Status Report will collect information about the number of research participants. The status report will be due by the anniversary of the original approval. If a status report is not submitted within 90 days of the anniversary of the approval date, the protocol will be administratively closed.

Legacy Protocols. Research approved by expedited review before effective date of the revised Common Rule (18-January 2018) will undergo customary continuing review on the next due date. The IRB reviewer may determine that either continuing review should continue (and give an explanation as described above) or may be discontinued. The determination will be documented in the protocol file, and investigators will be required to submit an annual status report.

### ***3.10.5 When Continuing Review Might be Required***

The WSU IRB may determine that continuing review is required for any research protocol that is eligible for expedited review. Justification for requiring continuing review must be documented and may include, but is not limited to:

1. Required by other applicable regulations (e.g., FDA, DOJ/NIJ);
2. The research involves topics, procedures, or data that may be considered sensitive or controversial;
3. The research involves particularly vulnerable subjects or circumstances that increase subjects' vulnerability;
4. An investigator has minimal experience in research or the research type, topic, or procedures; and/or
5. An investigator has a history of noncompliance

When the WSU IRB determines that continuing review is required for such research, it will document the rationale in the IRB record and communicate the requirement to the investigator in the IRB determination letter.

### ***3.10.6 Continuing Review Process***

The IRB Office staff will send courtesy renewal notices to investigators approximately three months, two months, and one month in advance of the expiration date; however, it is the investigator's responsibility to ensure that the continuing review of ongoing research is approved by the expiration date. By federal regulation, no extension to that date can be granted.

Investigators must submit the following for continuing review:

1. the continuing review form, updated with any changes,
2. the Protocol Change form if applicable,
3. the current consent document,



4. any newly proposed consent document, and;

In conducting continuing review of research not eligible for expedited review, all IRB members are provided with and review all of the above material and the Primary Reviewer will review the complete protocol, including any modifications previously approved by the IRB. At the meeting, the Primary and Secondary Reviewers lead the IRB through the completion of the regulatory criteria for approval.

Review of currently approved or newly proposed consent documents must occur during the scheduled continuing review of research by the IRB, but informed consent documents should be reviewed whenever new information becomes available that would require modification of information in the informed consent document.

### ***3.10.7 Lapse in Continuing Review***

The regulations permit no grace period or approval extension after approval expiration. Research that continues after the approval period has expired is research conducted without IRB approval. If the continuing review does not occur within the timeframe set by the IRB, all research activities must stop, including recruitment (media advertisements must be pulled), enrollment, consent, interventions, interactions, and data collection, unless the IRB finds that it is in the best interests of individual subjects to continue participating in the research interventions or interactions. This will occur even if the investigator has provided the continuing information before the expiration date. Therefore, investigators must allow sufficient time for IRB review before the expiration date.

The IRB Office is responsible for notifying the investigator of the expiration of approval and that all research activities must stop.

If research participants are currently enrolled in the research project and their participation is ongoing, once notified of the expiration of approval the PI must promptly submit to the IRB Chair a list of research subjects for whom suspension of the research would cause harm. Enrollment of new subjects cannot occur and continuation of research interventions or interactions for already enrolled subjects should only continue when the IRB or IRB Chair finds that it is in the best interest of the individual subjects to do so.

Failure to submit continuing review information on time is noncompliance and will be handled according to the noncompliance policy (see [Section 10.3](#)).

Once approval has expired, IRB review and re-approval must occur prior to re-initiation of the research. If the study approval has lapsed more than 90 days and the PI has not provided the required continuing review information, the PI must submit a new application to the IRB for review and approval. If the study approval has lapsed 90 or less and the PI provides the required continuing review information, the existing protocol may be reviewed for consideration of continued IRB approval.

If a research protocol receives contingent approval at the time of the continuing review and the

approval expires before the PI responds to the contingencies, the PI may not enroll any new subjects or access medical records after the approval expiration date. Once the PI responds, the existing protocol will be reviewed for continuation.

### **3.11 Amendment of an Approved Protocol**

Investigators wishing to modify or amend an approved protocol must seek IRB approval before making any changes unless the change is necessary to eliminate an immediate hazard to the subject (in which case the IRB must then be notified as soon as practicable).

This requirement applies to all research approved by the WSU IRB, including any aspects of exempt research subject to limited IRB review (see [Section 3.3.1](#)), and research for which continuing review is not required.

Additionally, investigators conducting research determined to be exempt or Not-Human-Subjects-Research are urged to seek a determination from the ADRA (or designated HRPP staff) that proposed changes do not alter the underlying regulatory status of the activity.

Modifications may be approved if they are within the scope of what the IRB originally authorized. Modifications that substantially alter the scope of the originally approved protocol may require a new application.

Investigators must submit documentation about the changes to the study, including, but not limited to:

1. Completed amendment request via current form (if applicable) or eIRB submission.
2. Revised Investigator's protocol application or sponsor's protocol (if applicable).
3. Revised approved consent/parental permission/assent documents (if applicable) or other documentation that would be provided to subjects when such information might relate to their willingness to continue to participate in the study.
4. Revised or additional recruitment materials.
5. Any other relevant supporting documents provided by the investigator (e.g., data collection tools).

IRB Office staff will determine whether the proposed changes may be approved through an expedited review process, if the changes are minor, or whether the modification warrants full board review. The reviewer(s) using the expedited procedure has the ultimate responsibility to determine that the proposed changes may be approved through the expedited review procedure and, if not, must refer the protocol for full board review.

#### **3.11.1 Expedited Review of Protocol Modifications**

During the period for which approval has been authorized, an IRB may use expedited review procedures to review minor changes in ongoing research that was previously approved at a convened meeting if the proposed modification does not impact risks to participants. The

expedited review procedure may also be used to review modifications to research previously approved via the expedited procedure provided that the modification does not alter the risk or benefit in a way that would make the project ineligible for expedited review. An expedited review may be carried out by the IRB Chair and/or designee(s) among the IRB members.

The reviewer(s) completes a reviewer worksheet/checklist to determine whether the modifications meet the criteria allowing review of the amendment using the expedited procedure and, if so, whether the research with the proposed modifications continues to meet the regulatory criteria for approval.

The reviewer will also consider whether information about those modifications might relate to participants' willingness to continue to take part in the research and, if so, whether to provide that information to participants.

Minor amendments (administrative amendments) that clearly have no impact on risks to participants (e.g. addition of non-key research support staff, minor increase in participant numbers for a minimal risk project) may be reviewed via the expedited procedure by HRPP staff, most of whom serve as IRB members.

### ***3.11.2 Review of Protocol Modifications at Convened Meeting***

When a proposed change alters the risks or benefits of a protocol that is more than minimal risk or changes a minimal risk protocol to more than minimal risk, then the IRB must review and approve the proposed change at a convened meeting before the change can be implemented. The only exception is a change necessary to eliminate apparent immediate hazards to the research subjects. In such a case, the IRB should be promptly informed of the change following its implementation and should review the change to determine that it is consistent with ensuring the subjects' continued welfare.

All IRB members have access to all documents provided by the investigator.

At the meeting, the Primary Reviewer presents an overview of the modifications and leads the IRB through the completion of the regulatory criteria for approval. The IRB will determine whether the research with the proposed modifications continues to meet the regulatory criteria for approval.

When the IRB reviews modifications to previously approved research, the IRB considers whether information about those modifications might relate to participants' willingness to continue to take part in the research and, if so, whether to provide that information to participants.

## **3.12 Closure of Protocols**

The completion or termination of the study, whether premature or not, is a change in activity and must be reported to the IRB. Although subjects will no longer be "at risk" under the study, a final report to the IRB allows it to close its files and provides information that may be used by the IRB

in the evaluation and approval of related studies. Investigators must submit a project closure report to the IRB.

### **3.13 Reporting IRB Actions**

All IRB actions are communicated to the PI, or designated primary contact person, for the protocol by email within ten (10) working days via a template letter prepared by the IRB staff.

For an approval, along with written notification of approval, a copy of the approved consent form containing the stamped approval with the dates of the approval and expiration (if applicable) on each sheet will be made available to the investigator. For a deferral, the notification will include the modifications required for approval along with the basis for requiring those modifications. For disapproval, termination or suspension, the notification will include the basis for making that decision.

All letters to investigators are filed in the protocol files maintained by the IRB.

The IRB reports its findings and actions to the institution in the form of its minutes, which are distributed by IRB staff to the WSU Institutional Official and are stored permanently and securely in the IRB Office.

### **3.14 Review and Reconsideration of IRB Decisions**

When an IRB protocol presented at a convened meeting is disapproved or deferred, the IRB will notify the PI in writing about the specific deficiencies and the modifications that are necessary for IRB approval. The IRB shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond.

In cases where there is disagreement between the IRB and the PI regarding the nature and extent of the requested changes and these disagreements cannot be resolved amicably, the PI and/or the IRB may ask the IO to assist in resolving the matter. The IO may organize a meeting to help facilitate discussion between the IRB and the PI. While the IO may provide input and make recommendations to the IRB for expeditious resolution of the matter, final determinations for approval remain under the purview of the IRB.

Since the IO is responsible for policies and procedures followed by the IRB, the IO may review IRB decisions to ensure that the decision-making process is appropriate. If the IO has concerns regarding the process that the IRB has followed in making a decision, he/she may require the IRB to reconsider the decision. However, the IO cannot overrule an IRB decision to approve research that the IRB has not approved. The IO (Institution) may disapprove research that has received IRB approval based on other factors (e.g., other required approvals such as IBC, IACUC are not in place, lack of appropriate university resources to conduct the research).

### **3.15 Use of Other IRBs**

The IO, DRA or ADRA may authorize the use of other IRBs to review and oversee certain research projects that involve human subjects.

### ***3.15.1 Situations in which use of another IRB would be appropriate:***

1. WSU physicians wish to conduct research involving patients under care at an affiliated hospital or need to access facilities at an affiliated hospital. In this case, the hospital IRB would have responsibility for review and oversight.
2. WSU investigators wish to participate in sponsored research involving human subjects and the sponsor proposes using a central IRB that would oversee the research at several centers (e.g., a clinical trial).
3. A WSU investigator wishes to participate in research sponsored by a component of the National Institutes of Health that has designated a central IRB to review and oversee the research.
4. The research is supported by an external sponsor and the grant or contract specifies that the sponsor will coordinate IRB review, or a specific commercial or central IRB is specified in the grant or contract.
5. The WSU PI requests review by an external/commercial IRB with which WSU has an established reliance or master services agreement and has made arrangements with the IO, DRA or ADRA to provide funding to support review and oversight.
6. When HRPP staff determine that a reliance agreement would be appropriate.

### ***3.15.2 WSU responsibilities prior to accepting oversight for a study by an external IRB***

When the submission packet is received, the ADRA or designee will review the materials and sponsor protocol, that may include:

1. The policies, procedures and resources of the external IRB and/or the terms of the FWA. Preference is for an accredited IRB. However, if this is not feasible, then the ADRA must assure that the policies are at least as rigorous as WSU's.
2. That the external IRB is appropriately registered and in good standing with HHS and FDA. When the project is federally funded, the ADRA or designee will also confirm that the external IRB has a current (e.g., not expired) FWA statement.
3. Principal Investigator's experience and assessment of prior noncompliance issues, if any.
4. Local resources available to the WSU investigator.
5. Involvement of special populations, e.g., minors/minor assent, adults unable to consent for themselves as well as any need for local context review (e.g., international research or research targeting specific tribal populations or occurring on Tribal lands)
6. Lack of conflict with existing WSU Policies and Procedures.

Once the review is completed, WSU and the external IRB will execute an inter-institutional agreement (reliance agreement). The IO or designee will sign on behalf of WSU. This document will describe the responsibilities of both institutions including: any financial aspects of IRB review

(when a commercial IRB is involved); providing any training necessary to conduct the research; monitoring the research; communication of relevant information, especially information related to safety of participants; and procedures for responding to allegations of noncompliance by WSU investigators. The PI will be required to confirm that institutional processes for financial disclosure/COI management requirements, budget review, and contract negotiation are either in process or completed. Additional reminders of local policies concerning special topics (minor assent, incapable adults etc.) may also be included in the notification to the independent IRB.

### ***3.15.3 WSU and IRB responsibilities after approval***

Reports of site monitoring activities (conducted either by WSU or another entity) with any finding that potentially impacts human subject protections will be shared between the external IRB and WSU. The external IRB provides copies to the WSU IRB all documents submitted to the PI of the study in question (or provides access to documents). WSU investigators approved through an independent IRB must report Unanticipated Problems to the WSU IRB Office, in addition to reporting such events to the external IRB.

## **3.16 Posting of Clinical Trial Consent Forms**

The revised Common Rule includes a requirement for the posting of one IRB-approved consent form to a publicly available Federal website for each clinical trial conducted or supported by a Common Rule department or agency after the clinical trial is closed to recruitment, and no later than 60 days after the last study visit by any subject. This requirement may be satisfied by either the awardee or the Federal department or agency. If the Federal department or agency supporting or conducting the clinical trial determines that certain information should not be made publicly available on a federal website (e.g., confidential commercial information), the department or agency may permit or require redactions to the information posted.

If WSU is the awardee and is responsible for posting the consent form, the PI is responsible for making it available on the designated site unless OR/ORSO has communicated in writing that they have or will do so on the PIs behalf.

## **3.17 Multisite Studies**

The following information must be supplied to the WSU IRB when the WSU investigator is the Lead Investigator on a Multi-Center Study or if the WSU site is the Coordinating Center for a Multi-Center Study. In the event a request is made for WSU IRB to serve as the IRB of record for one or more outside institutions or independent investigators, the information below will be used to develop a reliance agreement with each separate entity that will rely on WSU. The detailed standard operating procedures for development of reliance agreements are maintained in a separate document.

Exempt multi-site studies: For multi-site research involving WSU personnel that are determined to be exempt, the WSU HRPP may accept the determination of a qualified e.g. (appropriately registered and in good standing with OHRP) non-WSU HRPP/IRB. When this is done, acceptance

may be documented formally via a reliance agreement upon request but will normally be documented informally via written communication from the ADRA or designee. Non-WSU collaborators wishing to rely on a WSU determination of exemption should check with their own institutional IRB/HRPP regarding their willingness to accept/rely on WSUs determination. For non-affiliated researchers, WSU expects any personnel listed (key personnel) on a WSU protocol (exempt or otherwise) to comply with WSU policies and training requirements. The WSU PI will be responsible for ensuring appropriate training is in place for any non-WSU personnel, in the event that it is determined by audit that any on-WSU personnel do not have adequate training, they must be removed from the protocol.

### ***3.17.1 Role of the Lead Investigator***

A detailed description of the role of the lead investigator specifying his/her authorities and responsibilities (as distinct from those as principal investigators responsible for conduct of research at WSU). Reporting requirements to sponsor (if any).

### ***3.17.2 Study sites***

Name of site; site investigator; name and registration number of IRB responsible for oversight; research activities to be conducted.

### ***3.17.3 Site approvals***

Approval by IRB overseeing project at site. Letter from signatory authority approving research at the site.

### ***3.17.4 Communication among sites***

Plan to manage communication of information relevant to the protection of human subjects, such as reporting unexpected problems, protocol modifications, and interim results.

Plan for monitoring and auditing at sites (if applicable).

## **4. Documentation and Records**

WSU shall prepare and maintain adequate documentation of the IRB's activities. All records must be accessible for inspection and copying by authorized representatives of the FDA, OHRP, sponsors, and other authorized entities at reasonable times and in a reasonable manner.

### **4.1 IRB Records**

IRB records include but are not limited to:

1. Written operating procedures.

2. IRB membership rosters (see [Section 4.5](#)).
3. Training records. The IRB Administrator maintains accurate records listing research investigators, IRB members, and IRB staff who have fulfilled the facility's human subject training requirements. Electronic copies of documentation are maintained in the official IRB records located in the Human Research Protection Program. When IRB training is provided by a third-party vendor (e.g., CITI or PRIM&R) the IRB coordinator ensures continuous access to these training records or maintains a copy internally when access is not maintained.
4. IRB correspondence (other than protocol related).
5. IRB Study Files
6. Documentation of exemptions.
7. Documentation of convened IRB meetings minutes (see [Section 4.4](#) for information included in the minutes).
8. Documentation of review by another institution's IRB when appropriate.
9. Documentation of cooperative review agreements, e.g., Memoranda of Understanding (MOUs).
10. Federal Wide Assurance(s).
11. Protocol violations submitted to the IRB.
12. Quality assurance reviews.

Documentation for off-site IRBs include:

1. Electronic copy or on-line access to all applicable protocol documents.
2. MOU/Agreements of IRB Services.
3. Access to workflow/SOPs and membership rosters.
4. Notes/documents pertaining to administrative or cultural context reviews.

## 4.2 IRB Study Files

The IRB will maintain a separate IRB study file for each research application (protocol) that it receives for review. Protocols will be assigned a unique identification number by the IRB document management system and entered into the IRB tracking system.

Accurate records are maintained of all communications to and from the IRB. Copies are filed in the PI's project file. The WSU IRB maintains a separate file for each research protocol that includes, but is not limited to:

1. Protocol and all other documents submitted as part of a new protocol application.
2. Investigator brochure, if any.
3. Scientific evaluations when provided by an entity other than the IRB.
4. All other documents submitted as part of an application for continuing review/termination of research application.
5. Documents submitted and reviewed after the study has been approved, including reports of modifications to research/amendments and Adverse Event reports.
6. Copy of IRB-approved Consent Form.



7. DHHS-approved sample consent form document and protocol, when they exist.
8. IRB reviewer forms.
9. Documentation of type of IRB review.
10. For expedited review, documentation of any determinations required by the regulations and protocol-specific findings supporting those determinations, including reviewer confirmation that expedited review category is appropriate, or documentation of an alternate expedited category that is appropriate, waiver or alteration of the consent process, research involving pregnant women, fetuses, and neonates; research involving prisoners; and research involving children.
11. Documentation of all IRB review actions.
12. Notification of expiration of IRB approval to the PI, and instructions for submitting relevant continuing review materials.
13. Notification of suspension or termination of research.
14. Correspondence pertaining to appeals.
15. Copies of approval letters and forms that describe what the PI must do before beginning the study.
16. IRB correspondence with research investigators and IRB correspondence relevant to the research
17. For devices, a report of prior investigations.
18. Reports of unanticipated problems involving risk to subjects or others and adverse events.
19. Documentation of audits, investigations, reports of external site visits.

### **4.3 Documentation of Expedited Reviews**

IRB records for initial and continuing review by the expedited procedure must include the specific permissible category; that the activity described by the investigator satisfies all the criteria for approval under expedited review; the approval period and any determinations required by the regulations including protocol-specific findings supporting those determinations.

Additionally, records must include:

1. The rationale for conducting continuing review of research that otherwise would not require continuing review.
2. The rationale for a determination that research appearing on the expedited review list published in the Federal Register is more than minimal risk.

### **4.4 IRB Minutes**

Proceedings must be written and available for review by the next regularly scheduled IRB meeting date. Once accepted by the members at a subsequent IRB meeting, the minutes must not be altered by anyone, including a higher institutional authority.

A copy of IRB-approved minutes for each IRB meeting will be made available to the IO.

Minutes of IRB meetings must contain sufficient detail to show:

1. Attendance
2. Names of members present.
3. Names of members or alternate members who are participating through videoconference or teleconference and documentation that those attending through videoconferencing or teleconferencing received all pertinent material prior to the meeting and were able to actively and equally participate in all discussions.
4. Names of alternates attending in place of specified (named) absent members. (Alternates may substitute for specific absent members only as designated on the official IRB membership roster.)

Note: The initial attendance list shall include those members present at the beginning of the meeting. The minutes will indicate, by name, those members who enter or leave the meeting. The vote on each action will reflect those members present for the vote on that item. Members who recuse themselves because of a conflict of interest are listed by name and their reasons are documented.
5. Names of consultants, investigators, and guests present.
6. Announcements made by the Chair regarding member conflict of interest and confidentiality of discussion at meetings.
7. The presence of a quorum throughout the meeting, including the presence of one member whose primary concern is in a non-scientific area.
8. Business items discussed.
9. Continuing education.
10. Actions taken, including separate deliberations, actions, and votes for each protocol undergoing initial review, continuing review, or review of modifications by the convened IRB.
11. Votes on these actions (total number voting, number voting for, number voting against, number abstaining; number of those excused, number of those recused).
12. Basis or justification for these actions including required changes in research.
13. Summary of controverted issues discussed and their resolution.
14. Approval period for initial and continuing approved protocols, including identification of research that warrants review more often than annually and the basis for that determination.
15. Risk level of initial and continuing approved protocols.
16. Review of interim reports, e.g., unanticipated problems or safety reports, amendments, report of violation/deviations, serious or continuing non-compliance, suspensions/terminations, etc.
17. Review of Plans for Data and Safety Monitoring and Review of Data Safety Monitoring Board (DSMB) summary if applicable.
18. Justification for deletion or substantive modification of information concerning risks or alternative procedures contained in the DHHS-approved sample consent document.
19. Protocol-specific documentation that the research meets the required criteria [45 CFR 46.116(d)] when approving a consent procedure that does not include or that alters some or all the required elements of informed consent or when waiving the requirement to obtain an informed consent.
20. Protocol-specific documentation that the research meets the required criteria [45 CFR

- 46.117(c)] when the requirements for documentation of consent are waived.
21. When approving research that involves populations covered by Subparts B, C, or D of 45 CFR 46, the minutes will document the IRB's justifications and findings regarding the determinations stated in the Subparts or the IRB's agreement with the findings and justifications as presented by the investigator on IRB forms.
  22. Special protections warranted for other groups of subjects who are likely to be vulnerable to coercion or undue influence, such as cognitively impaired persons or economically or educationally disadvantaged persons, regardless of source of support for the research.
  23. The rationale for significant risk/non-significant risk device determinations.
  24. Determinations of conflict of interest (see [section 14](#)).
  25. Identification of any research for which there is need for verification from sources other than the investigator that no material changes are made in the research.
  26. A list of research approved since the last meeting utilizing expedited review procedures.
  27. An indication that, when an IRB member has a conflicting interest (see [Section 2.8](#)) with the research under review, the IRB member was not present during the deliberations or voting on the proposal and that the quorum was maintained.
  28. Key information provided by consultants will be documented in the minutes or in a report provided by the consultant.

## 4.5 IRB Membership Roster

A current membership list of IRB members must be maintained; it must identify members sufficiently to describe each member's chief anticipated contributions to IRB deliberations. The list must contain the following information about members:

1. Name.
2. Earned degrees.
3. Affiliated or non-affiliated status (described in [Section 1.3](#)).
4. Status as scientist or nonscientist
5. Indications of experience, such as board certifications or licenses sufficient to describe each member's chief anticipated contributions to IRB deliberations.
6. Representative capacities of each IRB member; which IRB member is a prisoner representative (as required by Subpart C), and which IRB members are knowledgeable about or experienced in working with children, pregnant women, cognitively impaired individuals, and other vulnerable populations locally involved in research.
7. Role on the IRB (Chair, Vice-Chair, etc.).
8. Voting status.
9. For alternate members, the primary member or class of members for whom the member could substitute.

The DRA may be appointed as ex officio alternate member of the IRB. As the primary compliance officer for the HRPP, the ADRA may be appointed as an ex officio member only and may participate in discussions, conduct reviews and render opinion about interpretation of regulations, but does not participate in voting.

The HRPP office must keep the IRB membership list current.

## **4.6 Access to IRB Records**

The IRB follows WSU IT policies and procedures to protect the confidentiality of research information:

1. Electronic records are kept on secure servers maintained by contractors with whom WSU has entered into licensing agreements. Doors to the IRB Offices are closed and locked when the rooms are unattended.
2. Ordinarily, access to all IRB records is limited to the DRA/ADRA, IRB Chair, IRB members, IRB staff, authorized institutional officials, and officials of federal and state regulatory agencies (e.g., OHRP, FDA). Research investigators are provided reasonable access to files related to their research. Appropriate accreditation bodies are provided access and may recommend additional procedures for maintaining the security of IRB records. All other access to IRB records is limited to those who have legitimate need for them, as determined by the IO and DRA/ADRA. Records are accessible for inspection and copying by authorized representatives of regulatory agencies during regular business hours.
3. Records may not be removed from the IRB Office; however, the IRB staff will provide copies of records for authorized personnel if requested.
4. All other access to IRB study files is prohibited.

## **4.7 Record Retention**

IRB minutes may be retained indefinitely, when not retained according to the WSU record retention schedule.

IRB records of protocol reviews must be retained by the facility for at least three (3) years after completion of the research.

Record retention must be in compliance with WSU record retention policies, and when funded must comply with funding agency requirements.

# **5. Informed Consent**

No investigator conducting research under the auspices of WSU may involve a human being as a subject in research without obtaining the legally effective informed consent of the subject or the subject's legally authorized representative unless a waiver of consent has been approved by the IRB in accordance with [Section 5.8](#) of these procedures.

The IRB will evaluate both the consent process and the procedures for documenting informed consent to ensure that adequate informed consent is obtained from participants according to the following procedures.

The following procedures describe the requirements for obtaining consent from participants in research conducted under the auspices of WSU.

## 5.1 Definitions

**Legally Authorized Representative (LAR)** – A legally authorized representative (LAR) is an individual or body authorized under applicable law to provide permission on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research. For the purposes of this policy, a legally authorized representative includes, but is not limited to, not only a person appointed as a health care agent under a Durable Power of Attorney for Health Care (DPAHC) or a court appointed guardian of the person but also next-of-kin in the following order of priority unless otherwise specified by applicable state law: spouse, adult child (18 years of age or older), parent, adult sibling (18 years of age or older), grandparent, or adult grandchild (18 years of age or older).

**Legal guardian** – A person appointed by a court of appropriate jurisdiction.

## 5.2 Basic Requirements

The requirement to obtain the legally effective informed consent of individuals before involving them in research is one of the basic protections provided for by the federal regulations and the WSU HIRPP. Investigators are required to obtain legally effective informed consent from a subject or the subject's legally authorized representative. When informed consent is required, it must be sought prospectively and documented properly.

The informed consent process involves three key features: (a) disclosing to the prospective human subject information needed to make an informed decision; (b) facilitating the understanding of what has been disclosed; and (c) promoting the voluntariness of the decision about whether to participate in the Research.

Informed consent is more than just a signature on a form. It is a process of information exchange to include reading and signing the informed consent document. The informed consent process is the critical communication link between the prospective human subject and an investigator, beginning with the initial approach of an investigator and continuing through the completion of the research study. Investigators must have received the appropriate training and be knowledgeable about the study protocol so they can answer questions to help provide understanding to the study participant or potential study participant. The exchange of information between the investigator and study participant can occur via one or more of the following modes of communication, among others: face-to-face contact, mail, telephone, email, internet, or fax.

Investigators must obtain consent prior to entering a subject into a study and/or conducting any procedures required by the protocol, unless consent is waived by the IRB.

If someone other than the investigator conducts the interview and obtains consent from a

participant, the investigator needs to formally delegate this responsibility, and the person so delegated must have received appropriate training to perform this activity. The person so delegated must be knowledgeable about the research to be conducted and the consenting process and must be able to answer questions about the study.

Sample or draft consent documents may be developed by a sponsor or cooperative study group. However, the IRB-of-record is the final authority on the content of the consent documents that are presented to the prospective study participants.

These informed consent requirements are not intended to preempt any applicable federal, state, or local laws that require additional information to be disclosed for informed consent to be legally effective.

### **5.3 General Requirements for Informed Consent**

Informed consent must be obtained under the following circumstances:

1. Informed consent may only be obtained from subjects who have the legal and mental capacity to give consent. For subjects without that capacity, consent must be obtained from a legal guardian or a legally authorized representative.
2. The informed consent process will be sought under circumstances that provide the subject (or legally authorized representative) with sufficient opportunity to discuss and consider whether to participate.
3. The informed consent process shall be sought under circumstances that minimize the possibility of coercion or undue influence.
4. The informed consent information must be presented in language that is understandable to the subject or LAR. To the extent possible, the language should be understandable by a person who is educated to 8th grade level and in non-technical terms should be used in the description of the research.
5. For subjects whose native language is not English, informed consent must be obtained in a language that is understandable to the subject or the subject's LAR. In accordance with this policy, the IRB requires that informed consent conferences include a reliable translator when the prospective subject does not understand the language of the person who is obtaining consent.
6. Informed consent must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject or LAR in understanding the reasons why one might or might not want to participate in the research. This part of the informed consent must be organized and presented in a way that facilitates comprehension
7. Generally, the beginning of an informed consent should include a concise explanation of the following:
  - a. The fact that consent is being sought for research and that participation is voluntary;
  - b. The purposes of the research, the expected duration of the prospective subject's participation, and the procedures to be followed in the research;

- c. The reasonably foreseeable risks or discomforts to the prospective subject;
- d. The benefits to the prospective subject or to others that may reasonably be expected from the research; and
- e. Appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the prospective subject.

However, based upon the facts of an individual protocol, the IRB may require that different (or additional) information be presented at the beginning of an informed consent to satisfy this requirement.

Informed consent must present information in sufficient detail relating to the research and must be organized and presented in a way that does not merely provide lists of isolated facts, but rather facilitates the prospective subject's or LAR's understanding of the reasons why one might or might not want to participate.

No informed consent may include any exculpatory language through which the subject or the LAR is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the investigator, the sponsor, WSU, or its agents from liability for negligence.

The PI is responsible for ensuring that each prospective subject is adequately informed about all aspects of the research and understands the information provided.

## **5.4 Basic Elements of Informed Consent**

To be valid, the consent process must provide the following basic elements of information to potential subjects:

A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures that are experimental, a description of any reasonably foreseeable risks or discomforts to the subject,

1. A description of any benefits to the subject or to others that may reasonably be expected from the research.
2. A disclosure of appropriate alternative procedures or courses of treatment, if any, might be advantageous to the subject.
3. A statement describing the extent, if any, to which confidentiality of records identifying the subject must be maintained.
4. For research involving more than minimal risk, an explanation as to the availability of medical treatment in the case of research-related injury, including who will pay for the treatment and whether other financial compensation is available.
5. An explanation of whom to contact on the research team for answers to pertinent questions about the research or to voice concerns or complaints about the research, and whom to contact in the event of a research-related injury to the subject.
6. Contact information for the IRB to obtain answers to questions about the research, to voice

concerns or complaints about the research, to obtain answers to questions about their rights as a research participant, in the event the research staff could not be reached, and in the event the subject wishes to talk to someone other than the research staff.

7. A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.
8. One of the following statements about any research that involves the collection of identifiable private information or identifiable biospecimen:
  - a. identifiers might be removed from the identifiable private information or identifiable biospecimens and that, after such removal, the information or biospecimens could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative, if this might be a possibility; or
  - b. subject's information or biospecimen collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.
  - c. Data will be destroyed.

#### **5.4.1 FDA regulated studies**

For FDA-regulated studies, the possibility that the Food and Drug Administration may inspect the records needs to be included in the statement regarding subject confidentiality.

#### **5.4.2 Additional elements of informed consent**

Elements be applied, as appropriate:

1. A statement that the treatment or procedure may involve risks to the subject, which are currently unforeseeable. (For example, include when the research involves investigational test articles or other procedures in which the risk to subjects is not well known.)
2. A statement that if the subject is or becomes pregnant, the treatment or procedure may involve risks to the embryo or fetus, which are currently unforeseeable. (For example, include when the research involves pregnant women or women of childbearing potential and the risk to fetuses of the drugs, devices, or other procedures involved in the research is not well known.)
3. Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent. (For example, include when there are anticipated circumstances under which the investigator may terminate participation of a subject.)
4. Any additional costs to the subject that may result from participation in the research. (For example, include when it is anticipated that subjects may have additional costs.)
5. The consequences of a subject's decision to withdraw from the research. (For example, include when withdrawal from the research is associated with adverse consequences.)
6. Procedures for orderly termination of participation by the subject. (For example, include when the protocol describes such procedures.)



7. A statement that significant new findings developed during the research which may relate to the subject's willingness to continue participation will be provided to the subject. (For example, include when the research is long term and interim information is likely to be developed during the conduct of the research.)
8. The approximate number of subjects involved in the study. (For example, include when the research involves more than minimal risk.)
9. A statement that the subject's biospecimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit.
10. A statement regarding whether clinically relevant research results, including individual research results, will be disclosed to subjects, and if so, under what conditions.
11. For research involving biospecimens, whether the research will (if known) or might include whole genome sequencing (i.e., sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen).
12. **WSU Additional Consent Disclosure Requirement: Broad Consent and consent for specified future use:** Related to item #11 above, the WSU IRB and HRPP requires disclosure of the potential risk of re-identification when biospecimens (when collected under broad consent or consent for specified future uses) may be used for genomic sequencing, and in particular whole genomic sequencing, at any time in the future.

#### ***5.4.3 General Data Protection Regulation (GDPR)***

WSU investigators conducting research in one of the Member States of the European Union or European Economic Area, or of Iceland, Liechtenstein, Norway, or the UK, (or any other country that opts to follow GDPR or similar regulatory requirements, e.g. Kenya and many other African countries) must be aware that research subjects within those countries have additional rights under the General Data Protection Regulations (GDPR) including the right to withdraw their consent to participate as easily as they gave their consent initially. They may request that data about them collected during research be erased and the investigators must honor the request or explain why the request cannot be honored.

### **5.5 Broad Consent**

Broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens (collected for either research studies other than the proposed research or non-research purposes) is permitted under the revised Common Rule. Broad consent is not currently recognized in FDA regulation or guidance.

The following elements of broad consent [§46.116(d)] shall be provided to each subject or the subject's LAR:

1. A description of any reasonably foreseeable risks or discomforts to the subject;
2. A description of any benefits to the subject or to others which may reasonably be expected from the research;
3. A statement describing the extent, if any, to which confidentiality of records identifying the

- subject must be maintained;
4. A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled;
  5. For research involving biospecimens, a statement that the subject's biospecimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit;
  6. For research involving biospecimens, whether the research will (if known) or might include whole genome sequencing (i.e., sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen);
  7. A general description of the types of research that may be conducted with identifiable private information or identifiable biospecimen. This description must include sufficient information such that a reasonable person would expect that the broad consent would permit the types of research conducted;
  8. A description of the identifiable private information or identifiable biospecimens that might be used in research, whether sharing of identifiable private information or identifiable biospecimens might occur, and the types of institutions or researchers that might conduct research with the identifiable private information or identifiable biospecimens;
  9. A description of the period of time that the identifiable private information or identifiable biospecimens may be stored and maintained (which period could be indefinite), and a description of the period that the identifiable private information or identifiable biospecimens may be used for research purposes (which period could be indefinite);
  10. Unless the subject or legally authorized representative will be provided details about specific research studies, a statement that they will not be informed of the details of any specific research studies that might be conducted using the subject's identifiable private information or identifiable biospecimens, including the purposes of the research, and that they might have chosen not to consent to some of those specific research studies;
  11. Unless it is known that clinically relevant research results, including individual research results, will be disclosed to the subject in all circumstances, a statement that such results may not be disclosed to the subject; and
  12. An explanation of whom to contact for answers to questions about the subject's rights and about storage and use of the subject's identifiable private information or identifiable biospecimens, and whom to contact in the event of research-related harm.

**WSU Additional Consent Disclosure Requirement: Broad Consent and consent for specified future use:** Related to item # 6 above, the WSU IRB and HRPP requires disclosure of the potential risk of re-identification when biospecimens (when collected under broad consent or consent for specified future uses) may be used for genomic sequencing, and in particular whole genomic sequencing, at any time in the future.

Investigators must include information regarding the circumstances under which broad consent will be obtained, the proposal for tracking of responses, and the proposed consent form(s) (or oral script if a waiver of documentation of consent is sought) and any other consent materials (e.g., information sheet, audio-visual materials, etc.) in their submission to the IRB. The WSU IRB will

review the information provided with the aid of a checklist to ensure that all requirements are satisfied. The outcome of the IRB's review will be communicated to the investigator in writing.

When investigators propose research involving the use of identifiable private information and/or identifiable biospecimens research for which broad consent was obtained, the investigators must include documentation of the IRB approval for the storage or maintenance of the information or specimens and a copy of the consent form and/or other materials. The WSU IRB will review the information provided to ensure that all requirements are satisfied. The outcome of the IRB's review will be communicated to the investigator in writing.

## **5.6 Documentation of Consent**

Unless the requirement for documentation of consent is waived by the IRB, informed consent must be documented by the use of written informed consent document (ICD) approved by the IRB and signed (including in an electronic format) by the subject or the subject's LAR. A written copy must be given to the person signing the ICD. When signed in an electronic format, to comply with Washington state regulatory requirements and FDA requirements, there must be a permanent record of the signed consent and the system must require attribution (e.g., multi-factor authentication that proves the person signing is the individual whose name appears on the form).

The ICD may be either of the following:

1. A written consent document that embodies the basic and required additional elements of informed consent. The investigator shall give either the subject or the subject's LAR adequate opportunity to read the informed consent form before it is signed; alternatively, this form may be read to the subject or the subject's legally authorized representative; or
2. A short form written consent document stating that the elements of informed consent have been presented orally to the subject or the subject's LAR and that the key information required by §46.116(a)(5)(i) (See [Section 5.3](#) (5a)) was presented first to the subject before other information, if any, was provided. When this method is used:
  - a. The oral presentation and the short form written document should be in a language understandable to the subject; and
  - b. There must be a witness to the oral presentation; and
  - c. The IRB must approve a written summary of what is to be said to the subject (the approved full consent document may serve as this summary); and
  - d. The short form document is signed by the subject;
  - e. The witness must sign both the short form and a copy of the summary; and
  - f. The person obtaining consent must sign a copy of the summary; and
  - g. A copy of the summary must be given to the subject or LAR, in addition to a copy of the short form.

## **5.7 Special Consent Circumstances**

### **5.7.1 Non-English-Speaking Subjects**

Expected enrollment of non-English speaking subjects: In some protocols, the PI expects non-English-speaking subjects to enroll because, for example, the protocol is studying a disease or condition that is likely to attract them or the PI is actively recruiting them. When the study subject population includes non-English speaking people or the PI and/or the IRB anticipates that consent discussions will be conducted in a language other than English, the IRB shall require a translated consent document to be prepared. In order to assure itself that the translation is accurate, the IRB may choose to require a certified translation, to have an independent back translation or to have a review of the consent document by an IRB member or other person who is fluent in that language. The subjects are given a copy of the signed translated consent document.

Unexpected enrollment of a non-English speaking subject: If a non-English speaking subject is unexpectedly eligible for protocol enrollment, there may not be an extant IRB-approved written translation of the consent document. Investigators should carefully consider the ethical and legal ramifications of enrolling subjects when a language barrier exists. If the subject does not clearly understand the information presented at the signing of the consent document or in subsequent discussions, his/her consent may not be informed, and therefore, not effective.

If a PI decides to enroll a subject into a protocol for which there is not an existent IRB-approved informed consent document in the prospective subject's language, the PI must receive IRB approval to follow the procedures for a "short form" written consent in as described in [Section 5.7.2](#).

### ***5.7.2 Use of interpreters in the consent process***

Unless the person obtaining consent is fluent in the prospective subject's language, an interpreter will be necessary to deliver information in the IRB-approved script and to facilitate the consent conversation. Preferably someone who is independent of the subject (i.e., not a family member) should assist in presenting information and obtaining consent. Whenever possible, interpreters should be provided copies of the short form and the IRB-approved consent script well before (24 to 48 hours if possible) the consent conversation with the subject. If the interpreter also serves as the witness, she/he may sign the short form consent document and script as the witness and should note "Interpreter" under the signature line. The person obtaining consent must document that the "short form" process was used 5.7.2 Braille Consent.

For blind subjects who read Braille, the IRB may approve a consent document prepared in Braille. In order to assure itself that a Braille consent document is accurate, the IRB may require a transcription into print text or review of the document by an IRB member or other person who reads Braille. If possible, the subject will sign the Braille consent; otherwise, verbal consent will be obtained, witnessed, and documented as described below.

### ***5.7.3 Oral Consent***

When subjects are unable to read a written consent form (such as blind or illiterate subjects), the IRB may approve an oral consent process, provided the subject (a) retains the ability to understand the concepts of the study and evaluate the risk and benefits of being in the study

when it is explained verbally and (b) is able to indicate approval or disapproval to study entry.

For research that is no more than minimal risk, documentation of consent may be waived according to the criteria in [Section 5.10](#).

For more than minimal risk research, the consent form must be read to the subjects and the subjects must be given an opportunity to ask questions. An audio-recording approved by the IRB may be used. If capable of doing so, the subject signs, or marks an X to signify consent. If that is not possible, the subject will provide verbal consent. The person obtaining consent and a witness will sign the written study consent form with a statement that documents that an oral process was used and, if necessary, that the subject gave verbal consent. For medical research when appropriate, the consent process will also be documented in the medical record or in accord with the WSU's policy. Signed copies of the consent form are given to the subject and, whenever possible, these documents should be provided to the subject on audio or video tape.

## **5.8 Consent Monitoring**

In reviewing the adequacy of informed consent procedures for proposed research, the IRB may on occasion determine that special monitoring of the consent process by an impartial observer (a consent monitor) is required in order to reduce the possibility of coercion and undue influence, ensure that the approved consent process is being followed, or ensure that subjects are truly giving informed consent.

Such monitoring may be particularly warranted for:

1. High risk studies.
2. Studies that involve particularly complicated procedures or interventions.
3. Studies involving highly vulnerable populations (e.g., ICU patients, children).
4. Studies involving study staff with minimal experience in obtaining consent to potential study participants.
5. Other situations where the IRB has concerns that the consent process is not being conducted appropriately.

Monitoring may also be appropriate as a corrective action where the IRB has identified problems associated with a particular investigator or a research project.

## **5.9 Subject Withdrawal or Termination**

For a variety of reasons, a subject enrolled in a research study may decide to withdraw from the research, or an investigator may decide to terminate a subject's participation in research regardless of whether the subject wishes to continue participating. Investigators must plan for the possibility that subjects will withdraw from research and include a discussion of what withdrawal will mean and how it will be handled in their research protocols and informed consent documents.

Regulatory requirements regarding the retention and use of data after subject withdrawal or

termination differ between research that is subject to FDA regulations and research that is not subject to FDA regulations. Under applicable FDA regulations, data collected on human subjects enrolled in an FDA-regulated clinical trial up to the time of subject withdrawal must remain in the trial database for the study to be scientifically valid. For research not subject to FDA regulations, investigators, in consultation with the funding agency, can choose to honor a research subject's request that the investigator destroy the subject's data or that the investigator exclude the subject's data from any analysis.

When seeking informed consent from subjects, the following information regarding data retention and use must be included:

1. For FDA-regulated clinical trials, when a subject withdraws from a study, the data collected on the subject to the point of withdrawal remain part of the study database and may not be removed. The consent document cannot give the subject the option of having data removed.
2. For research not subject to FDA regulations, the investigator should inform subjects whether the investigator intends to either (i) retain and analyze already collected data relating to the subject up to the time of subject withdrawal, or (ii) honor research subject's request that the investigator destroy the subject's data or that the investigator exclude the subject's data from any analysis.
3. For subjects from nations included under GDPR, these regulations must be also followed.
4. Sometimes a subject wants to withdraw from the primary interventional component of a study but is willing to allow the investigator to continue other research activities described in the IRB-approved protocol and informed consent document that involve participation of the subject, such as (a) obtaining data about the subject through interaction with the subject (e.g., through follow-up interviews, physical exams, blood tests, or radiographic imaging); or (b) obtaining identifiable private information from the subject's medical, educational, or social services agency records or from the subject's healthcare providers, teachers, or social worker. When a subject's withdrawal request is limited to discontinuation of the primary interventional component of a research study, research activities involving other types of participation for which the subject previously gave consent may continue. The investigator should ask a subject who is withdrawing whether the subject wishes to provide continued follow-up and further data collection subsequent to their withdrawal from the interventional portion of the study. Under this circumstance, the discussion with the subject would distinguish between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through noninvasive chart review and address the maintenance of privacy and confidentiality of the subject's information.
5. If a subject withdraws from the interventional portion of the study but agrees to continued follow-up of associated clinical outcome information as described in the previous paragraph, the investigator must obtain the subject's informed consent for this limited participation in the study (assuming such a situation was not described in the original informed consent form). IRB approval of informed consent documents would be required.
6. If a subject (a) withdraws from the interventional portion of a study, (b) does not consent to continued follow-up of associated clinical outcome information, and (c) does not request

removal of their data, the investigator must not access for purposes related to the study the subject's medical record or other confidential records requiring the subject's consent. However, an investigator may review study data related to the subject collected prior to the subject's withdrawal from the study, and may consult public records, such as those establishing survival status.

## **5.10 Waiver or Alteration of Informed Consent**

When reviewing research subject to the revised Common Rule, the WSU IRB will evaluate requests for waivers or alterations of informed consent in accordance with the requirements and criteria specified in the revised rule and summarized below. The IRB's determination will be documented in the IRB record and communicated to the investigator.

FDA regulations do not provide for waivers of informed consent except in emergency situations (the WSU IRB does not normally review FDA regulated emergency research).

### ***5.10.1 General Waiver or Alteration of Consent***

In order to approve a request from an investigator to waive the requirement for informed consent, or to omit or alter one or more basic or additional element of consent (an "Alteration"), under this provision the WSU IRB must determine and document that the below criteria are satisfied.

1. The research involves no more than minimal risk to the subjects;
2. The research could not practically be carried out without the requested waiver or alteration;
3. If the research involves using identifiable private information or identifiable biospecimens, the research could not practicably be carried out without using such information or biospecimens in an identifiable format;
4. The waiver or alteration will not adversely affect the rights and welfare of the subjects; and
5. Whenever appropriate, the subjects or LARs will be provided with additional pertinent information after participation.
6. Investigators may be asked to provide justification, or additional information or documentation, to support that the above criteria are satisfied.

Restrictions:

Waivers

1. If an individual was asked to provide broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens in accordance with the requirements in [Section 5.5](#), and refused to consent, an IRB cannot waive consent for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.

Alterations

1. An IRB may not approve a request to alter or omit any of the general requirements for

informed consent described in [Section 5.3](#). If a broad consent procedure is used, an IRB may not alter or omit any of the elements described in [Section 5.5](#).

### **5.10.2 Waiver or Alteration of Consent in Research Involving Public Benefit and Service Programs**

In order to approve a request from an investigator to waive the requirement for informed consent, or to omit or alter one or more basic or additional element of consent (an “Alteration”), under this provision the WSU IRB must determine and document that the below criteria are satisfied.

1. The research or demonstration project is to be conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or, otherwise examine:
  - a. Public benefit or service programs;
  - b. Procedures for obtaining benefits or services under those programs;
  - c. Possible changes in or alternatives to those programs or procedures; or
  - d. Possible changes in methods or levels of payment for benefits or services under those programs; and
2. The research could not practically be carried out without the waiver or alteration.
3. Waivers –
  - a. If an individual was asked to provide broad consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens in accordance with the requirements in [Section 5.5](#), and refused to consent, an IRB cannot waive consent for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.
4. Alterations
  - a. An IRB may not approve a request to alter or omit any of the general requirements for informed consent described in [Section 5.3](#).
  - b. If a broad consent procedure is used, an IRB may not alter or omit any of the elements described in [Section 5.5](#).

## **5.11 Screening, Recruiting, or Determining Eligibility**

The revised Common Rule removes the requirement for partial waivers of consent for the use of information or specimens for the purposes of screening, recruiting, or determining the eligibility of prospective subjects for inclusion in the research. Pursuant to the revised rule, the WSU IRB may approve a research proposal in which an investigator will obtain information or biospecimens for these purposes without the informed consent of the prospective subject or the subject’s LAR if either of the following conditions is met:

1. The investigator will obtain information through oral or written communication with the prospective subject or LAR, or
2. The investigator will obtain identifiable private information or identifiable biospecimen by accessing records or stored identifiable biospecimen.



When research is subject to the revised Common Rule, and the above conditions are met, investigators do not have to request waivers of consent for the purposes of screening, recruiting, or determining eligibility but do have to describe the activities in the application or protocol submitted to the IRB. The above does not negate the requirements of other rules, such as HIPAA, when applicable. It also does not negate the requirement to obtain consent, or a waiver of consent, before involving a subject (including the use of their identifiable private information or biospecimens) in other research activities.

## **5.12 Waiver of Documentation of Informed Consent**

The IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either of the following:

1. The only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality.  
Note 1: Subjects must be asked whether they want documentation linking them with the research, and their wishes must govern. (For example, domestic violence research where the primary risk is discovery by the abuser that the subject is talking to researchers.)  
Note 2: In order to waive written documentation of consent where the only record linking the participant and the research would be the consent document, the IRB must determine that the research was not FDA-regulated.
2. The research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context. Procedures such as non-sensitive surveys, questionnaires, and interviews generally do not require written consent when conducted by non-researchers (e.g., marketing surveys, telemarketing).
3. The subjects or LARs are members of a distinct cultural group or community in which signing forms is not the norm, that the research presents no more than minimal risk of harm to subjects and provided there is an appropriate alternative mechanism for documenting that informed consent was obtained.

In cases in which the documentation requirement is waived, the IRB requires the investigator to provide in the application materials a written summary of the information to be communicated to the subject, and the IRB will consider whether to require the investigator to provide subjects with a written statement regarding the research.

1. Waivers of documentation of consent for internet based minimal risk research (e.g., surveys, interviews) will be automatically granted if all the following are true:
2. The research is not only minimal risk but does not specifically target a vulnerable population as defined in 45CFR46.
3. The research is not FDA regulated and not subject to FERPA or any other regulations that specifically require signed consent (or a documented IRB approval of a waiver).
4. The investigator provides a written summary of information that includes the minimal elements of informed consent, that participants must review prior to proceeding to the survey/interview (e.g., “click-through” consent)

5. That participants have the option/ability to print or save a copy of the informed consent information (or are provided contact information for obtaining a copy).
6. For any project that involves other activities in addition to online research, this waiver applies ONLY to the online survey/interview procedures where documentation of consent is impractical and would not normally be required outside of the research context.

### **5.13 Informed Consent, Assent and Parental Permission**

Requirements and procedures related to the informed consent (and child assent/parental permission process) for research involving vulnerable populations are addressed in [Section 6](#).

## **6. Vulnerable Subjects in Research**

When participants in research conducted under the auspices of WSU are likely to be vulnerable to coercion or undue influence or have diminished decision-making capacity, the research must include additional safeguards to protect the rights and welfare of these participants. The IRB must ensure that all the regulatory requirements for the protection of vulnerable subjects are met and that appropriate additional protections for vulnerable subjects are in place.

The following procedures describe the requirements for involving vulnerable participants in research under the auspices of WSU.

### **6.1 Involvement of Vulnerable Populations**

When participants in a protocol are likely to be vulnerable to coercion or undue influence, the IRB should include additional safeguards to protect their rights and welfare. Examples of the vulnerable populations that might be involved in research include children, fetuses, neonates, prisoners, or individuals with impaired decision-making capability, students, employees, or homeless persons.

If the IRB reviews research that involves categories of participants vulnerable to coercion or undue influence, the review process will include one or more individuals who are knowledgeable about or experienced in working with these participants. 45 CFR 46 has additional subparts designed to provide extra protection for vulnerable populations that also have additional requirements for IRBs.

Subpart B – Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research

Subpart C – Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects

Subpart D – Additional Protections for Children Involved as Subjects in Research

DHHS-funded research that involves any of these populations must comply with the requirements of the relevant subparts. Research funded by other federal agencies may or may not be covered by the subparts.

Under WSU's FWA, the subparts only apply to DHHS-funded research and research funded by another federal agency that requires compliance with the subparts. (FDA regulations include Subpart D, which applies to all FDA-regulated research). The following policies and procedures, which are based on the subparts, apply to all research regardless of funding. The individual sections describe how the subparts apply to DHHS-funded research.

## **6.2 Responsibilities**

1. The PI is responsible for identifying the potential for enrolling vulnerable subjects in the research proposal. The PI is responsible for identifying participants who are at risk for impaired decisional capacity who are being asked to participate in a research study. The IRB shall include representation, either as members or ad hoc consultants, individual(s) who have professional interest in or who have experience with the vulnerable populations involved in a research proposal.
2. The IRB reviews the PI's justifications for including vulnerable populations in the research to assess appropriateness of the research proposal.
3. The IRB must ensure that additional safeguards have been included in each study to protect the rights and welfare of vulnerable subjects as needed at the time of initial review of the research proposal.
4. Information reviewed as part of the continuing review process should include the number of participants considered as members of specific vulnerable populations.
5. For studies that do not have or are not required to have a Data and Safety Monitoring Board (DSMB) or a Data Monitoring Committee and have entered vulnerable subjects, the IRB needs to carefully review the safety monitoring plan.
6. The IRB should be knowledgeable about and experienced in working with populations who are vulnerable to coercion and undue influence. If the IRB requires additional qualification or expertise to review a protocol, it should obtain consultation.

## **6.3 Procedures**

### ***6.3.1 Initial Review of Research Proposal***

1. The PI should identify the potential to enroll vulnerable subjects in the proposed research at initial review and provide the justification for their inclusion in the study.
2. The IRB evaluates the proposed plan for consent of the specific vulnerable populations involved. If the research involves adults unable to consent, the IRB evaluates the proposed plan for permission of legally authorized representatives.
3. The IRB evaluates and approves the proposed plan for the assent of participants.
4. The IRB evaluates the research to determine the need for additional protections and considers the use of a Data and Safety Monitoring Board (DSMB) or Data Monitoring Committee as appropriate.

5. The PI should provide appropriate safeguards to protect the subjects' rights and welfare, which may include the addition of an independent monitor. The independent monitor is a qualified individual not involved in the research study who will determine the subject's capacity to provide voluntary informed consent.
6. The IRB assesses and documents the adequacy of additional protections for vulnerable populations provided by the PI.

## **6.4 Research Involving Pregnant Women, Human Fetuses, and Neonates**

WSU IRB does not review research on neonates or fetuses of uncertain viability.

### ***6.4.1 Research Involving Pregnant Women or Fetuses***

The following applies to all research regardless of funding source. Since, according to the WSU FWA, Subpart B of 45 CFR 46 applies only to DHHS-funded research, the funding-source specific requirements are noted in the appropriate sections.

#### **6.4.1.1 Research Not Funded by DHHS**

For research not funded by DHHS, no additional safeguards are required and there are no restrictions on the involvement of pregnant women in research where the risk to the fetus is no more than minimal.

Pregnant women or fetuses may be involved in research not funded by DHHS involving more than minimal risk to fetuses if all the following conditions are met:

1. Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing risks to pregnant women and fetuses.
2. The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus.
3. Any risk is the least possible for achieving the objectives of the research.
4. If the research holds out the prospect of direct benefit to the pregnant woman and/or the prospect of a direct benefit both to the pregnant woman and the fetus, then the consent of the pregnant woman is obtained in accord with the provisions for informed consent.
5. If the research holds out the prospect of direct benefit solely to the fetus, then the consent of the pregnant woman and the father is obtained in accord with the provisions for informed consent, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest.
6. Each individual providing consent under paragraph (4) or (5) of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate.

7. For children who are pregnant, assent and permission are obtained in accord with the provisions of permission and assent.
8. No inducements, monetary or otherwise, will be offered to terminate a pregnancy.
9. Individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy.
10. Individuals engaged in the research will have no part in determining the viability of a neonate.

#### **6.4.1.2 Research Funded by DHHS**

For DHHS-funded research, 45 CFR Subpart B applies to all research involving pregnant women. Under 45 CFR Subpart B, pregnant women or fetuses may be involved in research funded by DHHS if all the following conditions are met:

1. Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing risk to pregnant women and fetuses.
2. The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus or, if there is no such prospect of benefit, the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means.
3. Any risk is the least possible for achieving the objectives of the research.
4. If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, or no prospect of benefit for the woman nor the fetus when risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means, then the consent of the pregnant woman is obtained in accord with the provisions for informed consent.
5. If the research holds out the prospect of direct benefit solely to the fetus, then the consent of the pregnant woman and the father is obtained in accord with the provisions for informed consent, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest.
6. Each individual providing consent under paragraph (4) or (5) of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate.
7. For children who are pregnant, assent and permission are obtained in accord with the provisions of permission and assent in [Section 6.6.2](#).
8. No inducements, monetary or otherwise, will be offered to terminate a pregnancy.
9. Individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy.
10. Individuals engaged in the research will have no part in determining the viability of a neonate.

### **6.4.2 Research Involving Neonates**

A neonate, after delivery, that has been determined to be viable may be included in research only to the extent permitted by and in accord with the requirements of IRB Review Process and Research Involving Children.

### **6.4.3 Research Involving, After Delivery, the Placenta, the Dead Fetus or Fetal Material**

Research involving, after delivery, the placenta; the dead fetus; macerated fetal material; or cells, tissue, or organs excised from a dead fetus, must be conducted only in accord with any applicable federal, state, or local laws and regulations regarding such activities.

If information associated with material described above in this section is recorded for research purposes in a manner that living individuals can be identified, directly or through identifiers linked to those individuals, those individuals are research subjects, and all pertinent sections of this manual are applicable.

## **6.5 Research Involving Prisoners**

### **6.5.1 Applicability**

The following applies to all research involving prisoners, regardless of funding source. The requirements in this section are consistent with Subpart C of 45 CFR 46, which applies to DHHS-funded research.

For the purposes of this section, the definition(s) of prisoner that may be applied are as follows:

#### Prisoner or Justice Involved Person:

- (A) Individuals whose circumstances match the federal definition(s) as outlined in 45CFR46.303 (Subpart C) or other federal regulations and/or;
- (B) As defined under 18 USC 3635(4), a person who has been sentenced to a term of imprisonment pursuant to a conviction for a Federal criminal offense, or a person in the custody of the Bureau of Prisons and/or;
- (C) As defined under RCW 72.09.015, a person committed to the custody of the department, including but not limited to persons residing in a correctional institution or facility and persons released from such facility on furlough, work release, or community custody, and persons received from another state, state agency, county, federally recognized tribe, or federal jurisdiction and/or;
- (D) Individuals whose circumstance do not match the federal or state definition(s) of prisoner, but whose similarly vulnerable situation indicate that these individuals deserve heightened protections as recommended by SACHRP.
  - 1. These individuals may collectively be referred to as “Justice Involved”, meaning persons who are now, or who have in the past been, involved with the criminal justice system as

- a defendant or who have spent time in jail, prison, youth correctional facility or similar institutions and/or;
2. Any person who is now or has in the past been convicted or incarcerated.

The above definitions may be applied during review as follows:

- For any research protocol funded or supported by or conducted within a facility controlled by the Department of Justice (DOJ), National Institute of Justice (NIJ) or Federal Bureau of Prisons (BOP) and/or that includes individuals meeting the definition of “prisoner” under “A” or both “A” and “B” as a priority population, the protections described under Subpart C shall be applied.
- For individuals meeting the definition of prisoner under “B” above, but not “A”, the protections described under Subpart C shall be applied, except for requirements that are specific to those meeting the definition under “A” (e.g., 45CFR46.305(b) and (c))
- For individuals meeting the definition of prisoner under “C” or for individuals that meet the definition of a justice involved person under “D”:
  - The general requirements for heightened protections, as outlined under Subpart A, for individuals whose vulnerability is situation specific may be applied (e.g., individuals voluntarily confined to a substance abuse treatment program in lieu of any of the situations outlined under “B”).
  - Additionally, a member with expertise working with prisoner populations (prisoner representative) or a consultant reviewer shall be assigned to review all protocols involving A, B or C and may also be assigned to D below at the discretion of the ADRA, Chair or coordinator.
  - The expert member may, at their discretion, elect to apply the additional protections outlined under subpart C of 45CFR46 when appropriate to any protocol that includes justice involved individuals as a priority population when the protocol is not funded or supported by DOJ, NIJ or BOP.
  - The reviewer checklist used should be inclusive of DOJ, NIJ and BOP regulatory requirements and have a separate section for review under the expanded definition(s).

Even though WSU IRB may approve a research protocol involving prisoners as subjects according to this policy, investigators are still subject to Revised Code of Washington (RCW), Washington State Administrative Code (WAC) and any other applicable state or local law [See 45 CFR 46.301].

### ***6.5.2 Composition of the IRB and Role of the Prisoner Representative***

In addition to satisfying the general requirements detailed in the IRB section of this manual, when reviewing research involving prisoners, the IRB must also meet the following requirements:

1. A majority of the IRB (exclusive of prisoner members) must have no association with the prison(s) involved, apart from their membership on the IRB.

2. At least one voting member of the IRB must be a prisoner, or a prisoner representative with appropriate background and experience to serve in that capacity, except that where a particular research project is reviewed by more than one IRB, only one IRB need satisfy this requirement.
3. The prisoner representative may be listed as an alternative member who becomes a voting member when needed.
4. The prisoner representative must review research involving prisoners, focusing on the requirements in Subpart C or equivalent protections.
5. The prisoner representative must receive all review materials pertaining to the research (same as primary reviewer)
6. The prisoner representative must be present at a convened meeting when the research involving prisoners is reviewed. If the prisoner representative is not present, research involving prisoners cannot be reviewed or approved.
7. The prisoner representative may attend the meeting by phone, video conference, or webinar, if the representative is able to participate in the meeting as if they were present in person at the meeting.
8. The prisoner representative must present his/her review either orally or in writing at the convened meeting of the IRB when the research involving prisoners is reviewed.
9. Minor modifications to research may be reviewed using the expedited procedure described below, using either of the two procedures described based on the type of modification.
10. Modifications involving more than a minor change reviewed by the convened IRB – must use the same procedures for initial review including the responsibility of the prisoner representative to review the modification and participate in the meeting (as described above).
11. Continuing review must use the same procedures for initial review including the responsibility of the prisoner representative to review the continuing review materials and participate in the meeting (as described above).

If no participants have been enrolled, the research may receive continuing review using the expedited procedure under expedited category #8.

### ***6.5.3 Use of Expedited Review Procedures***

1. For research involving interaction with prisoners reviewed by the expedited procedure:
2. Research involving interaction with prisoners may be reviewed by the expedited procedure, if a determination is made that the research involves no greater than minimal risk for the prison population being studied.
3. The prisoner representative must concur with the determination that the research involves no greater than minimal risk.
4. The prisoner representative must review the research as a reviewer, designated by the chair, or consultant. This may be as the sole reviewer or in addition to another reviewer, as appropriate.
5. Review of modifications and continuing review must use the same procedures for initial review using this expedited procedure including the responsibility of the prisoner



representative.

6. For research that does not involve interaction with prisoners (e.g., existing data, record review) reviewed by the expedited procedure:
  - a. Research that does not involve interaction with prisoners may be reviewed by the expedited procedure, if a determination is made that the research involves no greater than minimal risk for the prison population being studied.
  - b. Review by a prisoner representative is not required.
  - c. The prisoner representative may review the research as a reviewer or consultant if designated by the IRB chair.
  - d. Review of modifications and continuing review must use the same procedures as initial review.

#### **6.5.4 Exempt Determinations**

The WSU IRB does not make exempt determinations when reviewing research subject to subpart C, except for research aimed at involving the broader subject population that only incidentally includes prisoners.

Research that is determined not to meet the federal definition(s) of human subject research is determined to be not human subject research (NHSR) rather than exempt. Some examples include the use of de-identified or anonymized prisoner data.

#### **6.5.5 When a Participant Becomes a Prisoner**

If a participant becomes a prisoner while enrolled in a research study that was not reviewed according to Subpart C, then the following steps must be carried out by the IRB and the investigator:

1. Confirm that the participant meets the definition of a prisoner.
2. Terminate enrollment or review the research study under Subpart C if it is feasible for the participant to remain in the study.
3. Before terminating the enrollment of the incarcerated participant, the IRB should consider the risks associated with terminating participation in the study.
4. If the prisoner's participation cannot be terminated for health or safety reasons, then the IRB may:
  - a. Allow the prisoner to remain enrolled in the study and review the research under Subpart C.
  - b. If some of the requirements of Subpart C cannot be met, but it is in the best interests of the participant to remain in the study, then the IRB may allow the prisoner to remain enrolled and inform OHRP of the decision along with the justification.
  - c. Remove the participant from the study and keep the participant on the study intervention under an alternate mechanism such as compassionate use, or off label use.

#### **6.5.6 Additional Duties of the IRB when prisoners are involved**

In addition to all other responsibilities prescribed for IRB in the WSU Institutional Review Board and IRB Review Process sections of this manual, the IRB will review research involving prisoners and approve such research only if it finds the following:

1. The research falls into one of the following permitted categories [See 45 CFR 46.306]:
  - a. Study of the possible causes, effects, and processes of incarceration and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;
  - b. Study of prisons as institutional structures or of prisoners as incarcerated persons, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;
  - c. Research on conditions particularly affecting prisoners as a class (e.g., research on social and psychological problems such as alcoholism, drug addiction, and sexual assaults);
  - d. Research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subjects.
2. Any possible advantages accruing to the prisoner through his or her participation in the research, when compared to the general living conditions, medical care, quality of food, amenities and opportunity for earnings in the prison, are not of such a magnitude that his/her ability to weigh the risks of the research against the value of such advantages in the limited choice environment of the prison is impaired.
3. The risks involved in the research are commensurate with risks that would be accepted by non-prisoner volunteers.
4. Procedures for the selection of subjects within the prison are fair to all prisoners and immune from arbitrary intervention by prison authorities or prisoners. Unless the principal investigator provides to the IRB justification in writing for following some other procedures, control subjects must be selected randomly from the group of available prisoners who meet the characteristics needed for that research project.
5. The information is presented in language which is understandable to the subject population.
6. Adequate assurance exists that Parole Board will not take into account a prisoner's participation in the research in making decisions regarding parole, and each prisoner is clearly informed in advance that participation in the research will have no effect on his or her parole.
7. Where the IRB finds there may be a need for follow-up examination or care of subjects after the end of their participation, adequate provision has been made for such examination or care, taking into account the varying lengths of individual prisoners' sentences and for informing subjects of this fact.

#### **6.5.6.1 Certification to HHS**

Under 45 CFR 46.305(c), the institution responsible for conducting research involving prisoners that is supported by HHS shall certify to the Secretary (through OHRP) that the IRB has made the seven findings required under 45 CFR 46.305(a). For all HHS conducted or supported

research, WSU will send to OHRP a certification letter to this effect, which will also include the name and address of the institution and specifically identify the research protocol in question and any relevant HHS grant application or protocol. HHS conducted or supported research involving prisoners as subjects may not proceed until OHRP issues its approval in writing to WSU on behalf of the Secretary under 45 CFR 46.306(a)(2).

Under its authority at 45 CFR 46.115(b), OHRP requires that the institution responsible for the conduct of the proposed research also submit to OHRP a copy of the research proposal so that OHRP can determine whether the proposed research involves one of the categories of research permissible under 45 CFR 46.306(a)(2), and if so, which one. The term "research proposal" includes the IRB-approved protocol, any relevant HHS grant application or proposal, any IRB application forms required by the IRB, and any other information requested or required by the IRB to be considered during initial IRB review.

The above requirement does not apply to research that is not conducted by HHS or supported.

#### **6.5.6.2 Waiver for Epidemiology Research**

The Secretary of DHHS has waived the applicability of 45 CFR 46.305(a)(1) and 46.306(a)(2) for certain research conducted or supported by DHHS that involves epidemiological studies that meet the following criteria:

1. The sole purposes are:
  - a. to describe the prevalence or incidence of a disease by identifying all cases, or
  - b. to study risk factor associations for a disease, and
2. The IRB has approved the research and fulfilled its duties under 45 CFR 46.305(a)(2) – (7) and determined and documented that
  - a. the research presents no more than minimal risk and no more than inconvenience to the prisoner-subjects, and
  - b. Prisoners are not a particular focus of the research.
3. The specific type of epidemiological research subject to the waiver involves no more than minimal risk and no more than inconvenience to the human subject participants. The waiver would allow the conduct of minimal risk research that does not now fall within the categories set out in 45 CFR 46.306(a)(2).
4. The range of studies to which the waiver would apply includes epidemiological research related to chronic diseases, injuries, and environmental health. This type of research uses epidemiologic methods (such as interviews and collection of biologic specimens) that generally entail no more than minimal risk to the subjects.
5. In order for a study to be approved under this waiver, the IRB would need to ensure that, among other things, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of the data. Research Involving Children

The following procedures apply to all research involving children, regardless of funding source. The requirements in this section are consistent with Subpart D of 45 CFR 46, which applies to DHHS- funded research and Subpart D of 21 CFR 50, which applies to FDA-regulated research

involving children.

## 6.6 Research Involving Children

### 6.6.1 Allowable Categories

Research on children must be reviewed and categorized by the IRB into one of the following groups:

1. Research not involving physical or emotional risk greater than that ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests (i.e., minimal risk). Adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians as set forth in [Section 6.7.2](#).
2. Research involving greater than minimal risk but presenting the prospect of direct benefit to the individual subject:
  - a. the risk is justified by the anticipated benefit to the subjects; and
  - b. adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians as set forth in [Section 6.7.2](#).
3. Research involving greater than minimal risk and no reasonable prospect of direct benefit to the individual subject but likely to yield generalizable knowledge about the subject's disorder or condition:
  - a. the risk represents a minor increase over minimal risk;
  - b. the intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations;
  - c. adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians as set forth in [Section 6.7.2](#).
4. Research not otherwise approvable which presents an opportunity to understand, prevent, or alleviate serious problems affecting the health or welfare of children:
  - a. federally funded research in this category must be approved by the Secretary of Health and Human Services;
  - b. FDA-regulated research in this category must be approved by the Commissioner of Food and Drugs;
  - c. for non-federally funded, non-FDA research, the IRB will consult with a panel of experts in pertinent disciplines (e.g., science, medicine, ethics, law). Based on the recommendation of the panel, the IRB may approve the research based on whether
    - i. the research in fact satisfies the conditions of the previous categories, as applicable; or
    - ii. the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children; and
  - d. the research will be conducted in accord with sound ethical principles; and
5. adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians as set forth in [Section 6.7.2](#).

## **6.6.2 Parental Permission and Child Assent**

### **6.6.2.1 Parental Permission**

The IRB must determine that adequate provisions have been made for soliciting the permission of each child's parent or guardian.

Parents or guardians must be provided with the basic elements of consent and any additional elements the IRB deems necessary, as described in [Section 5.5](#).

The IRB may find that the permission of one parent is sufficient for research to be conducted under Categories (a) and (b) above. The IRB's determination of whether consent must be obtained from one or both parents will be documented in the consent checklist when a protocol receives expedited review and in meeting minutes when reviewed by the convened committee.

Consent from both parents is required for research to be conducted under Categories (c) and (d) above unless:

1. One parent is deceased, unknown, incompetent, or not reasonably available; or
2. When only one parent has legal responsibility for the care and custody of the child.

For research not covered by the FDA regulation, the IRB may waive the requirement for obtaining consent from a parent or legal guardian if:

1. the research meets the provisions for waiver in [Section 5.8](#), or
2. if the IRB determines that the research protocol is designed for conditions or a subject population for which parental or guardian permission is not a reasonable requirement to protect the subjects (e.g., neglected or abused children) provided an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted and that the waiver is not inconsistent with federal, state, or local law. The choice of an appropriate mechanism would depend upon the nature and purpose of the activities described in the protocol; the risk and anticipated benefit to the research subjects; and their age, maturity, status, and condition.

Parental permission may not be waived for research covered by FDA regulations.

Permission from parents or legal guardians must be documented in accordance with and to the extent required by [Section 5.6](#) and [Section 5.9](#).

### **6.6.2.2 Assent from Children**

Because "assent" means a child's affirmative agreement to participate in research, the child must actively show his/her willingness to participate in the research, rather than just complying with directions to participate and not resisting in any way. When judging whether children are capable of assent, the IRB is charged with taking into account the ages, maturity, and psychological state

of the children involved. The IRB has the discretion to judge children's capacity to assent for all the children to be involved in a proposed research activity or on an individual basis.

The IRB should take into account the nature of the proposed research activity and the ages, maturity, and psychological state of the children involved when reviewing the proposed assent procedure and the form and content of the information conveyed to the prospective subjects. For research activities involving adolescents whose capacity to understand resembles that of adults, the assent procedure should likewise include information similar to what would be provided for informed consent by adults or for parental permission. For children whose age and maturity level limits their ability to fully comprehend the nature of the research activity but who are still capable of being consulted about participation in research, it may be appropriate to focus on conveying an accurate picture of what the actual experience of participation in research is likely to be (e.g., what the experience will be, how long it will take, whether it might involve any pain or discomfort). The assent procedure should reflect a reasonable effort to enable the child to understand, to the degree they are capable of, what their participation in research would involve.

The IRB presumes that children ages 7 and older should be given an opportunity to provide assent. Generally, oral assent through the use of a script should be obtained from children 7 - 11 years of age. Written assent using a written document for the children to sign may be sought for older children.

At times there may be inconsistency between parent permission and child assent. Usually a "no" from the child overrides a "yes" from a parent, but a child typically cannot decide to be in research over the objections of a parent. Obviously, there are individual exceptions to these guidelines (such as when the use of an experimental treatment for a life-threatening disease is being considered).

The general idea, however, is that children should not be forced to be research subjects, even when their parents' consent to it.

If the IRB determines that the capability of some or all the children is so limited that they cannot reasonably be consulted or that the intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health or well-being of the children and is available only in the context of the research, the assent of the children is not a necessary condition for proceeding with the research.

Even when the IRB determines that the subjects are capable of assenting, the IRB may still waive the assent requirement under circumstances detailed in the Waiver of Informed Consent section of this manual.

### **6.6.2.3 The Assent Form**

When the IRB determines that assent is required, it will also determine whether and how assent must be documented.

Researchers should try to draft a form that is age appropriate and study specific, taking into

account the typical child's experience and level of understanding, and composing a document that treats the child respectfully and conveys the essential information about the study. The assent form should:

1. tell why the research is being conducted,
2. describe what will happen and for how long or how often,
3. say it's up to the child to participate and that it's okay to say no,
4. explain if it will hurt and if so for how long and how often,
5. say what the child's other choices are,
6. describe any good things that might happen,
7. say whether there is any compensation for participating, and
8. ask questions.

For younger children, the document should be limited to one page if possible. Illustrations might be helpful, and larger type makes a form easier for young children to read. Studies involving older children or adolescents should include more information and may use more complex language.

#### **6.6.2.4 Children Who Are Wards**

Children who are wards of the state or any other agency, institution, or entity can be included in research involving greater than minimal risk and no prospect of direct benefit to individual subjects but likely to yield generalizable knowledge about the subject's disorder or condition, only if such research is:

1. related to their status as wards; or
2. conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.

If the research meets the condition(s) above, an advocate must be appointed for each child who is a ward (one individual may serve as advocate for more than one child), in addition to any other individual acting on behalf of the child as legal guardian or in loco parentis.

The advocate must be an individual who has the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except in the role as advocate or member of the IRB) with the research, the investigator(s), or the guardian organization.

### **6.7 Persons with Impaired Decision-Making Capacity**

The requirements in this section apply to all research involving persons with mental disabilities or persons with impaired decision-making capacity regardless of funding source.

Research involving persons with impaired decision-making capability may be approved only when the following conditions apply:

1. Only incompetent persons or persons with impaired decision-making capacity are suitable as research subjects. Competent persons are not suitable for the proposed research. The investigator must demonstrate to the IRB that there is a compelling reason to include incompetent individuals or persons with impaired decision-making capacity as subjects. Incompetent persons or persons with impaired decision-making capacity must not be subjects in research simply because they are readily available.
2. The proposed research entails no significant risks, tangible or intangible, or if the research presents some probability of harm, there must be at least a greater probability of direct benefit to the participant. Incompetent people or persons with impaired decision-making capacity are not to be subjects of research that imposes a risk of injury, unless that research is intended to benefit that subject and the probability of benefit is greater than the probability of harm.
3. Procedures have been devised to ensure that participant's representatives are well informed regarding their roles and obligations to protect incompetent subjects or persons with impaired decision-making capacity. Health care agents, appointed under Durable Power of Attorney for Health Care (DPAHC), and next-of-kin, or guardians, must be given descriptions of both proposed research studies and the obligations of the person's representatives. They must be told that their obligation is to try to determine what the subject would do if competent, or if the subject's wishes cannot be determined, what they think is in the incompetent person's best interest.

### ***6.7.1 IRB Composition***

The IRB membership must include at least one member who is an expert in the area of research. Consideration may be given to adding another member who is a member of the population, a family member of such a person, or a representative of an advocacy group for that population. The IRB may utilize a consultant as necessary.

### ***6.7.2 Determination of Decision-Making Capacity***

The decision-making capacity of a potential research subject should be evaluated when there are reasons to believe that the subject may not be capable of making voluntary and informed decisions about research participation.

The investigator and research staff must have adequate procedures in place for assessing and ensuring subjects' capacity, understanding, and informed consent or assent. The IRB will evaluate whether the proposed plan to assess capacity to consent is adequate.

For research protocols that involve subjects with mental disorders that may affect decision-making capacity, the IRB may determine that capacity assessments are necessary, unless the investigator can justify why such assessments would be unnecessary for a particular group.

For research that poses greater than minimal risk, the IRB may require investigators to use independent and qualified professionals to assess whether potential subjects have the capacity to give voluntary, informed consent. Even in research involving only minimal risk, the IRB may



require that the study include a capacity assessment if there are reasons to believe that potential subjects' capacity may be impaired. It is not necessary to require a formal capacity assessment by an independent professional for all potential research subjects with mental disorders.

For research protocols involving subjects who have fluctuating or limited decision-making capacity the IRB may ensure that investigators establish and maintain ongoing communication with involved caregivers. Periodic re-consent should be considered in some cases. Third party consent monitors may be used during the recruitment and consenting process or waiting periods may be required to allow more time for the subject to consider the information that has been presented.

It is often possible for investigators and others to enable persons with some decisional impairments to make voluntary and informed decisions to consent or refuse participation in research. Potential measures include repetitive teaching, group sessions, audiovisual presentations, and oral or written recall tests. Other measures might include follow-up questions to assess subject understanding, videotaping or audiotaping of consent interviews, second opinions, use of independent consent observers, interpreter for hearing-impaired subjects, allowing a waiting period before enrollment, or involvement of a trusted family member or friend in the disclosure and decision-making process.

Both investigators and IRB members must be aware that for some subjects, their decision-making capacity may fluctuate. For subjects with fluctuating decision-making capacity or those with decreasing capacity to give consent, a re-consenting process with surrogate consent may be.

Though competent to provide informed consent, some persons may resist participating in a research protocol approved by their representatives.

In the event research participants become incompetent or impaired in decision making capacity after enrolment, the PI is responsible for notifying the IRB and HRPP office. The PI is responsible for developing a monitoring plan which follows the guidelines outlined above for incompetent and impaired decision-making research participants.

Decisional capacity in the research context has been interpreted by the American Psychiatric Association as requiring:

1. ability to communicate a choice,
2. ability to understand relevant information,
3. ability to appreciate the situation and its likely consequences, and
4. ability to manipulate information rationally.

A range of professionals and methods may be utilized to assess capacity. In general, the consent assessor should be a researcher or consultant familiar with dementia and qualified to assess and monitor capacity and consent in such subjects on an ongoing basis. The IRB will consider the qualifications of the proposed individual(s) and whether he/she is sufficiently independent of the research team.

A person who has been determined to lack capacity to consent to participate in a research study should be notified of that determination before permission may be sought from his or her legally authorized representative to enroll that person in the study. If permission is given to enroll such a person in the study, the potential subject should then be notified. If the person objects to participating, this objection should be heeded.

### **6.7.3 Informed Consent and Assent**

Whenever the participants have the capacity to give consent (as determined by qualified professionals), informed consent should be obtained and documented in accordance with [Section 5](#) above. When participants lack the capacity to give consent, investigators may obtain consent from the legally authorized representative of a subject (i.e., surrogate consent) as described below.

A person who is incompetent or has been determined to lack capacity to consent to participate in a research study should be informed about the research to the extent compatible with the subject's

understanding and, if possible, the subject should give their assent to participate, and sign and date the written informed consent or a separate assent form

Surrogate consent may be obtained from a legally authorized representative as described in [Section 5.2](#).

## **6.8 Cultural Context and Informed Consent, Assent and Permission**

There are a variety of contextual situations that may impact the appropriateness of a consent process, including tribal elders providing permission for the participation of a tribal community. For cultural context review of consent/assent processes, see [Section 17](#).

# **7. FDA Regulated Research**

WSU will not normally enter into a sponsored research agreement to conduct clinical trials associated with an IND application, except with specific approval by DRA, ADRA or the Vice President for Research. Any research associated with an IND application may be reviewed by a commercial IRB (e.g., Advarra, WCG IRB). Any WSU IRB that undertakes the review of an FDA regulated IND project will be assessed by the ADRA/DRA to ensure appropriate qualifications and expertise of the board and assigned reviewers. The ADRA or designee will provide the board with continuing education relevant to FDA requirements prior to or concurrent with the conduct of the review.

FDA regulations apply to any research that involves a "test article" in a "clinical investigation" involving "human subjects" as defined by the FDA regulations. For FDA regulated research, the IRB must apply the FDA regulations at 21 CFR 50 and 21 CFR 56, as well as, where appropriate, 45 CFR 46.

Use of investigational drugs must be conducted according to FDA IND regulations, 21 CFR Part 312, and other applicable FDA regulations. Use of an investigational device in a clinical trial to obtain safety and effectiveness data must be conducted according to FDA's IDE regulations, 21 CFR Part 812, and other applicable FDA regulations.

The following definitions and procedures describe the review of FDA-regulated research conducted under the auspices of WSU.

## 7.1 Definitions

**Investigational Drug** – An investigational drug for clinical research use is one for which the PI or a sponsor has filed an IND application (21 CFR Part 312) or an approved drug that is being studied for an unapproved or approved use in a controlled, randomized, or blinded clinical trial.

**Investigational Device** – A medical device that is the subject of a clinical study designed to evaluate the effectiveness and/or safety of the device. As further stated, a device is any healthcare product that does not achieve its primary intended purpose by chemical action or by being metabolized.

**IND** – An investigational new drug application in accordance with 21 CFR Part 312.

**IDE** – An investigational device exemption in accordance with 21 CFR 812.

**Significant Risk (SR)** – A significant risk device is an investigational device that

12. is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject; or
13. is purported or represented to be for a use in supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a subject; or
14. is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health and presents a potential for serious risk to the health, safety, or welfare of a subject; or
15. otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

**Non-Significant Risk (NSR)** – An investigational device other than a significant risk device.

## 7.2 Procedures

At initial submission, the PI must indicate whether the research involves a test article and is a clinical investigation involving human subjects on the application form. The PI may use the FDA Determination Checklist to assist in making this determination.

During the pre-review process, the ADRA, Chair, coordinator or assigned reviewer will confirm whether FDA regulations are applicable using the FDA Determination Checklist. If FDA

regulations apply and the research is not exempt\*, the IRB Administrator will indicate on the agenda that the protocol is an FDA-regulated study.

\*This does not include exempt research where abbreviated FDA requirements may still apply.

### **7.3 Investigational Drugs and Devices**

Clinical studies of drugs that require an IND will not be conducted at WSU without approval by the VPR (or DRA or ADRA)). Drug studies that are exempt from IND requirements and medical device studies may be conducted at WSU and may be overseen either by the WSU IRB or an external IRB. The PI must indicate on the IRB application whether the research involves investigational drugs or devices. If so, the PI must indicate if there is an IND Exemption/IDE for the research and provide documented assurance from the sponsor that the manufacture and formulation of investigational or unlicensed test articles conform to federal regulations. Documentation of the IND Exemption/IDE could be:

1. an industry-sponsored protocol with IND Exemption/IDE.
2. a letter from the FDA.
3. a letter from industry sponsor.
4. other documents and/or communication verifying the IND Exemption/IDE.

For investigational devices, NSR device studies follow abbreviated IDE requirements and do not have to have an IDE application approved by the FDA. If a sponsor has identified a study as NSR, then the investigator must provide an explanation of the determination. If the FDA has determined that the study is NSR, documentation of that determination must be provided.

If the research involves drugs or devices and there is no IND Exemption/IDE, the PI must provide a rationale as to why it is not required.

The IRB will review the application and determine:

1. whether there is an IND Exemption/IDE and if so, whether there is appropriate supporting documentation;
2. if the research involves drugs or devices with no IND/IDE and whether the research meets the criteria in 7.4 and/or 7.5 below.
3. If the reviewer agrees with the risk and/or exemption determinations made by the sponsor (or PI as sponsor when not externally sponsored), this concurrence should be documented in their review.
4. If the reviewer disagrees with the sponsor or PI determinations, this must be documented in the review with basis provided.

### **7.4 IND Exemption**

For drugs, an IND is not necessary if the research falls in one of the following categories:

1. The drug being used in the research is lawfully marketed in the United States and all the following requirements are met:
  - a. The research is not intended to be reported to FDA in support of a new indication for use or to support any other significant change in the labeling for the drug.
  - b. The research is not intended to support a significant change in the advertising for the product.
  - c. The research does not involve a route of administration or dosage level, use in a subject population, or other factors that significantly increase the risks (or decreases the acceptability of the risks) associated with the use of the drug product.
  - d. The research is conducted in compliance with the requirements for IRB review and informed consent [See 21 CFR parts 56 and 50, respectively].
  - e. The research is conducted in compliance with the requirements concerning the promotion and sale of drugs [See 21 CFR 312.7].
  - f. The research does not intend to invoke FDA regulations for planned emergency research [See 21 CFR 50.24].
2. The research only involves one or more of the following: (i) Blood grouping serum, (ii) Reagent red blood cells, or (iii) Anti-human globulin.
3. For clinical investigations involving an in vitro diagnostic biological product, an IND is not necessary if (i) it is intended to be used in a diagnostic procedure that confirms the diagnosis made by another, medically established, diagnostic product or procedure; and (ii) it is shipped in compliance with 312.160.

## **7.5 Medical Devices**

### **7.5.1 IDE Requirements**

The PI must indicate on the IRB application whether the research involves investigational devices. If so, the PI must indicate if there is an IDE for the research and provide documented assurance from the sponsor that the manufacture and formulation of investigational or unlicensed test articles conform to federal regulations. Documentation of the IDE could be:

1. an industry-sponsored protocol with IDE.
2. a letter from the FDA.
3. a letter from industry sponsor.
4. other document and/or communication verifying the IDE.

For investigational devices, NSR device studies follow abbreviated IDE requirements and do not have to have an IDE application approved by the FDA. If a sponsor has identified a study as NSR, then the investigator must provide an explanation of the determination. If the FDA has determined that the study is NSR, documentation of that determination must be provided.

If the research involves devices and there is no IDE, the PI must provide a rationale as to why it is not required.

The IRB will review the application and determine:

1. whether there is an IDE and if so, whether there is appropriate supporting documentation;
2. if the research involves drugs or devices with no IDE and whether the research meets the criteria below.
3. If the reviewer agrees with the risk and/or exemption determinations made by the sponsor (or PI as sponsor when not externally sponsored), this concurrence should be documented in their review.
4. If the reviewer disagrees with the sponsor or PI determinations, this must be documented in the review with basis provided.

### ***7.5.2 Exempted IDE Investigations***

For devices, an IDE is not necessary if:

1. The research involves a device, other than a transitional device, in commercial distribution immediately before May 28, 1976, when used or investigated in accordance with the indications in labeling in effect at that time.
2. The research involves a device other than a transitional device, introduced into commercial distribution on or after May 28, 1976, that FDA has determined to be substantially equivalent to a device in commercial distribution immediately before May 28, 1976, and that is used or investigated in accordance with the indications in the labeling FDA reviewed under subpart E of 21 CFR 807 in determining substantial equivalence.
3. The research involves a diagnostic device and if the sponsor complies with applicable requirements in 21 CFR 809.10(c), and if the testing
  - a. is noninvasive,
  - b. does not require an invasive sampling procedure that presents significant risk,
  - c. does not by design or intention introduce energy into a subject, and
  - d. is not used as a diagnostic procedure without confirmation of the diagnosis by another medically established diagnostic product or procedure.
4. The research involves a device undergoing consumer-preference testing, testing of a modification, or testing of a combination of two or more devices in commercial distribution, if the testing is not for the purpose of determining safety or effectiveness and does not put subjects at risk.
5. The research involves a device intended solely for veterinary use.
6. The research involves a device shipped solely for research on/or with laboratory animals and labeled in accordance with 21 CFR 812.5(c).
7. The research involves a custom device as defined in 21 CFR 812.3(b), unless the device is being used to determine safety or effectiveness for commercial distribution.

## **7.6 Responsibilities**

### ***7.6.1 Principal Investigator***

1. The PI is responsible for ensuring that the research is conducted according to all regulatory guidelines and WSU policies and procedures.
2. The PI must obtain approval from the IRB before initiating any research activities.
3. The PI proposing the drug/device research will be required to provide a plan – to be evaluated by the IRB – that includes storage, security, and dispensing of the (test items (drug/device)).
  - a. The PI is responsible for the investigational drug/device accountability, which includes storage, security, dispensing, administration, return, disposition, and records of accountability.
  - b. All test items received for a study must be stored in a controlled environment under secure control with limited access. The area must be within an area of PI's control. A log must be kept regarding the receipt, use, and/or dispensing of the test items and the disposition of remaining test items at the conclusion of the investigation.
4. The PI shall report all unanticipated problems involving risk to subjects or others to the IRB according to the procedures outlined in [Section 8](#).
5. For research involving investigational drugs, the PI will maintain the following:
  - a. Current curriculum vitae (CV).
  - b. Protocol.
  - c. Records of receipt and disposition of drugs.
  - d. List of any co-investigators with their curricula vitae.
  - e. Certification that all physicians, dentists, and/or nurses responsible in the study have appropriate valid licenses for the duration of the investigation.
  - f. Case histories with particular documentation on evidence of drug effects. Emphasis is on toxicity and possible untoward happenings. All unexpected adverse effects are reportable, even if the investigator considers that the event is not related to the drug. All unexpected adverse effects must be reported immediately to the IRB in the manner defined by the protocol.
  - g. IRB letters of approval.
  - h. Other documents as outlined in the Human Subject Protection Program – Standard Operating Procedures.
6. For research involving investigational devices,
  - a. If a device is considered NSR by the PI or sponsor, but after review, the IRB determines the device to have significant risk, the PI is responsible for notifying the sponsor of the IRB's determination upon receipt of written notice from IRB. The PI must provide the IRB with confirmation of this action.
  - b. If the PI is storing the devices, he/she must maintain a log indicating the identification/serial number of the device, name of subject, date dispensed, by whom it was dispensed, and amount remaining; and
  - c. The PI will maintain the following:
    - i. Current curriculum vita (CV).
    - ii. Protocol of the study.
    - iii. Records of animal study reports.
    - iv. Records of receipt and disposition of devices.
    - v. List of any co-investigators with their curricula vitae.
    - vi. Certification that all physicians, dentists, and/or nurses responsible in the

- study have appropriate valid licenses for the duration of the investigation.
  - vii. Case histories with particular documentation on evidence of effects. The emphasis is on safety and possible untoward happenings. All adverse device effects are reportable.
  - viii. IRB letters of approval.
  - ix. Device training.
  - x. Other documents as outlined in the Human Subject Protection Program – Standard Operating Procedures.
7. Following completion of the study, the log must be completed regarding the receipt, use and/or dispensing of the test items and the disposition of remaining test items at the conclusion of the investigation.
  8. If, after use, the PI keeps the test items, he/she must maintain a log regarding the receipt, use, and/or re-dispensing of the devices and the disposition of remaining test items at the conclusion of the investigation.
  9. The PI will submit to the sponsor and to the IRB a report of any unanticipated adverse effects occurring during an investigation as soon as possible, but in no event later than ten
  10. (10) working days after the investigator first learns of the effect.
  11. When a PI files an IDE, the PI is considered the sponsor and as such is accountable for all the FDA regulatory responsibilities and reporting obligations of both the PI and the sponsor, as described in the FDA regulations. The Research Plan asks the PI if he/she also acts as the sponsor of the research and, if so, asks him/her to affirm that he/she has reviewed the Guidance Document on Requirements of the Sponsor and the Investigator as a Sponsor and will comply with the regulatory responsibilities of a sponsor. The investigator is responsible for arranging any necessary education or training required to make the regulatory filings and conduct the study. The Office of Research Compliance will conduct random audits of PIs holding an IDE as per the Research Quality Improvement Program (per [Section 1.12](#)).

## **7.6.2 IRB**

1. The IRB will review the research in accordance with the following requirements and the same criteria it would use in considering approval of any research involving an FDA-regulated product. [See 21 CFR 56.111]
2. For research involving investigational devices,
  - a. The IRB will review the control plan and determine whether it is adequate. If the Chair determines that the IRB does not have the necessary expertise to evaluate the plan, outside consultation will be used.
  - b. Unless the FDA has already made a risk determination for the study, the IRB will review NSR studies and determine if the device represents significant or non-significant risk and report the findings to the PI in writing. The IRB will consider the risks and benefits of the medical device compared to the risks and benefits of alternative devices or procedures. NSR device studies do not require submission of an IDE application but must be conducted in accordance with the abbreviated requirements of IDE regulations. If IRB considers the study that has been



submitted as NSR to be considered SR, then IRB may approve the study, but the study cannot begin until an IDE is obtained.

- c. The IRB will not review protocols involving SR devices under expedited review.
- d. The IRB will document in the minutes and provide written documentation to the PI of the rationale for determining whether a device is classified as NSR/SR.
- e. If the FDA has already made the SR or NSR determination for the study, the agency's determination is final, and the IRB does not need to make a risk determination.

## **8. Reportable Events, Non-Reportable Events and Unanticipated Problems Involving Risks to Subjects or Others**

WSU complies with DHHS and FDA regulations which state that institutions must have written policies on reporting unanticipated problems involving risks to subjects or others to the IRB, institutional officials, and relevant federal agencies and departments.

The following procedures describe how unanticipated problems involving risk to subjects or others are handled in research under the auspices of WSU.

### **8.1 Definitions**

**UPIRSO** - Unanticipated problems involving risk to subjects or others –Any incident, experience, outcome, or new information that meets all the following criteria:

- 7. Unexpected (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent document; and (b) the characteristics of the subject population being studied;
- 8. Related or possibly related to participation in the research (possibly related means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research); and
- 9. Suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

**Unexpected** – The incident, experience, or outcome is not expected (in terms of nature, severity, or frequency), given the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent documents, and the characteristics of the subject population being studied.

**Unanticipated adverse device effect** - Any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational

plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects [See 21 CFR 812.150(a)].

**Related** – There is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research.

**Adverse Event** – Any untoward physical or psychological occurrence in a human subject participating in research. An AE can be any unfavorable or unintended event including abnormal laboratory finding, symptom or disease associated with the research or the use of a medical investigational test article.

Note: Only a fraction of Adverse Events are UPIRSOs and not all UPIRSOs are Adverse Events.

## 8.2 Reportable Event Procedures

### 8.2.1 Reporting by Investigator

Investigators must promptly report (according to reporting schedule in [Section 8.2.2](#)) the following problems to the IRB:

1. Adverse events involving direct harm to participants which, in the opinion of the principal investigator, meet the criteria for an unanticipated problem involving risk to subjects or others.
2. An unanticipated event related to the research that exposes participants to risk but that does not involve direct harm to participants.
3. An unanticipated event related to the research that exposes individuals other than the research participants (e.g., investigators, research assistants, students, the public, etc.) to risk.
4. IND Safety Reports from sponsors that meet the criteria for an unanticipated problem involving risk to subjects.

Note: WSU will not conduct research on drugs that require an IND

5. New information that indicates a change to the risks or potential benefits of the research. For example,
  - a. An interim analysis or safety-monitoring report indicates that frequency or magnitude of harms or benefits may be different than initially presented to the IRB.
  - b. A paper is published from another study that shows that the risks or potential benefits of your research might be different than initially presented to the IRB.
  - c. A breach of confidentiality.
  - d. Incarceration of a participant in a protocol not approved to enroll prisoners.
  - e. Changes increasing the risk to subjects and/or affecting significantly the conduct of the trial.
  - f. Complaint of a participant when the complaint indicates unexpected risks or cannot be resolved by the research team.
  - g. Protocol violation (meaning an accidental or unintentional change to the IRB

- approved protocol) that harmed participants or others or that indicates participants or others may be at increased risk of harm.
- h. Sponsor imposed suspension for risk.
- i. Change in FDA labeling or withdrawal from marketing of a drug, device, or biologic used in a research protocol.
- j. Unanticipated adverse device effect.
- k. Any other event that indicates participants or others might be at risk of serious, unanticipated harms that are reasonably related to the research.

### **8.2.2 Submission of Reports by Investigator**

Investigators must report possible unanticipated problems to the IRB promptly.

If the event requires immediate intervention to prevent serious harm to participants or others, the investigator must report the event within five (5) days of receiving notice of the event.

Investigators must report all other possible unanticipated problems occurring at the local research site and non-local research sites to the IRB as soon as possible but no later than ten (10) business days or as soon as practicable from the date of the event or from the date the investigator is notified of the event.

Problems occurring within thirty (30) days after participants' active participation or treatment must be reported according to the above schedule.

Investigators or the study team must report possible unanticipated problems to the HRPP Office in writing using the IRB/HRPP Reporting Form or via the electronic submission system. The written report should contain all of the following:

1. Detailed information about the possible unanticipated problems, including relevant dates.
2. Any corrective action, planned or already taken, to ensure that the possible unanticipated problems are corrected and will not occur again.
3. An assessment of whether any subjects or others were placed at risk as a result of the event or suffered any physical, social, or psychological harm and any plan to address these consequences.
4. Any other relevant information.
5. Any other information requested by the HRPP Office.
6. A report of a possible unanticipated problem involving risks to participants or others will be immediately forwarded to the DRA, ADRA and/or IRB Chair if the IRB staff believes that immediate intervention may be required to protect participants or others from serious harm.

Upon receipt of a report of a possible unanticipated problem from someone other than the investigator or study staff, the ADRA will notify the PI on the study when appropriate.

### **8.2.3 Processing Reports of Possible Unanticipated Problems**

### 8.2.3.1 Review by IRB Staff and Chair

1. Upon receipt of an IRB/HRPP Reporting Form from a PI, the HRPP staff checks the form for completeness. If any applicable sections of the form are incomplete or have been answered unsatisfactorily, the HRPP staff will contact the investigator or the designated contact person to obtain additional information. Corrections are documented in the IRB file, indicating the date, the person spoken with, and the HRPP staff making the correction.
2. The reviewer (IRB chairperson and/or other experienced IRB member(s), or HRPP office staff) receives and reviews the report of the event(s) considered to be an unanticipated problem. The reviewer will make the final determination as to whether the event is to be regarded as an unanticipated problem.
3. Based on the information received from the investigator, the DRA/ADRA or IRB Chair may temporarily suspend research to ensure protection of the rights and welfare of participants. Suspension directives made by the DRA/ADRA or IRB Chair must be reported to a meeting of the convened IRB.
4. The DRA/ADRA, the IRB or the IRB chairperson has authority to require submission of more detailed contextual information by the PI, the sponsor, the study coordinating center, or DSMB/DMC about any Adverse Event occurring in a research protocol as a condition of the continuation of the IRB's approval of the research.
5. The reviewer will assess whether a reported event:
  - a. Was anticipated or unanticipated
  - b. If participants or others were harmed or at increased risk of harm.
6. If the reviewer considers that the problem was foreseen (was expected):
  - a. the reviewer indicates that the problem is not an unanticipated problem.
  - b. A report is filed in the protocol record, the determination is communicated to the investigator, and no further action is taken.
  - c. The reviewer advises the investigator that anticipated problems that are adverse events may be reported in summary form at time of continuing review or status report and that anticipated problems that are not adverse events are non-reportable (e.g. events not listed in [Section 8.2.1](#)).
7. If the reviewer considers that the problem was not foreseen (was unexpected/unanticipated) AND determines that participants or others were not harmed, potentially harmed or are at increased risk of harm:
  - a. The reviewer indicates that the event, while unanticipated, is not a UPIRSO,
  - b. A report is filed in the protocol record and the determination is communicated to the investigator
  - c. The investigator is advised to report unanticipated problems affecting the research but NOT involving risks to subjects or others in summary form at time of continuing review or status report (events not listed in [Section 8.2.1](#)).
8. If the reviewer considers that the problem is an unanticipated problem involving, or potentially involving risks to subjects or others, but that the risk is no more than minimal, the reviewer will:
  - a. Review the currently approved protocol, consent document and investigators brochure/recruitment documents (if one exists) and;

- b. Review previous reports of unanticipated problems involving risks to participants or others, and
- c. After reviewing all of the materials, the reviewer will take appropriate action depending on the nature of the risk involved, including requiring modification of the protocol or the consent form, if applicable.
- d. The results of the review will be recorded in the protocol record, communicated to the investigator, and reported to the IRB.
- e. All events determined to be unanticipated problems will be reported to the relevant regulatory agencies and institutional officials according to the procedures in [Section 11](#).

#### **8.3.2.2 IRB Review**

All reported unanticipated problems where the risk is more than minimal will be reviewed at a convened IRB meeting. If a report suggests that participant safety is at risk, the IRB may immediately suspend or terminate the research.

1. The reviewer will conduct their assessment as outlined in [Section 8](#) above with the following exceptions:
  - a. The reviewer will provide a report summarizing the problem
  - b. The convened IRB will review the report and make the final determination regarding how to classify the problem based on the following considerations:
    - i. Whether the reported event is an unanticipated problem involving risks to participants or others according to the definition in this policy.
    - ii. What action in response to the report is appropriate.
    - iii. Whether suspension or termination of approval is warranted.
    - iv. Whether further reporting to Institutional and/or federal officials is required.
  - c. The convened IRB will specify actions to be taken or will designate a subcommittee or individual(s) with appropriate expertise to ensure that appropriate corrective actions are taken, including but not limited to:
    - i. Requiring modifications to the protocol.
    - ii. Revising the continuing review timetable.
    - iii. Modifying the consent process.
    - iv. Modifying the consent document.
    - v. Providing additional information to current participants (e.g., whenever the information may relate to the participant's willingness to continue participation).
    - vi. Providing additional information to past participants.
    - vii. Requiring additional training of the investigator and/or study staff.
    - viii. Taking other actions appropriate for the local context.
    - ix. Additional actions that may be taken if the event is determined to be a UPIRSO:
      1. Reconsidering approval.
      2. Requiring that current participants re-consent to participation.
      3. Monitoring the research.

4. Monitoring the consent.
  5. Making referral to other organizational entities (e.g., legal counsel, risk management, Institutional Official).
  6. Suspending the research.
  7. Terminating the research.
- d. The determination of the IRB will be communicated to the investigator along with any corrective actions required

### **8.3.2.3 Reporting**

Any suspension (not including temporary suspension during investigation or information gathering) or termination of research by the convened IRB must be promptly reported to the IO, and OHRP (if supported by HHS), and FDA (if FDA-regulated research) through the IO. This should be done in writing.

If, after reviewing a report, the IRB finds that the event is an unanticipated problem involving risks to participants or others or that suspension or termination of approval is warranted, the IRB will:

1. notify the investigator in writing of its findings, with copies to the Chair of the investigator's department and/or research unit, other affected units, and the investigator's supervisor; and
2. report its findings and recommendations to the IO for further reporting to the appropriate federal officials (e.g., NSF, OHRP, and FDA).

## **8.3 Reporting Other Events**

All events, problems, and new information that do not meet the above reporting requirements should be reported to the IRB in summary form at the time of the next continuing review, status report, or protocol closure report.

The IRB recognizes that sponsors may require that the PI report all serious adverse events and safety reports to the IRB. To comply with sponsor requirements, PIs should report adverse events and safety reports that do not meet the above reporting requirements. HRPP staff will acknowledge receipt of these reports by returning a dated acknowledgement to the PI.

# **9. Protocol Exceptions & Deviations**

Protocol exceptions and deviations must be reported to the IRB.

## **9.1 Exceptions**

A protocol exception is a one-time, intentional action or process that departs from the IRB-approved protocol.

It is the responsibility of the Investigator to report exceptions to the IRB. The IRB will perform an expedited review of the Request for Protocol Change form submitted by the PI along with documentation of sponsor justification and approval. Exceptions must be approved by the sponsor and IRB before being implemented.

Exceptions may not increase risk or decrease benefit, affect the participants' rights, safety, welfare, or affect the integrity of the resulting data.

## **9.2 Deviations**

A protocol deviation is defined as a violation that is unanticipated and happens without any prior agreement (e.g., protocol visit scheduled outside protocol window, blood work drawn outside protocol window, etc.)

It is the responsibility of the PI not to deviate from the protocol approved by the IRB, except to avoid an immediate hazard to the participant. The PI must submit an amendment request to the IRB and receive written approval prior to implementation of any change to the protocol.

Deviations that increase risk, have potential to recur, or are undertaken to eliminate an immediate hazard would be considered an Unanticipated Problem and should be handled according to [Section 8](#).

When a sponsor requests that the IRB be notified of a deviation, the completed form will be forwarded to the IRB chair or designate for review of the Request for Protocol Change form submitted by the PI.

Deviations may be ruled by the IRB to constitute non-compliance resulting in suspension of IRB approval.

## **9.3 Reporting & Review**

Deviation/Exception Reports are to be completed for those events that qualify as a protocol deviation or exception. These reports should be filed with the IRB Office. The IRB Office will forward the report to the IRB Chair or experienced IRB member or HRPP staff for review. An acknowledged report will be sent back to the PI for the study file. The Chair may choose to place any deviation or exception on the agenda of the next convened IRB meeting for discussion. The PI may be asked to appear at that meeting to answer any questions or clarify issues for the IRB.

# **10. Complaints, Concerns and Non-Compliance**

As part of its commitment to protecting the rights and welfare of human subjects in research, WSU reviews all complaints and allegations of non-compliance and takes any necessary action to ensure the ethical conduct of research.

All PIs and other study personnel involved in human subjects research are required to comply with all laws and regulations governing their research activities, as well as with requirements and determinations of the IRB. Study personnel include the PI and any staff member directly involved with participants or the informed-consent process.

The following procedures describe how complaints and allegations of non-compliance are handled by the IRB. Not all allegations are the same, and some may require that the IRB complete each of the steps outlined below, however in most instances, a determination can be made and an effective remediation plan implemented without completing every step outlined below.

At WSU all complaints, concerns and allegations of non-compliance are centrally reported to the Office of Research Assurances through a variety of mechanisms including an Office of Research on-line confidential reporting tool, a telephone hotline and e-mail. All reports received by the ORA are by the ADRA or designee. All credible IRB related reports are relayed to the IRB Chair by the Office of Research Assurances.

## 10.1 Definitions

**Allegation of Noncompliance** – An unproved assertion of non-compliance.

**Concern** – An inquiry, question or request for clarification regarding conduct of research that is not specifically an allegation of non-compliance. Concerns are handled similarly to complaints unless it becomes apparent that the concern should be handled as an allegation of non-compliance.

**Noncompliance** – Failure to comply with any of the regulations and policies described in this document and failure to follow the determinations of the IRB. Non-compliance may be minor or sporadic or it may be serious or continuing.

**Serious noncompliance** – Failure to follow any of the regulations and policies described in this document or failure to follow the determinations of the IRB, and which, in the judgment of either the IRB Chair or the convened IRB, increases risks to participants, decreases potential benefits, or compromises the integrity of the HRPP. Research being conducted without prior IRB approval or participation of subjects in research activities without their prior consent (i.e., in studies where consent was not specifically waived by the IRB) is considered serious noncompliance. This determination may only be made by the convened IRB.

**Continuing noncompliance** – A pattern of non-compliance that, in the judgment of the IRB Chair or convened IRB, suggests a likelihood that instances of non-compliance will continue without intervention. Continuing non-compliance also includes failure to respond to a request to resolve an episode of non-compliance or repetitive non-compliance following implementation of an IRB required remediation plan. A pattern of non-compliance that is determined by the convened IRB to undermine the credibility of the HRPP may also be considered continuing non-compliance.

**Finding of Noncompliance** – An allegation of non-compliance that is proven true or a report of



non-compliance that is clearly true. For example, a finding on an audit of an unsigned consent document, or an admission of an investigator that the protocol was willfully not followed would represent reports of non-compliance that would require no further action to determine their truth and would therefore represent findings of non-compliance. A finding of non-compliance may also occur subsequent to investigation when either the IRB Chair or convened IRB determines that the evidence supports the allegation of non-compliance. Once a finding of non-compliance is made, it must be categorized as serious, non-serious, or continuing.

## **10.2 Complaints**

The ADRA, Chair of the IRB (or designated highly qualified HRPP staff) will promptly handle (or delegate ORA or IRB staff to handle) and, if necessary, investigate all complaints, concerns, and appeals received by the IRB. This includes complaints, concerns, and appeals from investigators, research participants, and others.

All complaints, written or oral (including telephone complaints), and regardless of point of origin, are recorded and forwarded to the IRB Chair and ADRA.

Upon receipt of the complaint, the Chair, ADRA or designee will make a preliminary assessment of whether the complaint warrants immediate suspension of the research project. If a suspension is warranted, the procedures in [Section 3.9.1](#) will be followed.

If the complaint meets the definition of non-compliance, it will be considered an allegation of non-compliance according to [Section 10.3](#).

If the complaint meets the definition of an unanticipated problem involving risk to subjects or others, it will be handled according to [Section 8](#).

Within three (3) business days of receipt of the complaint (or as soon as is practicable), the IRB Chair and/or ADRA (or designee) will generate a letter to acknowledge that the complaint has been received and is being investigated. A follow-up contact name will be provided to the complainant/relator unless the complainant/relator has indicated they do not wish to be contacted or the report was submitted anonymously.

## **10.3 Noncompliance**

Investigators and their study staff are required to report instances of possible non-compliance. The PI is responsible for reporting any possible noncompliance by study personnel to the IRB. However, any individual or employee may report observed or apparent instances of noncompliance to WSU IRB. In such cases, the reporting party is responsible for making these reports in good faith, maintaining confidentiality, and cooperating with any IRB and/or institutional review of these reports.

If an individual, whether investigator, study staff, or other, is uncertain whether there is cause to report noncompliance, he/she may contact the IRB Chair, Vice Chair(s), IRB Coordinator, DRA

or ADRA directly to discuss the situation informally.

Reports of noncompliance must be submitted to the IRB Office within ten (10) business days of discovery of this noncompliance. The report must include a complete description of the noncompliance, the personnel involved. Any non-compliance that could or will result in increased risk of harm to participants or others should be reported to the IRB Office immediately, or as soon as is practicable after taking steps to minimize or eliminate the potential for further harm. Complainants may choose to remain anonymous or may request that reports keep their identity confidential.

### ***10.3.1 Review of Allegations of Noncompliance***

All allegations of non-compliance will be reviewed by the ADRA, IRB Chair, DRA or appropriately qualified HRPP designee in the Office of Research Assurances, who will review all applicable documents, including but not limited to:

1. all documents relevant to the allegation;
2. the last approval letter from the IRB;
3. the last approved IRB application and protocol;
4. the last approved consent document;
5. the grant, if applicable; and
6. any other pertinent information (e.g., questionnaires, DSMB reports, etc.).

When the review is conducted by a designee, the designee will summarize the allegation review in writing and submit the report to the ADRA and/or IRB Chair.

The ADRA and/or IRB Chair will review the allegation and determine the credibility of the allegation. The ADRA or Chair may request additional information or an audit of the research in question.

When the ADRA and/or IRB Chair determines that noncompliance did not occur because the incident was within the limits of an approved protocol for the research involved, the determination is reported in writing to the PI and, if applicable, to the reporting party. The determination letter will be copied to the IO in cases where the IO and any other parties had been notified at the outset.

If, in the judgment of the ADRA or IRB Chair, the reported allegation of non-compliance is credible and/or likely true, the non-compliance will be processed according to [Section 10.3.2](#).

If, in the judgment of the ADRA or IRB Chair, any allegation or findings of non-compliance warrant suspension of the research before completion of any review or investigation to ensure protection of the rights and welfare of participants, the ADRA and/or DRA and/or Chair may suspend the research as described in [Section 3.9](#) with subsequent review by the IRB.

The ADRA or IRB Chair may determine that additional expertise or assistance is required to make

these determinations and may form an ad hoc committee to assist with the review and fact gathering process. When an ad hoc committee assists in the review process, the Chair is responsible for assuring that minutes of the meeting are generated and kept to help support any determinations or findings made by the ad hoc committee.

### **10.3.2 Review of Findings of Noncompliance**

**Noncompliance is not serious or continuing** – When the ADRA and/or IRB Chair determines that the noncompliance occurred, but the noncompliance does not meet definition of serious or continuing noncompliance, the determination is reported in writing to the PI and, if applicable, to the reporting party. The ADRA and/or Chair will develop a corrective action plan and, in some cases, will work with the PI to develop a corrective action plan to prevent future noncompliance. Reports of minor noncompliance and corrective action plans are reported to the IRB in summary form. Reports and corrective action plans are available to any member of the IRB individually by uploading these documents to the electronic protocol file and/or as part of the IRB meeting documents that are shared IRB prior to any convened meeting and are presented individually or in summary form during a convened meeting. If, however, the PI refuses to cooperate with the corrective action plan or disagrees with the finding of minor non-compliance, the matter is referred to a convened meeting of the IRB with notification to the IO.

**Serious or Continuing Noncompliance** – When the ADRA or IRB Chair determines that noncompliance has occurred and that the noncompliance likely meets the definition of serious or continuing noncompliance, or if the ADRA or Chair are unsure if the allegation meets the definition(s) of serious or continuing, the report of noncompliance is submitted for review by the IRB at the next convened meeting.

However, the ADRA or Chair may use discretion and call an emergency IRB meeting should the circumstances warrant such an urgent meeting.

All findings of serious or continuing non-compliance submitted to the IRB will be reviewed at a convened meeting. All IRB members will receive:

1. all documents relevant to the allegation,
2. the last approval letter from the IRB,
3. the last approved IRB protocol, and
4. the last approved consent document.

At this stage, the IRB may:

1. find that there is no issue of non-compliance,
2. find that there is noncompliance that is neither serious nor continuing and an adequate corrective action plan is in place,
3. find that there is serious or continuing non-compliance and approve any changes proposed by the Chair and/or ad hoc committee,
4. find that there may be serious or continuing non-compliance and direct that a formal inquiry (described below) be held, or
5. request additional information.

### **10.3.3 Inquiry Procedures**

If the convened IRB is unable to make a determination regarding alleged non-compliance or requires additional information to substantiate an allegation, a determination may be made by the IRB that an inquiry is necessary. Depending upon the complexity, the IRB may choose to designate either a designee within the HRPP or a subcommittee consisting of IRB members, HRPP staff and non- members (if appropriate) to ensure fairness and expertise. HRPP staff will work with the subcommittee (or designee) to ensure that records of the proceedings and findings of the subcommittee (or designee) are maintained and will draft any reports or letters that the subcommittee (or designee) requires. The subcommittee or HRPP designee is given a charge by the IRB, which can include any or all of the following:

1. review of protocol(s) in question;
2. review of sponsor audit report of the investigator (if appropriate);
3. review of any relevant documentation, including consent documents, case report forms, subject's investigational and/or medical files, etc. as they relate to the investigator's execution of her/his study involving human subjects;
4. interview of appropriate personnel (if necessary);
5. prepare either a written or oral report of the findings, which is presented to the full IRB at its next meeting;
6. recommend actions if appropriate.

### **10.3.4 Final Review**

The results of the inquiry will be reviewed at a convened IRB meeting where the IRB will receive a report from the subcommittee. If the results of the inquiry substantiate the finding of serious or continuing non-compliance, the IRB's possible actions could include, but are not limited to the following:

1. Request a correction action plan from the investigator.
2. Verify that participant selection is appropriate and observe the actual informed consent.
3. Increase data and safety monitoring of the research activity.
4. Request a directed audit of targeted areas of concern.
5. Request a status report after each participant receives intervention.
6. Modify the continuing review cycle.
7. Request additional PI and staff education.
8. Notify current subjects if the information about the non-compliance might affect their willingness to continue participation.
9. Require modification of the protocol.
10. Require modification of the information disclosed during the consent process.
11. Require current participants to re-consent to participation.
12. Suspend the study (see below).
13. Terminate the study (see below).

In cases where the IRB determines that the event of noncompliance also meets the definition of unanticipated problem involving risks to subjects or others, the policy and procedure for review of such events will also be followed.

If the IRB determines that the non-compliance was serious or continuing, the results of the final review will be reported as described below in [Section 11](#).

**Appeals:** The investigator is informed of the IRB determination and the basis for the determination in writing and is given a chance to respond in writing. As with all actions and determinations of the IRB, the IRB decision is final, however if the PI disagrees with the finding or believes that additional information that was not considered during the IRBs evaluation of the allegation could impact the IRB decision, they may submit an appeal in writing to the IO and/or IRB. If they agree, the IO may in turn request that the IRB reconsider the matter but may not overrule the IRBs final determination.

## **11. Reporting to Institutional Officials, Regulatory Agencies, and AAHRPP**

### **11.1 Reporting Triggers**

Federal regulations require prompt reporting to appropriate institutional officials and, if the research is funded by an agency of the federal government, to the department or agency head of any unanticipated problems involving risks to subjects or others or any serious or continuing noncompliance with this policy or the requirements or determinations of the IRB; and (b) any suspension or termination of IRB approval. The WSU HRPP will comply with this requirement, and the following procedures describe how these reports are handled.

Reporting procedures are initiated as soon as the IRB takes any of the following actions:

1. Determines that an event may be considered an unanticipated problem involving risks to participants or others.
2. Determines that non-compliance was serious or continuing.
3. Suspends or terminates approval of research.

### **11.2 Preparation of Report**

The ADRA or designee is responsible for preparing reports or letters which include the following information:

1. The nature of the event (e.g., unanticipated problem involving risks to participants or others, serious or continuing non-compliance, suspension or termination of approval of research).

2. Name of the institution(s) conducting the research.
3. Title of the research project and/or grant proposal in which the problem occurred.
4. Name of the PI on the protocol.
5. Number of the research project assigned by the IRB, or a note that no approved protocol was in place where this is the case, and the number of any applicable federal award(s) (e.g., grant, contract, or cooperative agreement).
6. A detailed description of the problem including the findings of WSU and the reasons for the IRB's decision.
7. Actions the institution is taking or plans to address the problem (e.g., revise the protocol, suspend subject enrollment, terminate the research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.).
8. Plans, if any, to send a follow-up or final report by the earlier of
9. a specific date, or
10. when an investigation has been completed or a corrective action plan has been implemented.
11. The IRB Chair and the IO review the letter and modify the letter/report as needed.
12. The IO signs all correspondence from the facility.

### **11.3 Recipients of Report**

The ADRA or designee sends a copy of the report to the following:

1. The IRB, by including the letter in the next agenda packet as an information item.
2. The IO.
3. The following federal agencies:
4. OHRP, if the study is subject to DHHS regulations or subject to DHHS Federal wide Assurance.
5. FDA, if the study is subject to FDA regulations.
6. If the study is conducted or funded by any federal agency other than DHHS that is subject to "The Common Rule," the report is sent to OHRP, or the head of the agency as required by the agency.
7. Note: Reporting to a regulatory agency is not required if the event occurred at a site that was not subject to the direct oversight of Washington State University, and the agency has been notified of the event by the investigator, sponsor, another organization, or other mechanisms.
8. The PI.
9. The Sponsor, if the study is sponsored.
10. Contract research organization, if the study is overseen by a contract research organization.
11. College Dean or Department Chair/immediate supervisor of the PI.
12. The Privacy Officer of a covered entity, if the event involved unauthorized use, loss, or disclosure of individually identifiable patient information from that covered entity
13. The Information Security Officer of an organization if the event involved violations of information security requirements of that organization.
14. Compliance and Risk Management Office (if appropriate).

15. Others as deemed appropriate by the IO.

The DRA/ADRA ensures that all steps of this policy are completed within ten (10) working days of the determination. For more serious actions, the DRA/ADRA will expedite reporting.

## **11.4 Reporting to AAHRPP**

If WSU is accredited by AAHRPP, when required WSU will report to AAHRPP:

1. Any negative actions by a government oversight office, including, but not limited to, OHRP Determination Letters, FDA Warning Letters, FDA 483 Inspection Reports with official action indicated, FDA Restrictions Placed on IRBs or Investigators, and corresponding compliance actions taken under non-US authorities related to human research protections.
2. Any litigation, arbitration, or settlements initiated related to human research protections, subject to approval by university counsel (AGO).
3. Any press coverage (including but not limited to radio, TV, newspaper, online publications) of a negative nature regarding the Organization's HRPP.

The report will be developed by the ADRA and signed by the IO as soon as possible but generally within 48 hours after the organization becomes aware of any of the triggering events listed above.

# **12. Investigator Responsibilities**

PIs are ultimately responsible for the conduct of research. PIs may delegate research responsibility; however, investigators must maintain oversight and retain ultimate responsibility for the conduct of those to whom they delegate responsibility.

The following procedures describe the investigator's responsibilities in the conduct of research involving human participants.

## **12.1 Investigators**

### ***12.1.1 Principal Investigators***

At WSU only a faculty member (or staff who have a research requirement associated with their position) may serve as the Principal Investigator (PI) or as the sponsor on a research project involving human subjects. Other individuals, such as research scientists or post-doctoral fellows may be allowed to be the PI at the discretion of the VPR/DRA/ADRA. The IRB recognizes one PI for each study. The HRPP will follow a written SOP established in coordination with the Office of Research for determining PI eligibility.

### ***12.1.2 Student Investigators***

Students may not serve as PI but may serve as a Co-I. They must have a faculty sponsor who fulfills the PI eligibility criteria and who will serve as PI and faculty advisor on the study.

### **12.1.3 Research Team**

These include the PI and other individuals, also known as key personnel, who contribute to the scientific development or execution of a project in a substantive, measurable way, regardless of whether they receive salaries or compensation under the protocol. The research team also consists of individuals who intervene or interact directly with human subjects (including the recruitment or consenting thereof), or who analyze data and/or tissue samples derived from humans.

## **12.2 Responsibilities**

To satisfy the requirements of this policy, investigators who conduct research involving human subjects must:

1. develop and conduct research that is in accordance with the ethical principles in the Belmont Report;
2. develop a research plan that is scientifically sound and minimizes risk to the subjects;
3. have sufficient resources necessary to protect human subjects, including
  - a. access to a population that would allow recruitment of the required number of subjects.
  - b. sufficient time to conduct and complete the research.
  - c. adequate number of qualified staff.
  - d. adequate facilities.
  - e. a process to ensure that all persons assisting with the research are adequately informed about the protocol and their research-related duties and functions.
  - f. availability of medical or psychological resources that subjects might require as a consequence of the research.
4. assure that all procedures in a study are performed with the appropriate level of supervision and only by individuals who are licensed or otherwise qualified to perform such under the laws of Washington and the policies of WSU;
5. ensure that all personnel are educated in the regulatory requirements regarding the conduct of research and the ethical principles upon which they are based;
6. protect the rights and welfare of prospective subjects;
7. ensure that risks to subjects are minimized: (i) By using procedures that are consistent with sound research design and that do not unnecessarily expose subjects to risk; and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes;
8. recruit subjects in a fair and equitable manner;
9. obtain and document informed consent as required by the IRB and ensure that no human subjects are involved in the research prior to obtaining their consent;
10. monitor the data collected for the safety of research subjects;
11. protect the privacy of subjects and maintain the confidentiality of data;
12. when some or all of the subjects are likely to be vulnerable to coercion or undue influence,



such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, include additional safeguards in the study to protect the rights and welfare of these subjects;

13. have a procedure to receive complaints or requests for additional information from subjects and respond appropriately;
14. ensure that pertinent laws, regulations, and institution procedures and guidelines are observed by investigators and research staff;
15. ensure that all non-exempt research involving human subjects receives IRB review and approval in writing before commencement of the research;
16. comply with all IRB decisions, conditions, and requirements;
17. ensure that protocols are submitted for timely continuing IRB review and approval, when required;
18. report unanticipated problems involving risk to subjects or other and any other reportable events to the IRB (see [Section 8](#));
19. obtain documentation of IRB review and approval before changes are made to approved protocols or consent forms; and
20. seek IRB assistance when in doubt about whether proposed research requires IRB review.

## **12.3 Training and Ongoing Education of Investigators and Research Team**

As stated above, one component of a comprehensive HRPP is an education program for all individuals involved with research subjects. WSU is committed to providing training and an ongoing educational process for investigators and members of their research team related to ethical concerns and regulatory and institutional requirements for the protection of human subjects.

### ***12.3.1 Initial Education***

All personnel must complete the WSU Required Core Modules in the CITI Course in the Protection of Human Research Subjects.

New research protocols and applications for continuing review will not be accepted from PIs who have not completed the initial education requirement.

While research protocols and applications for continuing review will be accepted and reviewed if the PI holds a current certification of training, final approval will not be granted until all co-investigators and members of the research team have completed the initial education requirement.

### ***12.3.2 Waiver of Initial Education***

If investigators or members of their research team can verify (provide documentation) that they have successfully completed human subjects research training equivalent to that required by

WSU, they may request a waiver of the requirement for Initial Education. However, all investigators or members of their research team must complete the requirements of Continuing Education.

### **12.3.3 Continuing Education and Recertification**

All investigators and members of their research teams must meet WSU continuing education requirement every five (5) years after certification of Initial Education through the review of appropriate refresher modules at the CITI web-based training site for as long as they are involved in human subject research. There is no exception to this requirement. Other training may be acceptable. In these cases the researcher should check with the IRB Office for a determination. The specific CITI modules accepted to meet this requirement will be listed on the HRPP/IRB web page.

Note: WSU Office of Research required Responsible Conduct of Research training, which is also provided through CITI has a different recertification period (4 years). For NIH sponsored clinical studies, Good Clinical Practice (GCP) training is also required in addition to the requirements listed above. The WSU Office of Research also requires completion of WSU Harassment and Discrimination through the HRS training portal for all WSU personnel working on research protocols, regardless of funding.

Investigators must submit, or verify via annual check in or continuing review, evidence of continuing education prior to the expiration of their training certification. New research protocols and applications for continuing review will not be accepted from PIs who have not submitted satisfactory evidence of continuing education.

Investigators who are also IRB Chair, IRB members, or HRPP staff will satisfy the training requirements for IRB members and staff described in this policy under [Section 2.10](#).

## **12.4 Investigator Concerns**

Investigators who have concerns or suggestions regarding WSU's HRPP should convey them to the ADRA/DRA, IO or other parties (e.g., college dean, departmental chair) regarding the issue, when appropriate. The IO will research the issue, and when deemed necessary, convene the parties involved to form a response for the investigator or make necessary procedural or policy modifications, as warranted. In addition, the IRB Chair or the DRA/ADRA will be available to address investigators' questions, concerns, and suggestions.

## **13. Sponsored Research**

These procedures apply to clinical research trials of drugs and medical devices that are conducted according to FDA regulations.

WSU Office of Research/Office of Research Support and Operations (ORSO) will not normally

enter into sponsored research agreements to conduct clinical trials that require Investigational New Drug Exemptions (INDs). As appropriate (i.e., if trained investigators and adequate facilities are available), then ORSO may enter into sponsored agreements to conduct research on approved drugs and on medical devices.

See [Section 7](#) for a description of the circumstances under which WSU may enter into a sponsored research agreement to conduct a clinical trial associated with an IND application.

## 13.1 Definitions

**Sponsor** – The company, institution, individual donor, or organization responsible for the initiation, management, or financing of a research study.

**Sponsored research** – Research funded by external entities through a grant or contract that involves a specified statement of work (e.g., the research proposal) with a related transfer of value to the sponsor, including clinical trials involving investigational drugs, devices, or biologics.

## 13.2 Contracts

1. ORSO will negotiate contracts for research involving human subjects, and ORSO and the Office of Research Assurances (ORA) will share information as necessary to ensure that protocol, consent, and contract language are consistent.
2. Contracts for sponsored research involving human subjects will be reviewed for the following provisions by both ORSO and ORA:
  - a. All sponsor contracts will indicate that the WSU investigator will follow the protocol, applicable regulations, and applicable ethical standards.
  - b. All sponsor contracts will define who will provide care for research-related injuries and who will pay for it.
  - c. If the sponsor will monitor the conduct of the research, the contract will be required to state that if the study monitor uncovers information that could affect the safety of participants or their willingness to continue participation, influence the conduct of the study, or alter the IRB's approval to continue the study, the sponsor will make sure that the information is promptly (no longer than 30 days) communicated to the IRB.
  - d. Contracts or other funding agreements require the sponsor to send data and safety monitoring plans and reports to the organization. Contracts or other funding agreements specify the time frame for providing routine and urgent data and safety monitoring reports to the organization as indicated in the data and safety monitoring plan approved by the IRB (see [Section 3.6.7](#) for further details regarding safety monitoring).
  - e. If the sponsor discovers results that could affect the safety or medical care of subjects or others involved in the study, the sponsor will make sure the IRB is notified. This requirement survives for a period following the closure of a study to be determined on a case-by-case basis (e.g., two years).
  - f. Payment arrangements among sponsors, organizations, investigators, and those

referring research participants may place participants at risk of coercion or undue influence or cause inequitable selection. Payment (i.e., “finder’s fees”) in exchange for referrals of prospective participants from researchers (e.g., physicians) is not permitted. Similarly, payments designed to accelerate recruitment that is tied to the rate or timing of enrollment (“bonus payments”) are also not permitted.

## **14. [This section will undergo revision pending the outcome of WSU COI policy development, in progress as of 10/1/2022.] Financial Conflicts of Interest in Human Subjects Research**

It is WSU position, as reflected in relevant WSU policies, to preserve public trust in the integrity and quality of research at WSU by minimizing actual or perceived conflict of interest in the conduct of research. This section is meant to summarize WSU requirements for disclosure and management of COI and as such does not supersede any WSU policy requirements. Should WSU policies regarding COI be updated, this section will defer to the current WSU COI policies.

WSU Policy (EP-27) “Ethics, Conflict of Interest and Technology Transfer Policy” requires disclosure of conflicts of interest, including significant financial conflicts of interest. The procedures for reporting and handling of conflicts of interest for PHS funded projects and non-PHS funded projects are both addressed in EP-27. The relevant policies should be consulted when making any required disclosures or reports.

### **14.1 Definition of Financial Conflict of Interest**

Conflict of interest may occur when a university faculty/staff member meets any one of the following criteria:

1. The faculty/staff member is:
  - a. an officer, director, trustee, sole proprietor, partner, employee, sales representative or agent of, or
  - b. a consultant, independent contractor or advisory board member to an external organization or corporation either seeking to do or doing business with the University, funding a sponsored project, or providing goods or services under a sponsored project in which the faculty/staff member is participating in any capacity; or
2. The faculty/staff member is the actual or beneficial owner of more than five percent (5%) of the voting stock or controlling interest of such organization or corporation, or the market value of her/his stock exceeds \$5,000; or
3. The faculty/staff member has dealings with such organization or corporation from which he/she derives income (e.g., royalties, stipends, salary) of more than \$5,000 per year, exclusive of dividends and interest; or

4. The assets of the faculty/staff member's Family/Household, alone or in combination with the assets of the faculty/staff member, meet any of the criteria stated in paragraphs 1, 2 and 3 above. Family/Household is defined to include a) immediate family (spouse, parents and children) and b) persons living at the same residence as the faculty/staff member, except their tenants or employees.

**NSF.** Significant financial interests of the investigator (including those of the investigator's spouse and dependent children) (i) that would reasonably appear to be affected by the research or educational activities funded or proposed for funding by NSF; or (ii) in entities whose financial interests would reasonably appear to be affected by such activities.

**PHS.** A significant financial interest that could directly and significantly affect the design, conduct, or reporting of PHS-funded research.

**FDA.** For clinical studies involving the use of new human drugs and biological products or medical devices, certifications and disclosure requirements are defined in FDA regulations, 21 CFR Part 54.

## **14.2 Training in Financial Conflict of Interest**

**PHS.** Public Health Service regulations and WSU Policy require that all PHS grantees undergo training in financial conflict of interest at least every 4 years. This obligation can be satisfied by taking the CITI course in Conflicts of Interest in Research Involving Human Subjects.

**All other sponsors.** The Conflict-of-Interest module included in WSU's CITI initial and refresher courses for biomedical and social and behavioral research satisfies all other COI training requirements. Refresher training must be taken as outlined in ORSO policy but no less than once every 5 years.

## **14.3 Personnel Who Must Disclose (also called Key Personnel or Participating Faculty/Staff)**

**PHS:** The Project Director or Principal Investigator and any other person identified as senior/key personnel in Washington State University's grant application, progress report, or any other report submitted to the PHS by Washington State University.

**WSU Policy:** Participating faculty/staff members in a sponsored project include:

1. The project director/principal investigator.
2. Co-project director/co-principal investigator, and
3. Any other person at the University who is responsible for the design, conduct, or reporting of research or educational activities funded or proposed for funding through a sponsored project.

## **14.4 Individual Conflicts of Interest**

In the environment of research, openness and honesty are indicators of integrity and responsibility, characteristics that promote quality research and can only strengthen the research process.

Therefore, conflicts of interest should be eliminated when possible and effectively disclosed and managed when they cannot be eliminated.

### ***14.4.1 Disclosure and Evaluation of Investigator Financial Interests in Research***

Investigators conducting externally sponsored research are required to file a Financial Disclosure Statement no later than the time when a grant proposal is submitted, then either annually or as new reportable financial interests are obtained. There are separate forms for PHS-sponsored projects and all other externally sponsored research.

All disclosures of financial interest are reviewed by the Conflict-of-Interest Committee.

### ***14.4.2 Management of COI***

If the ORSO/The Conflict-of-Interest Committee (CoIC) determines that a significant financial interest in a research project presents a conflict of interest, then a COI Management Plan will be developed to protect the rights and welfare of human research participants and the integrity of the institution. The elements of a management plan might include:

1. Disclosure to subjects through the consent process.
2. Modification of the research protocol or safety monitoring plan.
3. Monitoring of research by independent reviewers.
4. Disqualification of the conflicted party from participation in all or a portion of the research.
5. Appointment of a non-conflicted PI.
6. Divestiture of significant financial interests.
7. Severance of relationships that create actual or potential conflicts.
8. Prohibition of the conduct of the research at WSU.

The PI or the ORSO CoIC will communicate the COI Management Plan to the IRB, which will consider it when it reviews the protocol. The WSU IRB has final authority to decide whether the financial conflict of interest and its management, if any, allows the research to be approved. If the COI Management plan omits elements that the IRB determines to be required for the minimization of risks to participants (see 45CFR46.111), including those elements listed above, they may either require protocol specific disclosures or they may ask the CoIC to reconsider the management plan and provide suggested revisions.

If the conflict cannot be adequately resolved, the matter will be referred to the CoIC, which will consider the matter, develop a management plan, and refer it to the IRB for review and approval. In the event that the IRB has required changes to an existing management plan and the CoIC elects not to amend, the IRB will not approve the protocol.

## **14.5 Institutional Conflict of Interest**

These procedures apply to all human subject research conducted under the auspices of WSU. This applies to investigators, IRB members and staff, and institutional officials.

The position of WSU is to ensure that the welfare of human subjects and the integrity of research will not be compromised, or appear to be compromised, by competing institutional interests or obligations.

### ***14.5.1 Responsibilities***

The Conflict-of-Interest Committee (CoIC) will be responsible for evaluating potential institutional conflict of interest and will take actions as required to avoid, or to appropriately manage, apparent institutional COI. These actions may involve referral to appropriate advisors outside the facility or obtaining advisement from WSU AGO. If used, outside advisors will be individuals who have sufficient seniority, expertise, and independence to evaluate the competing interests at stake and to make credible and effective recommendations. All outside advisors will be independent of the management of oversight for the HRPP within the institution. The use of outside advisors will increase the transparency of the deliberations and enhance the credibility of determinations.

After reviewing a significant financial interest in research, the CoIC will communicate its conclusions, along with any management arrangements to be imposed, to the IRB. All relevant conflicts will be disclosed to research participants in a form to be determined by the IRB. The CoIC also will communicate conclusions and COI management strategies to the IO and the PI.

### ***14.5.2 Management of Conflict of Interest***

As part of its review of institutional COI, the committee will ask if any related research involves human subjects. If yes, any conflict management plan which is developed will be forwarded to the IRB by either the PI or the CoIC.

#### ***14.5.2.1 Presumption of Conflict of Interest***

If Washington State University retains a significant financial interest, or if an IO with direct responsibility for the HRPP holds a significant financial interest in the invention, then the CoIC must assess the potential conflict of interest and weigh the magnitude of any risk to human participants. When reviewing potential institutional conflict of interest, the CoIC will assume an inclination against the conduct of human participants research at, or under the auspices, of the institution where a COI appears to exist. However, the assumption may be overturned by the Committee when the circumstances are compelling, and the Committee has approved an effective conflict management plan.

#### **14.5.2.2 Decision-Making**

A key aspect in decision-making is to analyze when it would be appropriate and in the public interest to accept and manage a COI, rather than require that the COI be eliminated. In some cases, the benefits of conducting a proposed research activity at the institution will be potentially high, and the risks will be low. In other cases, the scientific advantages of conducting the research may be speculative and the risks may be great. In these latter instances, the conflict should be avoided by disapproving the research application.

#### **14.5.2.3 Evaluation of Risk**

Each case should be evaluated based upon the following:

1. The nature of science.
2. The nature of the interest.
3. How closely the interest is related to the research.
4. The degree of risk that the research poses to human participants.
5. The degree to which the interest may be affected by the research.

The CoIC will consider whether the institution is uniquely qualified, by virtue of its attributes (e.g., special facilities or equipment, unique patient population) and the experience and expertise of its investigators, to conduct the research and safeguard the welfare of the human subjects involved.

#### **14.5.2.4 Potential Actions**

Potential actions to be considered to better protect subjects are any or a combination of the following:

1. Public disclosure of financial interest.
2. Not conducting proposed research at that institution or halting it if it has commenced.
3. Reducing or otherwise modifying the financial (equity or royalty) stake involved.
4. Increasing the segregation between the decision-making regarding the financial and the research activities.
5. Requiring an independent DSMC or similar monitoring body.
6. Modifying of role(s) of research staff or changes in location for certain research activities, e.g., a change of the person who seeks consent, or a change in investigator.
7. Establishing a research monitoring process, so that the research can be closely scrutinized to ensure that potential conflicts do not undermine the integrity of the work and of WSU.

## **15. Community Outreach**

WSU is committed to ensuring that educational opportunities offered to research participants, prospective research participants, and community members will enhance their understanding of



research involving human participants at WSU.

### **15.1 HRPP Outreach Activities**

The HRPP office dedicates a section of the website to research participants entitled “Information for Research Participants.” This website includes resources and a listing of relevant research-related links to the Office for Human Research Protections (OHRP) campaign to inform the general public about participating in research.

### **15.2 University Outreach Activities**

Colleges and departments offer annual programs that enhance understanding of research among the university and Mt Pleasant communities.

The Office of Research Support and Operations, the College of Medicine and College of Nursing, and many health sciences and SBER colleges and departments sponsor annual research exhibitions and symposia throughout the year.

The Department of Psychology and Murrow College operate the SONA Student Pool, which encourages students enrolled in psychology or communication courses to participate in ongoing research projects.

The College of Education supports ongoing outreach programs as part of its mission.

Additionally, various academic units offer events designed to inform the university and communities surrounding the WSU campuses (and statewide via global campus) about current research on issues of concern to the community.

### **15.3 Evaluation**

WSU is committed to ensuring that educational opportunities are offered to research participants, prospective research participants, and community members that will enhance their understanding of research involving human participants at WSU. The academic and administrative entities that sponsor outreach programs are responsible for periodically evaluating their programs.

## **16. Health Insurance Portability and Accountability Act (HIPAA)**

Protected health information obtained by WSU may not be used internally or disclosed to any outside person or organization for research purposes without prior approval of the IRB or the privacy board or privacy office of the entity responsible for the records. WSU researchers must also abide by all corporate HIPAA policies regarding HIPAA privacy and security.

The following describes the procedures for conducting research at WSU in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## 16.1 Definitions

**Access** –The mechanism of obtaining or using information electronically, on paper, or other medium for the purpose of performing an official function.

**Authorization** – A detailed document that gives covered entities permission to use protected health information for specified purposes, which are generally other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual.

**Covered entity** –The term applied to institutions that must comply with the Privacy Rule. These include:

1. Health plans.
2. Health care clearinghouses.
3. Health care providers who conduct certain financial and administrative transactions electronically. These electronic transactions are those for which standards have been adopted by the Secretary under HIPAA, such as electronic billing and fund transfers.

**Common Rule** – A federal policy on human subject protection that provides for the primary source of regulation of research.

**De-identified Information** – Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. If information is de-identified, it no longer is subject to the Privacy Rule and is exempt from HIPAA.

**Deletion** – The removal, erasing, or expunging of information or data from a record.

**Disclosure** –The release, transfer, provision of access to, or divulging in any other manner information outside of the covered entity.

**Health Information** –Any information created or received by a health care provider or health plan that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or payment for the provision of health care to an individual.

**Identifiable Health Information** –A subset of health information including demographic information collected from an individual.

**Limited Data Set** –Protected health information that excludes specific direct identifiers of the individual or of relatives, employees, or household members of an individual. A limited data set

can only be used for the purposes of research, public health, or healthcare operations, and disclosed for the purpose of research.

**Minimum Necessary** –The principle that any access should be limited to the minimum amount of information needed to accomplish the intended purpose of the use or disclosure.

**Privacy Board** – A board comprised of members of varying backgrounds and appropriate professional competencies, as necessary, to review individual's privacy rights. It is an alternative to an IRB for privacy issues only. It cannot replace the IRB for Common Rule purposes.

**Privacy Act** –An Act of Congress that provides for the confidentiality of individually-identified and retrieved information about living individuals that is maintained in a system of records and permits the disclosure of records only when specifically authorized by the statute. The Act provides that the collection of information about individuals is limited to that which is legally authorized, relevant, and necessary.

**Privacy Rule** –Provides guidance on the use of protected health information in the conduct of research. It imposes requirements on those involved in research, both individuals and institutions. "Privacy" refers to a person's desire to control the access of others to information about him/herself. The evaluation of privacy involves consideration of how the investigator will access information from or about participants. The IRB members should know strategies to protect privacy interests relating to contact with potential participants and access to private information.

**Protected Health Information** – Individually identifiable health information transmitted or maintained electronically or in any other form or medium, except for education records or employment records, as excluded in the Privacy Rule.

**Preparatory Research** – The method applied to developing or designing a research study.

**Waiver of Authorization** –A means of requesting approval from an IRB or Privacy Board rather than asking each research subject for an authorization to access protected health information.

## **16.2 Research Under HIPAA**

HIPAA defines research as "a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge." This definition is identical to the one used in the Common Rule. HIPAA describes privacy standards for protecting PHI and so only applies to research that involves humans' (not animals') health information.

### ***16.2.1 Waiver of Authorization for Use or Disclosure of Protected Health Information in Research***

Under the Privacy Rule, covered entities are permitted to use and disclose protected health information for research with individual authorization or without individual authorization under limited circumstances. A covered entity may use or disclose protected health information for

research when presented with documentation that an IRB has granted a waiver of authorization [See 45 CFR 164.512(i)(1)(i)]. This provision of the Privacy Rule might be used, for example, to conduct records research, epidemiological studies, or other research where de-identified data is unavailable or not suited to the research purpose.

The waiver of documentation presented to the covered entity must include the following:

1. Identification of the IRB or Privacy Board and the date on which the alteration or waiver of authorization was approved;
2. A statement that the IRB or Privacy Board has determined that the alteration or waiver of authorization, in whole or in part, satisfies the three criteria in the Rule;
3. A brief description of the protected health information for which use or access has been determined to be necessary by the IRB or Privacy Board;
4. A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures; and
5. The signature of the Chair or other member, as designated by the Chair, of the IRB or the Privacy Board, as applicable.

The following criteria must be satisfied for the IRB to approve a waiver of authorization under the Privacy Rule:

1. The use or disclosure of protected health information involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:
2. An adequate plan to protect the identifiers from improper use and disclosure; and
3. An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and
4. Adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use or disclosure of protected health information would be permitted by this subpart; and
5. The research could not practicably be conducted without the waiver or alteration; and
6. The research could not practicably be conducted without access to and use of the protected health information.

### ***16.2.2 Review Preparatory to Research***

The Privacy Rule permits a covered entity to use or disclose protected health information to a researcher without authorization or waiver for the limited purpose of a “review preparatory to research.” Such reviews may be used to prepare a research protocol, or to determine whether a research site has a sufficient population of potential research subjects. Prior to permitting the researcher to access the protected health information, the covered entity must obtain representations from the researcher that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purposes preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that

protected health information for which access is sought is necessary for the research purpose.

Researchers should consult the covered entity regarding any forms or applications necessary to conduct a review preparatory to research.

Researchers conducting a review preparatory to research may not record information in identifiable form, nor may they use the information that they receive to contact potential subjects, unless the investigator is also the subject's treating physician. Because the Privacy Rule permits a covered entity to disclose protected health information to the individual who is the subject of the information, covered health care providers and patients may continue to discuss the option of enrolling in a clinical trial without patient authorization. Even when permitted by the Privacy Rule, however, any use of patient information for recruitment must comply with IRB recruitment policies (see discussion below).

1. All human subjects research requires IRB review to determine either (i) exempt status or (ii) need for further review.

Reviews preparatory to research that are permitted under HIPAA may or may not be human subjects research, depending on the investigation being conducted:

- a. Only those reviews of a database by an individual entitled to access that database intended to enumerate an available data set without reviewing PHI and for which no PHI is recorded do not require review. For example: medical records may be queried for information such as, "In the year XXXX, how many patients had a discharge diagnosis of [indicate disease/diagnosis]." IRB Privacy Board Review is required for all other uses of PHI as indicated.
- b. If the research involves a de-identified data set, defined as removing the following identifiers, then a de-identified data set certification form must be completed submitted for administrative review and certified prior to accessing the data set. This activity also requires an IRB-determined exemption from review:
  - i. Names
  - ii. Geographic information (city, state, and zip)
  - iii. Elements of dates (except years)
  - iv. Telephone numbers
  - v. Fax numbers
  - vi. E-mail address
  - vii. Social Security number
  - viii. Medical record, prescription numbers
  - ix. Health plan beneficiary numbers
  - x. Account numbers
  - xi. Certificate /license numbers
  - xii. VIN and Serial numbers, license plate numbers.
  - xiii. Device identifiers, serial numbers
  - xiv. Web URLs
  - xv. IP addresses

- xvi. Biometric identifiers (fingerprints)
- xvii. Full face, comparable photo images
- xviii. Unique identifying numbers

IRB Privacy Board review and approval is required prior to initiating this research. Investigators are not authorized to contact potential research subjects identified in reviews preparatory to research unless they are directly responsible for care of the potential subject and entitled to PHI as a result of that duty.

Investigators who have previously obtained full consent and authorization to contact a research subject as a result of a previously approved research project, may contact his/her former research subjects provided that the subject agreed to be contacted for information on future research conducted by the same PI or co-investigator(s).

### ***16.2.3 Research on Protected Health Information of Decedents***

The protections of the Common Rule apply only to living human beings; by contrast, the Privacy Rule also protects the identifiable health information of deceased persons (“decedents”). The Privacy Rule contains an exception to the authorization requirement for research that involves the PHI of decedents. A covered entity may use or disclose decedents’ PHI for research if the entity obtains representations from the researcher that the use or disclosure being sought is solely for research on the PHI of decedents, that the PHI being sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is being sought. Researchers should submit the applicable IRB form for IRB approval when they intend to conduct research involving decedents’ PHI.

### ***16.2.4 Limited Data Sets with a Data Use Agreement***

When a researcher does not need direct identifiers for a study but does require certain data elements that are not permitted in de-identified data, the Privacy Rule permits a covered entity to disclose a “limited data set” to the researcher without authorization or waiver, provided that the researcher has signed a data-use agreement. The limited data set is still considered to be protected health information, but it must exclude only specified direct identifiers of the individual or of relatives, employers, or household members of the individual.

If the research involves a limited data set, it is defined as removing the following 16 identifiers:

1. Names
2. Postal address information (other than city, state and zip)
3. Telephone
4. Fax numbers
5. Email addresses
6. Social Security numbers
7. Medical record, prescription numbers
8. Health plan beneficiary numbers

9. Account numbers
10. Certificate and license numbers
11. Vin and serial numbers, license plate numbers
12. Device identifiers, serial numbers
13. Web URLs
14. IP addresses
15. Biometric identifiers (fingerprints and voiceprints)
16. Full face, comparable photo images

The Privacy Rule requires that the data-use agreement, used in conjunction with the limited data set, contains provisions that:

1. Establish the permitted uses and disclosures of the limited data set by the recipient, consistent with the purposes of the research, and which may not include any use or disclosure that would violate the Rule if done by the covered entity; and
2. Limit who can use or receive the data; and
3. Require the recipient to agree to the following:
  - a. Not to use or disclose the information other than as permitted by the data-use agreement or as otherwise required by law; and
  - b. Use appropriate safeguards to prevent the use or disclosure of information other than as provided for in the data use agreement; and
  - c. Report to the covered entity any use or disclosure of the information not provided for by the data-use agreement of which the recipient becomes aware; and
  - d. Ensure that any agents, including a subcontractor, to whom the recipient provides the limited data set agrees to the same restrictions and conditions that apply to the recipient with respect to the limited data set; and
  - e. Not to identify the information or contact the individual.

The Privacy Rule contains certain grandfathering provisions that permit a covered entity to use and disclose PHI for research after the Rule's compliance date of April 14, 2003, if the researcher obtained any one of the following prior to the compliance date:

1. An authorization or other express legal permission from an individual to use or disclose protected health information for the research; or
2. The informed consent of the individual to participate in the research; or An IRB waiver of informed consent for the research.

Even if informed consent or other express legal permission was obtained prior to the compliance date, if new subjects are enrolled or existing subjects are re-consented after the compliance date, the covered entity must obtain the individual's authorization. For example, if there was a temporary waiver of informed consent for emergency research under the FDA's human subject protection regulations, and informed consent was later sought after the compliance date, individual authorization must be sought at the same time.

The transition provisions apply to both uses and disclosures of PHI for specific research protocols

and uses or disclosures to databases or repositories maintained for future research.

## **16.3 HIPAA and Documentation Requirements**

HIPAA documents include an authorization form, a waiver of authorization form, and a de-identification form. One of these documents must be used whenever PHI is utilized in the research.

## **16.4 Patient Rights and Research**

Under HIPAA, patients have certain rights. Those that may affect research include the right to receive a Notice of Privacy Practices, the right to access, inspect, and receive a copy of one's own PHI, the right to request an amendment to one's own PHI, and the right to an accounting of certain disclosures of PHI that occur outside the scope of treatment, payment, and health care operations that have not been authorized.

## **16.5 HIPAA and Existing Studies**

Any research subject enrolled in a study that uses PHI from a covered entity must sign a HIPAA-compliant authorization form. This form is in addition to the existing Informed Consent document and is federally required. In a few cases, the Informed Consent document may be combined with a HIPAA authorization.

## **16.6 Waivers to HIPAA Authorization Form**

In some cases, the WSU IRB may approve a waiver to use of the HIPAA authorization form. This may occur when the IRB finds that the research could not be practically done without the waiver, not without access to and use of the PHI, and that disclosure poses minimal risk to privacy.

# **17. Special Topics**

## **17.1 Certificate of Confidentiality (CoC)**

The privacy of the research subjects referred to in Public Health Service Act §301(d), 42 U.S.C. §241(d) Certificates of Confidentiality. These certificates of Confidentiality provide protection against compelled disclosure of identifying information about subjects enrolled in sensitive biomedical, behavioral, clinical, or other research. This protection is not limited to federally supported research.

Certificates of Confidentiality are issued by the National Institutes of Health (NIH) and other HHS agencies to protect identifiable research information from forced or compelled disclosure. They allow the investigator and others who have access to research records to refuse to disclose identifying information on research participants in civil, criminal, administrative, legislative, or



other proceedings, whether federal, state, or local. Certificates of Confidentiality may be granted for studies collecting information that, if disclosed, could have adverse consequences for subjects, such as damage to their financial standing, employability, insurability, or reputation. By protecting researchers and institutions from being compelled to disclose information that would identify research subjects, Certificates of Confidentiality help to minimize risks to subjects by adding an additional level of protection for maintaining confidentiality of private information.

Certificates of Confidentiality protect subjects from compelled disclosure of identifying information but do not prevent the voluntary disclosure of identifying characteristics of research subjects. Researchers, therefore, are not prevented from voluntarily disclosing certain information about research subjects, such as evidence of child abuse or a subject's threatened violence to self or others.

However, if a researcher intends to make such voluntary disclosures, the consent form should clearly indicate this. Furthermore, Certificates of Confidentiality do not prevent other types of intentional or unintentional breaches of confidentiality. As a result, investigators and IRBs must ensure that other appropriate mechanisms and procedures are in place to protect the confidentiality of the identifiable private information to be obtained in the proposed research.

### ***17.1.1 Statutory Basis for Protection***

Protection against compelled disclosure of identifying information about subjects of biomedical, behavioral, clinical, and other research is provided by the Public Health Service Act 301(d), 42 U.S.C. 241(d):

"The Secretary may authorize persons engaged in biomedical, behavioral, clinical, or other research (including research on mental health, including research on the use and effect of alcohol and other psychoactive drugs) to protect the privacy of individuals who are the subject of such research by withholding from all persons not connected with the conduct of such research the names or other identifying characteristics of such individuals. Persons authorized to protect the privacy of such individuals may not be compelled in any federal, state or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals."

### ***17.1.2 Usage***

Certificates of Confidentiality may be granted for studies collecting information that, if disclosed, could have adverse consequences for subjects or damage their financial standing, employability, insurability, or reputation. By protecting researchers and institutions from being compelled to disclose information that would identify research subjects, Certificates of Confidentiality help achieve the research objectives and promote participation in studies by assuring confidentiality and privacy to subjects.

Any investigator engaged in research in which sensitive information is gathered from human subjects (or any person who intends to engage in such research) may apply for a Certificate of Confidentiality. Research can be considered "sensitive" if it involves the collection of:

1. information about sexual attitudes, preferences, practices;
2. information about personal use of alcohol, drugs, or other addictive products; information about illegal conduct;
3. information that could damage an individual's financial standing, employability, or reputation within the community;
4. information in a subject's medical record that could lead to social stigmatization or discrimination; or
5. information about a subject's psychological well-being or mental health.

This list is not exhaustive. Researchers contemplating research on a topic that might qualify as sensitive should contact the IRB Office for help in applying for a certificate.

In the Informed Consent form, investigators should tell research subjects that a Certificate is in effect. Subjects should be given a fair and clear explanation of the protection that it affords, including the limitations and exceptions noted above. Every research project that includes human research subjects should explain how identifiable information will be used or disclosed, regardless of whether a Certificate is in effect.

### **17.1.3 Limitations**

The protection offered by a Certificate of Confidentiality is not absolute. A Certificate protects research subjects only from legally compelled disclosure of their identity. It does not restrict voluntary disclosures.

For example, a Certificate does not prevent researchers from voluntarily disclosing to appropriate authorities such matters as child abuse, a subject's threatened violence to self or others, or from reporting a communicable disease. However, if researchers intend to make such disclosures, this should be clearly stated in the Informed Consent form that research subjects are asked to sign.

In addition, a Certificate of Confidentiality does not authorize the person to whom it is issued to refuse to reveal the name or other identifying characteristics of a research subject if

1. the subject (or, if he or she is legally incompetent, his or her legal guardian) consents, in writing, to the disclosure of such information;
2. authorized personnel of the Department of Health and Human Services (DHHS) request such information for audit or program evaluation, or for investigation of DHHS grantees or contractors and their employees; or
3. release of such information is required by the federal Food, Drug, and Cosmetic Act or regulations implementing that Act. With the following limitations:
  - a. required by other Federal, State, or local laws, such as for reporting communicable diseases; OR,
  - b. The subject has consented to such disclosure; OR,
  - c. The disclosure is for the purposes of scientific research that is compliant with human subjects regulations

#### **17.1.4 Application Procedures**

Any person engaged in research collecting sensitive information from human research subjects may apply for a Certificate of Confidentiality.

NIH will automatically issue CoCs to all research funded by NIH that is collecting or using identifiable, sensitive information. Compliance requirements are outlined in the NIH Grants Policy Statement, which is a term and condition of all NIH awards.

If the PI is conducting a sensitive research project that is covered by the AHRQ confidentiality statute (42 U.S.C. section 299a-1(c) entitled "limitation on use of certain information") or the Department of Justice confidentiality statute (42 USC section 3789g), then a CoC is not required.

If there is an Investigational New Drug Application (IND) or an Investigational Drug Exemption (IDE), the sponsor can request a CoC from the FDA.

For more information, see the [NIH Certificates of Confidentiality Policy](#).

#### **17.2 Mandatory Reporting**

While any person may make a report if they have reasonable cause to believe that a child or elder was abused or neglected, Washington law mandates that certain persons who suspect child or elder abuse or neglect report this to the Washington State Department of Social and Health Services (DSHS) or relevant county social service office per RCW 74.34.020(10) and RCW 26.44.030. Reporting requirements under WSU Policy can be found on the [WSU's Compliance and Civil Rights Page](#).

WSU policy requires the solicitation of informed consent from all adult research subjects and assent from children involved as research subjects, in addition to the consent of their parents. In situations where conditions of abuse or neglect might be revealed, mandated reporters should make themselves known as such to parents of children under age 18, to subjects who are children, and to subjects who are potential victims of abuse or neglect.

Washington's mandatory reporting laws can be found at RCW 74.34 for vulnerable adults and RCW 26.44 for children.

Investigators should consult these sources to determine if potential subjects should be advised of mandatory reporting requirements during the informed consent process.

#### **17.3 WSU Students and Employees as Subjects**

When WSU students and/or employees are being recruited as potential subjects, researchers must ensure that there are additional safeguards for these subjects. The voluntary nature of their participation must be primary and without undue influence on their decision. Researchers must

emphasize to subjects that neither their academic status or grades, or their employment, will be affected by their participation decision.

To minimize coercion and undue influence, investigators should avoid, whenever possible, the use of their students and employees in procedures that are neither therapeutic nor diagnostic. In these latter situations, investigators should solicit subjects through means such as bulletin board notices, flyers, advertisements in newspapers, and announcements in classes or laboratories other than their own. When entering a classroom to recruit students and conduct research (e.g., administer a survey), investigators should do so at the end of the class period to allow non-participating students the option of leaving the classroom, thereby alleviating pressure to participate.

## **17.4 Student Research**

### ***17.4.1 Human Subjects Research and Course Projects***

Learning how to conduct ethical human subjects research is an important part of a student's educational experience. Research activities that are designed as part of a course requirement for purposes of learning experience only and are not designed to develop or contribute to generalizable knowledge will generally not require IRB review and approval.

Responsibility of the Course Instructor: The course instructor is responsible for communicating to the students the ethics of human subjects research, for ensuring the protection of human subjects (including a process is in place for obtaining voluntary informed consent from research subjects when appropriate), and for monitoring the students' progress.

When designing a project, students should be instructed on the ethical conduct of research and on the preparation of the IRB application when such is required. In particular, instructors and students should:

1. understand the elements of informed consent;
2. develop appropriate consent documents;
3. plan appropriate strategies for recruiting subjects;
4. identify and minimize risk to subjects;
5. assess the risk-benefit ratio for the project;
6. establish and maintain strict guidelines for protecting confidentiality; and
7. allow sufficient time for IRB review (if necessary) and completion of the project.
8. confirm completion of CITI training when it is a course requirement and not associated with an IRB protocol

In determining whether a class research project requires IRB review, the instructor is encouraged to err on the side of caution and to contact the IRB office for assistance.

### ***17.4.2 Individual Research Projects Conducted by Students***

Senior theses, masters and advanced degree research, and similar activities must be independently submitted for IRB review. It is important to keep in mind that any human subjects research activity that will ultimately contribute to part or all of a thesis, dissertation, or other type of publication or presentation must go through the IRB review process prior to enrolling subjects and collecting data. **IRB review cannot occur after a study has begun.**

Students and advisors should contact the HRPP office with any questions.

Students should also check with their department, program advisor, and the College of Graduate Studies to determine if there are additional requirements to be met that are not covered in this document.

### ***17.4.3 Theses and Dissertations***

These research activities are generally considered to meet the federal definition of human subjects research and must be independently submitted to the IRB by the student-researcher's faculty advisor. However, when students conduct research as part of a course of study, a faculty member ultimately is responsible for the protection of the subjects, even if the student is the primary researcher and actually directs the project. Advisers assume the responsibility for students engaged in independent research, and instructors are responsible for research that is conducted as part of a course.

Students may not serve as PIs. They must have a faculty sponsor who fulfills the PI eligibility criteria and who will serve as PI and faculty advisor on the study.

### **17.5 Pilot Studies**

Pilot studies serve various purposes such as determining whether a research project is feasible given available resources, and it is often not clear whether they meet the regulatory definition of research, namely a systematic investigation designed to develop or contribute to generalizable knowledge. Investigators should consult the IRB Chair or the ADRA. Pilot studies that do not meet the regulatory definition yet pose greater than minimal risk to subjects may be referred for separate review.

### **17.6 Case Reports Requiring IRB Review**

In general, an anecdotal report on a series of patients seen in one's own practice and a comparison of these patients to existing reports in the literature is not research and would not require IRB approval. Going beyond one's own practice to seek out and report cases seen by other clinicians creates the appearance of a systematic investigation with the intent to contribute to generalizable knowledge and, therefore, would be considered research and would require IRB approval.

Single Case Report – The external reporting (e.g., publication or poster/verbal presentation) of an interesting clinical situation or medical condition of a single patient. Case reports normally contain

detailed information about an individual patient and may include demographic information and information on diagnosis, treatment, response to treatment, follow-up after treatment, as well as a discussion of existing relevant literature. The patient information used in the report must have been originally collected solely for non-research purposes as the result of a clinical experience.

Case Series – The external reporting (e.g., publication or poster/verbal presentation) of an interesting clinical situation or medical condition in a series of patients (i.e., more than one patient). Case series usually contain detailed information about each patient and may include demographic information and information on diagnosis, treatment, response to treatment, follow-up after treatment, as well as a discussion of existing relevant literature. The information used in the report must have been originally collected solely for non-research purposes as the result of a clinical experience.

## **17.7 International Research**

For international research where WSU is responsible for the conduct of the research in foreign countries, the IRB will review the research to assure adequate provisions are in place to protect the rights and welfare of the participants.

Approval of research is permitted if “the procedures prescribed by the foreign institution afford protections that are at least equivalent to those provided in 45 CFR 46.”

All policies and procedures that are applied to research conducted domestically should be applied to research conducted in other countries, as appropriate.

The WSU IRB must receive and review the foreign institution’s or site’s IRB review and approval of each study prior to the commencement of the research at the foreign institution or site.

For federally-funded research, approval of research for foreign institutions or sites “engaged” in research is only permitted if the foreign institution or site holds an Assurance with OHRP and local IRB review and approval are obtained. Alternatively, personnel from a non-assured foreign institution may rely on WSU IRB via establishment of an Individual Investigator Agreement (IIA) in which they agree to abide by WSU policies and procedures. The appropriateness of an IIA must be assessed on a case-by-case basis as there may be other reasons (e.g., Export Controls concerns) why a foreign researcher may not be eligible to work on a federally funded project.

Approval of research for foreign institutions or sites “not engaged” in research is only permitted if one or more of the following circumstances exist:

1. When the foreign institution or site has an established Institutional Review Board (IRB) or Independent Ethics Committee (IEC), the PI must obtain approval to conduct the research at the “not engaged” site from the site’s IRB/IEC or provide documentation that the site’s IRB/IEC has determined that approval is not necessary for the PI to conduct the proposed research at the site.
2. When the foreign institution or site does not have an established IRB/IEC, a letter of

cooperation must be obtained demonstrating that the appropriate institutional or oversight officials are permitting the research to be conducted at the performance site.

3. IRB approval to conduct research at the foreign institution or site is contingent upon receiving documentation of the performance site's IRB/IEC determination or letter of cooperation, as applicable.
4. It is the responsibility of the WSU PI and the foreign institution or site to assure that the resources and facilities are appropriate for the nature of the research.
5. It is the responsibility of the WSU PI and the foreign institution or site to confirm the qualifications of the researchers and research staff for conducting research in that country(ies).
6. It is the responsibility of the WSU PI and the foreign institution or site to ensure that the following activities will occur.
  - a. Initial review, continuing review, and review of modification
  - b. Post-approval monitoring
  - c. Handling of complaints, non-compliance, and unanticipated problems involving risk to subjects or others.

The IRB will not rely on a local ethics committee that does not have policies and procedures for the activities listed above.

It is the responsibility of the WSU PI and the foreign institution or site to notify the IRB promptly if a change in research activities alters the performance site's engagement in the research (e.g., performance site "not engaged" begins consenting research participants, etc.).

The IRB will consider local research context when reviewing international studies to assure protections are in place are appropriate to the setting in which the research will be conducted.

In the case where there is no local IRB review, the IRB may require an expert consultant, either from the local country where the research is conducted or from an international organization, with the expertise or knowledge required to adequately evaluate the research in light of local context.

The informed consent documents must be in a language understandable to the proposed participants. Therefore, the IRB will review the document and a back translation of the exact content contained in the foreign language informed consent document which must be provided by the PI, with the credentials of the translator detailed in the IRB application or amendment form. Verification of the back translation should be made available for the IRB file.

### ***17.7.1 Monitoring of Approved International Research***

The IRB is responsible for the ongoing review of international research conducted under its jurisdiction through the continuing review process in accordance with all applicable federal regulations.

When the IRB and a local ethics committee will both be involved in the review of research, there is a plan for coordination and communication with the local ECs.

The IRB will require documentation of regular correspondence between the WSU PI and the foreign institution or site and may require verification from sources other than the WSU PI that there have been no substantial changes in the research since its last review.

## **17.8 Community-Based Research (CBR)**

Community-based research is research that is conducted as an equal partnership between academic investigators and members of a community. In CBR projects, the community participates fully in all aspects of the research process. Community is often self-defined, but general categories of community include geographic community, community of individuals with a common problem or issue, or a community of individuals with a common interest or goal.

Where research is being conducted in communities, PIs are encouraged to involve members of the community in the research process, including the design and implementation of research and the dissemination of results when appropriate. The HRPP Office will assist the PI in developing such arrangements.

The following are some questions that PIs should ask as they develop CBR. These are also the questions that the IRB should consider when reviewing CBR.

- Background, purpose, objectives
  - How was the community involved or consulted in defining the need?
  - Who came up with the research objectives and how?
  - Is this research really justified with respect to community concerns?
  - Are there concrete action outcomes?
  - Who benefits? How?
- Research methodology
  - How will the community be involved in the research? At what levels?
  - What training or capacity-building opportunities will be built in?
- Procedures
  - Will the methods used be sensitive and appropriate to various communities (consider literacy issues, language barriers, cultural sensitivities, etc.)?
  - How will scientific rigor and accessibility be balanced?
- Participants
  - Are the appropriate people being included to get the questions answered (e.g., service providers, community members, leaders etc.)?
  - How will the research team protect vulnerable groups?
  - Will the research process include or engage marginalized or disenfranchised community members? How?
  - Is there a reason to exclude some people? Why?
- Recruitment
  - What provisions have been put in place to ensure culturally-relevant and appropriate recruitment strategies and materials?
  - Have “power” relationships been considered in the recruitment strategies to



- minimize coercion?
  - Who approaches people about the study and how?
- Risks and potential benefits
  - What are the risks and potential benefits of the research for communities? For individuals?
  - Are the risks (including risks to the community) being presented honestly?
  - How will risks be minimized?
- Privacy and confidentiality
  - Where will data be stored? Who will have access to the data? How?
  - What processes will be put in place to be inclusive about data analysis and yet maintain privacy of participants?
  - What will be the rules for working with transcripts or surveys with identifying information?
  - How will boundaries between multiple roles (e.g., researcher, counselor, peer) be maintained?
- Compensation
  - How will people be reimbursed for their time and honored for their efforts without it becoming coercive?
  - How will compensation be approached?
  - What provisions have been made for minimizing barriers to participation (e.g., providing for food, travel, childcare)?
  - Who is managing the budget? How are these decisions negotiated?
- Conflicts of interest
  - What happens when the PI/research staff is the friend, peer, service provider, doctor, nurse, social worker, educator, funder, etc.?
  - How will power differentials be appropriately acknowledged and negotiated?
- Informed consent process
  - What does informed consent mean for “vulnerable” populations (e.g., children, mentally ill, developmentally challenged)?
  - What processes are in place for gathering individual consent?
  - Is written informed consent being obtained? If not, explain why.
  - What processes are in place for gathering community consent?
  - Where minors are to be included as participants, how will assent be obtained?
  - Are the consent processes culturally sensitive and appropriate for the populations being included?
- Outcomes and results
  - How will the research be disseminated to academic audiences?
  - How will the research be disseminated to community audiences?
  - What are the new ways that this research will be acted upon to ensure community/policy/social change?
- Ongoing reflection and partnership development
  - Is there a partnership agreement or memorandum of understanding to be signed by all partners that describes how they will work together?
  - What internal process evaluation mechanisms are in place?
  - When plans change to accommodate community concerns (as they invariably do

in CBR), how will this be communicated to the IRB?

## **17.9 State and Local Laws [Reserved]**

# **18 Additional Requirements of Federal Agencies**

If research is funded, supported by or otherwise subject to certain federal agencies or agreements, it could be subject to additional requirements to those in the Common Rule or FDA regulations. The WSU application to conduct Human Subjects Research will provide the IRB (IRB Chairs, IRB Coordinators/HRPP staff) with initial notification that the project may be subject to the additional requirements of one of these agencies. Checklists will normally be provided to assist reviewers in ensuring that all special considerations are met. IRB Coordinators, during pre-review, identify these requirements and confirm that they are documented.

For detailed requirements refer to the OHRP guidance.

## **18.1 Environmental Protection Agency (EPA)**

This section addresses requirements for research supported by or otherwise subject to the requirements of the Environmental protection Agency (EPA) and addresses the requirements that differ from or are in addition to current HRPP policies.

For detailed requirements refer to the regulatory links provided here:

- Environmental Protection Agency (EPA) 40 CFR 26

### ***18.1.1 Exposure to Substances; Protections for Pregnant Women, Children, and Others***

EPA prohibits research involving the intentional exposure of pregnant women, nursing women, or children to any substance.

EPA requires application of 40 CFR 26 Subparts C and D to provide additional protections to pregnant women and children as participants in observational research, i.e., research that does not involve intentional exposure to any substance.

Before the research can begin IRB determinations and approval must be submitted to the EPA Human Subjects Research Review official for final review and approval.

For research not conducted or supported by any federal agency that has regulations for protecting human research participants and for which the intention of the research is submission to the EPA, the EPA regulations protecting human research participants apply, including:

1. The provisions of 40 CFR 26 are extended to human research involving the intentional exposure of non-pregnant, non-nursing adults to any substance,
2. The intentional exposure of pregnant women, nursing women, or children to any substance is prohibited.
  - a. 40 CFR 26, 40 CFR 26.201-203, 40 CFR 26.304, 404-405,
  - b. 40 CFR 26.1101-1125 (Subpart K—Basic Ethical Requirements for Third-Party Human Research for Pesticides Involving Intentional Exposure of Non-pregnant, Non-nursing Adults)
  - c. 40 CFR 26.1201-1203 (Subpart L—Prohibition of Third-Party Research for Pesticides Involving Intentional Exposure of Human Subjects who are Children or Pregnant or Nursing Women)
  - d. [AAHRPP element I.1.D.]

### ***18.1.2 Children in Observational Research Greater than Minimal Risk but with Prospect of Direct Benefit***

Such research is allowable if:

1. The intervention or procedure holds out the prospect of direct benefit to the individual participant or is likely to contribute to the participant's well-being.
2. The risk is justified by the anticipated benefit to the participants.
3. The relation of the anticipated benefit to the risk is at least as favorable to the participants as that presented by available alternative approaches.
4. Adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians, as set forth in §26.406. 40 CFR 26.304, 40 CFR 26.404-405
  - a. 40 CFR 26, 40 CFR 26.201-203 (Subpart B—Prohibition of Research Conducted or Supported by EPA Involving Intentional Exposure of Human Subjects who are Children or Pregnant or Nursing Women)
  - b. 40 CFR 26.304 (Additional protections for pregnant women and fetuses involved in observational research)
  - c. [AAHRPP element II.4.A.]

## **18.2 Department of Energy**

This section addresses requirements for research supported by or otherwise subject to the requirements of the Department of Energy (DoE) and addresses the requirements that differ from or are in addition to current HRPP policies.

For detailed requirements refer to the regulatory links provided here: Department of Energy (DOE) DOE 443.1B

### ***18.2.1 Department of Energy (DOE) Requirements:***

Contractor Requirements

1. Regardless of the performer of the work, the contractor is responsible for compliance with the requirements of the Contractor Requirements Document (CRD), including periodically conducting self- assessments to ensure compliance with the Human Subject Research Program procedures and other requirements.
2. There is required prompt reporting to the DOE Human Subjects Research Program Manager for specified events.
  - DOE 443.1B, Contractor Requirements Document: Protection of Human Research Subjects
  - [AAHRPP elements I.5.A., III.2.D.]

#### Required Checklist for Researchers

1. Researchers submit a checklist, or respond to the corresponding questions within the electronic application system, for IRBs to use in verifying that HS research protocols comply with DOE requirements, including those for protection of Personally Identifiable Information
2. DOE Checklist to Verify Compliance with DOE Requirements
3. [AAHRPP elements II.3.E., III.2.C.]

#### Reporting – by Researchers

1. Researchers must report the following to the DOE Human Subjects Protection Program Manager (or as appropriate, the National Nuclear Security Administration (NNSA) HSP Program Manager):
  - a. Promptly (within 48 hours):
    - i. Any significant adverse events, unanticipated risks; and complaints about the research, with a description of any corrective actions taken or to be taken.
    - ii. Any suspension or termination of IRB approval of research.
    - iii. Any significant non-compliance with HRPP procedures or other requirements.
  - b. Immediately, and report to the DOE-Cyber Incident Response Capability ('Immediately' means as soon as breach is discovered)
    - i. Any finding of a suspected or confirmed data breach involving personally identifiable information in printed or electronic form and provide a description of corrective actions to be taken within 48 hours for concurrence by the appropriate HSP Program Manager.
    - ii. DOE 443.1B, Attachment 1: Contractor Requirements Document: Protection of Human Research Subjects
    - iii. [AAHRPP elements III.2.D.]

## 18.3 Department of Education (ED)

This section addresses requirements for research supported by or otherwise subject to the requirements of the Department of Education (ED), addresses both the requirements that differ from or are in addition to current HRPP policies as well as other Department of Education requirements that are congruent with current HRPP policies.

For detailed requirements refer to the regulatory links provided here: Department of Education (ED) 34 CFR 99 [FERPA]; 34 CFR 98

### ***18.3.1 Department of Education (ED) Requirements***

Obtaining Student Records or Personal Education Information

1. When researchers obtain student records or personal education information from an education program (as defined in 34 CFR 99.3), such activity is subject to the Family Educational Rights and Privacy Act (FERPA).
  - 34 CFR 99.3 [FERPA Definitions]
  - [AAHRPP element II.3.G.]

### ***18.3.2 Releasing Records Without Consent***

1. An educational institution may disclose personally identifiable information from an education record of a student without consent under certain conditions as listed in FERPA.
  - 34 CFR 99 [FERPA]
  - [AAHRPP element II.3.G.]

### ***18.3.3 Protection of Students***

No student shall be required, as part of any program specified in §98.1 (a) or (b), to submit without prior consent to psychiatric examination, testing, or treatment, or psychological examination, testing, or treatment, in which the primary purpose is to reveal information concerning:

- a. Political affiliations.
- b. Mental and psychological problems that are potentially embarrassing to the student or his or her family.
- c. Sex behavior and attitudes.
- d. Illegal, anti-social, self-incriminating and demeaning behavior.
- e. Critical appraisals of other individuals with whom the student has close family relationships.
- f. Legally recognized privileged and analogous relationships, such as those of lawyers, physicians, and ministers.
- g. Religious practices, affiliations, or beliefs of the student or student's parent.
- h. Income, other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under a program.
  - 34 CFR 98.4
  - [AAHRPP element II.4.B.]

Prior consent means:

- Prior consent of the student, if the student is an adult or emancipated minor; or

- Prior written consent of the parent or guardian, if the student is an un-emancipated minor. Schools and contractors obtain prior written parental consent before minor students are required to participate in any ED-funded survey, analysis, or evaluation.

#### ***18.3.4 For research not funded by the US Department of Education***

The IRB must verify compliance with U.S. Department of Education regulations that schools are required to develop and adopt policies in conjunction with parents regarding the following:

- The right of a parent of a student to inspect, upon the request of the parent, a survey created by a third party before the survey is administered or distributed by a school to a student.
- Any applicable procedures for granting a request by a parent for reasonable access to such survey within a reasonable period of time after the request is received.
- Arrangements to protect student privacy that are provided by the agency in the event of the administration or distribution of a survey to a student containing one or more of the following items (including the right of a parent of a student to inspect, upon the request of the parent, any survey containing one or more of such items):
  - Political affiliations or beliefs of the student or the student's parent.
  - Mental or psychological problems of the student or the student's family.
  - Sex behavior or attitudes.
  - Illegal, anti-social, self-incriminating, or demeaning behavior.
  - Critical appraisals of other individuals with whom respondents have close family relationships.
  - Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers.
  - Religious practices, affiliations, or beliefs of the student or the student's parent.
  - Income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program).
- The right of a parent of a student to inspect, upon the request of the parent, any instructional material used as part of the educational curriculum for the student.
- Any applicable procedures for granting a request by a parent for reasonable access to instructional material received.
- The administration of physical examinations or screenings that the school or agency may administer to a student.
- The collection, disclosure, or use of personal information collected from students for the purpose of marketing or for selling that information (or otherwise providing that information to others for that purpose), including arrangements to protect student privacy that are provided by the agency in the event of such collection, disclosure, or use.
- The right of a parent of a student to inspect, upon the request of the parent, any instrument used in the collection of personal information before the instrument is administered or distributed to a student.
- Any applicable procedures for granting a request by a parent for reasonable access to such instrument within a reasonable period of time after the request is received.

### ***18.3.5 Protection of Pupil Rights***

Inspection of instructional materials by parents or guardians; Limits on survey, analysis, or evaluations;

Local policies concerning student privacy, parental access to information, and administration of certain physical examinations to minors.

- 20 U.S.C. Ch.31, Subchapter III, Part 4, § 1232h especially (a),(b),(c)(1) (as was amended by PUBLIC LAW 107–110—JAN. 8, 2002 115 STAT. 2083)
- [AAHRPP element II.4.B.]

### ***18.3.6 Access to Instructional Material Used In Research***

All instructional material—including teachers' manuals, films, tapes, or other supplementary instructional material—which will be used in connection with any research or experimentation program or project shall be available for inspection by the parents or guardians of the children engaged in such program or project.

- 34 CFR 98.3
- [AAHRPP element III.2.C.]

### ***18.3.7 Other Department of Education Requirements that are Congruent with Current HRPP Policies***

Representation for Vulnerable Subjects on the IRB:

When an IRB reviews research that purposefully requires inclusion of children with disabilities or individuals with mental disabilities as research subjects, the IRB must include at least one person primarily concerned with the welfare of these research subjects.

- 34 CFR 356.3
- [AAHRPP element II.1.E.]

## **18.4 Department of Defense (DOD)/Department of the Navy (DON)**

This section addresses requirements for research supported by or otherwise subject to the requirements of the Department of Defense (DoD), including Department of the Navy (DON) and addresses both the requirements that differ from or are in addition to current HRPP policies as well as other DoD and DON requirements that are congruent with current HRPP policies.

For detailed requirements refer to the regulatory links provided here:

- Department of Defense (DoD) 32 CFR 219; DoD Directive 3216.02; 10 USC 980

- Department of the Navy (DON) SECNAVINST 3900.39D

### **18.4.1 International Research**

Research performed in a foreign country involving participants who are not US citizens or DoD personnel requires permission of the host country.

- DoD Directive 3216.02, 4.c.(2)(e)
- SECNAVINST 3900.39D, para. 6i
- [AAHRPP standard I-3]

### **18.4.2 Reporting – by Researchers, Institution**

Reporting for all types of DoD and DON research covered by this policy will be consistent with the reporting description provided in this section unless specifically described otherwise.

**18.4.2.1 DoD:** Promptly (within 30 days) notify the DoD Human Research Protection Officer (HRPO) as follows:

Researcher notifies:

1. When significant changes to the research protocol are approved by the IRB.
2. The results of the IRB continuing review.
3. If the IRB used to review and approve the research changes to a different IRB.

The institution notifies:

1. Any unanticipated problems involving risks to participants or others for any DoD-supported research.
  2. Any determinations of serious or continuing noncompliance of DoD supported research.
  3. When the institution is notified by any Federal dept or agency or national organization that any part of its HRPP is under investigation for cause involving a DoD-supported research protocol.
  4. Any suspension or termination of DoD supported research.
- DoD Directive 3216.02, para. 4.b.4
  - [AAHRPP element I.5.D, II.2.D, II.2.F, II.2.G]

**18.4.2.2 DON: The institution** notifies the DON HRPP Office of:

The initiation and results of all investigations of alleged non-compliance with human subject protections of DON-supported research protocols (also report regardless of the findings to Surgeon General of the Navy and appropriate sponsors).

1. All audits, investigations, or inspections of DON-supported research protocols.



2. All audits, investigations, or inspections of the institution's HRPP conducted by outside entities (e.g., the FDA or OHRP), and all restrictions, suspensions, or terminations of institutions' assurances.
  3. Significant communication between institutions conducting research and other federal departments and agencies regarding compliance and oversight.
- SECNAVINST 3900.39D, para. 6k, 8d(2)
  - [AAHRPP elements I.5.D., II.2.F]

### **18.4.3 Monitors**

For research involving more than minimal risk the IRB shall approve an independent research monitor by name. OSD (Office of the Secretary of Defense) and DoD Component heads may waive the research monitor requirement on a case-by-case basis when inclusion of a monitor is not necessary to provide additional protections for human subjects.

1. Required for research involving greater than minimal risk, although the IRB or organizational official can require this for a portion of the research or studies involving no more than minimal risk if appropriate.
  2. The research monitor is appointed by name and shall be independent of the team conducting the research.
  3. There may be more than one research monitor (e.g., if different skills or experience are needed).
  4. The monitor may be an ombudsman or a member of the data safety monitoring board.
  5. The IRB must approve a written summary of the monitors' duties, authorities, and responsibilities.
  6. The IRB or HRPP official shall communicate with research monitors to confirm their duties, authorities, and responsibilities.
  7. The duties of the research monitor are determined on the basis of specific risks or concerns about the research, such as:
    - o Perform oversight functions (e.g., observe recruitment, enrollment procedures, and the consent process, oversee study interventions and interactions, review monitoring plans and unanticipated problems involving risks to participants or others, oversee data matching, data collection and analysis).
  8. Discuss the research protocol with researchers, interview human subjects, and consult with others outside of the study.
  9. Report observations and findings to the IRB or a designated official.
  10. The research monitor has the authority to:
  11. Stop a research study in progress.
  12. Remove individuals from study.
  13. Take any steps to protect the safety and well-being of participants until the IRB can assess.
- DoD Directive 3216.02, para.8
  - [AAHRPP Element II.3.B]

#### ***18.4.4 Provision for research-related injury***

DON: Every project involving greater than minimal risk shall include an arrangement for emergency treatment and necessary follow-up of any research-related injury.

- SECNAVINST 3900.39D, para. 6a(5)
- [AAHRPP element II.3.F.]

#### ***18.4.5 Research involving surveys***

Surveys performed on Department of Defense personnel must be submitted, reviewed, and approved by the Department of Defense after the research protocol is reviewed and approved by the IRB.

- OPNAVINST 5300.8C
- SECNAVINST 3900.39D, para. 6e
- [AAHRPP element II.2.E]

#### ***18.4.6 DoD Personnel as participants***

##### **18.4.6.1 U.S. military personnel - minimizing undue influence:**

Officers and senior noncommissioned officers (NCOs) shall not influence the decisions of their subordinates to participate or not, and shall not be present at the time of research recruitment sessions and consent involving members of units under their command.

The IRB shall appoint an ombudsman for research involving Service Members as human subjects that is greater than minimal risk and when recruitment occurs in a group setting.

Superiors of Service members in the chain of command may have a separate opportunity to participate.

- DoD Directive 3216.02, 7.e.(1)(b), (d), (2)(d)
- SECNAVINST 3900.39D, para. 6a(6)
- [AAHRPP Element II.3.C]

##### **18.4.6.2 Compensation to Participants (Payment and Limits)**

Limitations on dual compensation prohibit US military personnel from receiving payment for research during duty hours, but the participant may be paid for participation during off duty hours. However, federal employees while on duty and non-federal persons may be compensated for research blood draws up to \$50 for each blood draw.

Non-federal employees may be compensated for research other than blood draws in a reasonable

amount as approved by the IRB.

- DoD Directive 3216.02, 11
- Dual Compensation Act (Title 5 USC Section 5533), 24 U.S.C 30
- [AAHRPP Element II.3.C]

#### ***18.4.7 Research Involving a Human Being as an Experimental Subject***

An activity, for research purposes, where there is an intervention or interaction with a human being for the primary purpose of obtaining data regarding the effect of the intervention or interaction (32 CFR 219.102(f)).

- DoD Directive 3216.02, Glossary Part II, Definitions
- [AAHRPP element II.3.G]

##### **18.4.7.1 Risk Evaluation; Definition of Minimal Risk**

The phrase “ordinarily encountered in daily life or during the performance of routine physical or physiological examinations or tests” in the definition of minimal risk shall not be interpreted to include the inherent risks certain categories of human subjects face in their everyday life.

For example, risks imposed in research focused on a special population should not be evaluated against the inherent risks encountered in their work environment (e.g., emergency responder, pilot, soldier in a combat zone) or having a medical condition (e.g., frequent medical tests or constant pain).

- DoD Directive 3216.02, 6.b.
- [AAHRPP element II.3.A]

##### **18.4.7.2 Vulnerable subjects**

Additional safeguards shall be provided for subjects who may be considered vulnerable to coercion or undue influence because of their age, health, employment, financial status, or other circumstances.

###### ***18.4.7.2.1 Pregnant women, fetuses and neonates***

DHHS 45 CFR 46 Subpart B applies, replacing the phrase “biomedical knowledge” with “generalizable knowledge”.

The applicability of Subpart B is limited to research that is more than minimal risk and includes interventions or invasive procedures to the woman or fetus; or research involving fetuses/neonates as human subjects.

Human subjects research using fetal tissue shall comply with U.S.C. title 42 (289g–289g-2).

#### **18.4.7.2.2 Prisoners**

DHHS 45 CFR 46 Subpart C applies, but note:

All prisoner research must be reviewed and approved at a convened IRB meeting, including research which meets the criteria for exemption. When the IRB reviews prisoner research, at least one prisoner representative must be present for quorum.

Epidemiological research is allowable, if the research:

1. Describes the prevalence or incidence of a disease by identifying all cases or studies potential risk factor associations for a disease;
2. Presents no more than minimal risk;
3. Presents no more than an inconvenience to the human subject;
4. Does not focus particularly on prisoners.

When a subject becomes a prisoner: If a participant becomes a prisoner, if the researcher asserts to the IRB that it is in the best interest of the prisoner-participant to continue to participate in the research while a prisoner, the IRB chair may determine that the prisoner-participant may continue to participate until the convened IRB can review this request to approve a change in the research protocol and until the organizational official and DoD Component office review the IRB's approval to change the research protocol. Otherwise, the IRB chair shall require that all research interactions and interventions with the prisoner-subject (including obtaining identifiable private information) cease until the convened IRB can review this request to approve a change in the research protocol. The convened IRB, upon receipt of notification that a previously enrolled human participant has become a prisoner, shall promptly re-review the research protocol to ensure that the rights and wellbeing of the human subject, now a prisoner, are not in jeopardy. The IRB should consult with a subject matter expert having the expertise of a prisoner representative if the IRB reviewing the research protocol does not have a prisoner representative. If the prisoner-participant can continue to consent to participate and is capable of meeting the research protocol requirements, the terms of the prisoner-participant's confinement does not inhibit the ethical conduct of the research, and there are no other significant issues preventing the research involving human participants from continuing as approved, the convened IRB may approve a change in the study to allow this prisoner-participant to continue to participate in the research. This approval is limited to the individual prisoner-participant and does not allow recruitment of prisoners as participants.

- Research involving a detainee as a human participant is prohibited.
- This prohibition does not apply to research involving investigational drugs and devices when the same products would be offered to US military personnel in the same location for the same condition.
- The exemption for research involving survey or interview procedures or observation of

public behavior, does not apply to research with children, except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.

- Research involving prisoners of war is prohibited.
- The IRB is aware of the definition of “prisoner of war” for the DoD component granting the addendum.

#### **18.4.7.2.3 Detainees and POWs**

Research involving prisoners of war (POW) and detainees is prohibited.

- DoD Directive 3216.02, 7
- SECNAVINST 3900.39D, para. 6a(3), para. 6a(6), para. 6a(8)
- 10 USC 980
- [AAHRPP element II.4.A]

Limitations on research where consent by legally authorized representatives is proposed.

In such cases, the determination that research is intended to be beneficial to the subject must be made by the IRB.

- DoD Directive 3216.02, para. 4.2.1
- [AAHRPP element II.4.A]

#### **18.4.8 Waivers of Informed Consent**

DON: Exception from consent in emergency medicine research is prohibited unless a waiver is obtained from the Secretary of the Navy.

DoD: For research involving a human being as an experimental subject, waivers of the consent process are prohibited unless granted by Assistant Secretary of Defense for Research and Engineering (or for DON, the Secretary of the Navy).

1. If the research participant meets the definition of “experimental subject,” prohibit a waiver of the consent process unless a waiver is obtained from the Assistant Secretary of Defense for Research and Engineering.
2. The Assistant Secretary of Defense for Research and Engineering may waive the requirements for consent when all of the following are met:
  - a. The research is necessarily to advance the development of a medical product for the Military Services.
  - b. The research might directly benefit the individual experimental subject.
  - c. The research is conducted in compliance with all other applicable laws and regulations.
  - d. For classified research, waivers of consent are prohibited.

- e. If the research participant does not meet the definition of “experimental subject,” the IRB is allowed to waive the consent process.
- DoD Directive 3216.02, 9
- SECNAVINST 3900.39D, para. 6a(3) and 7a(l)
- 10 USC 980 (b)
- [AAHRPP element II.3.G, II.4.C]

#### ***18.4.9 Other DoD and DON Requirements that are Congruent with Current HRPP Policies***

##### **18.4.9.1 Education and Training**

- DoD Directive 3216.02, 1.F and 5.d
- SECNAVINST 3900.39D para. 6a(2)
- [AAHRPP element I.1.E.]

##### **18.4.9.2 Scientific Review**

- DoD Directive 3216.02, 4.b.2
- [AAHRPP element I.1.F.]

##### **18.4.9.3 Conflict of Interest**

- SECNAVINST 3900.39D, para. 6b
- [AAHRPP Element I.6.B]

##### **18.4.9.4 Exempt Research**

- SECNAVINST 3900.39D, para. 6c
- [AAHRPP Element II.2.A]

##### **18.4.9.5 Definition: Human Subject Research**

- DoD Directive 3216.02, Glossary Part II: Definitions
- [AAHRPP element II.3.G]

##### **18.4.9.6 Children: DHHS 45 CFR 46 Subpart D applies**

- DoD Directive 3216.02, 7b.(3)
- 32 CFR 219.101(i) footnote #1
- [AAHRPP element II.4.A]

#### **18.4.9.7 When a subject becomes a prisoner**

- DoD Directive 3216.02, 7d.
- SECNAVINST 3900.39D, para. 6a(3), para. 6a(6), para. 6a(8)
- 10 USC 980
- [AAHRPP element II.4.A]

#### **18.4.9.8 Record Keeping and Retention**

- DoD Directive 3216.02, 15.a., d.
- [AAHRPP element II.5.A, II.5.B]

### **18.5 Department of Justice (DOJ)/National Institute of Justice (NIJ)**

This section addresses requirements for research supported by or otherwise subject to the requirements of the Department of Justice (DoJ), including the National Institute of Justice (NIJ) and Bureau of Prisons and addresses both the requirements that differ from or are in addition to current HRPP policies as well as other requirements that are congruent with current HRPP policies. As the DOJ has not yet signed onto the 2018 Revised Common Rule, research supported by or subject to DOJ requirements must be reviewed under and comply with 28CFR46.

#### ***18.5.1 For detailed requirements refer to the regulatory links provided here:***

##### **18.5.1.1 Pilot Projects not Considered Research**

- For research conducted within the Bureau of Prisons, the implementation of Bureau programmatic or operational initiatives made through pilot projects is not considered to be research.
- 28 CFR 512.10
- [AAHRPP element I.1.A.]

##### **18.5.1.2 28 CFR 512 - Judicial Administration Regulations**

- Research supported by DOJ shall comply with the Judicial Administration regulations covering research, 28 CFR 512 ("Subpart B").
- 28 CFR 512
- [AAHRPP element I.1.D.]

##### **18.5.1.3 Research Design**

- A project must have an adequate research design and contribute to the advancement of

knowledge about corrections.

- 28 CFR 512.11(a)(2)
- [AAHRPP element I.1.F.]

#### **18.5.1.4 Participant Protections and Payment**

- Risk to subjects minimized and reasonable in relation to anticipated benefits. Selection of subjects within any one institution must be equitable.
- When applicable, informed consent must be sought and documented.
- There may be no incentives to persuade inmate subjects to participate (soft drinks and snacks to be consumed at the test setting allowed): Reasonable accommodations may be offered to non-confined research subjects when certain criteria are met.
- 28 CFR 512.11(a)(4,5)
- [AAHRPP element II.3.C.]

#### ***18.5.2 National Institute of Justice (NIJ) funded research Requirements:***

All projects are required to have a Privacy Certificate approved by the NIJ Human Subjects Protection Officer, and all researchers and research staff are required to sign Employee Confidentiality Statements, which are maintained by the responsible researcher (PD).

Research conducted with the Bureau of Prisons must follow regulations for the receipt, use, and storage of individually identifiable information. For National Institute of Justice-funded research, a copy of all data must be de-identified and sent to the National Archive of Criminal Justice Data, including copies of the informed consent document, data collection instruments, surveys, or other relevant research materials.

Regulations prohibit the use of electronic storage/retrieval systems under certain circumstances.

- 28 CFR 22, 28 CFR 512.8,11,12,13,15
- [AAHRPP element II.3.E.]

#### ***18.5.3 For research conducted with the Bureau of Prisons:***

At least once a year, the researcher shall provide the Chief, Office of Research and Evaluation, with a report on the progress of the research.

At least 12 working days before any report of findings is to be released, the researcher shall distribute one copy of the report to each of the following: the chairperson of the Bureau Research Review Board, the regional director, and the warden of each institution that provided data or assistance. The researcher shall include an abstract in the report of findings.

In any publication of results, the researcher shall acknowledge the Bureau's participation in the research project.



The researcher shall expressly disclaim approval or endorsement of the published material as an expression of the policies or views of the Bureau.

Prior to submitting for publication the results of a research project conducted under this subpart, the researcher shall provide two copies of the material, for informational purposes only, to the Chief, Office of Research and Evaluation, Central Office, Bureau of Prisons.

#### ***18.5.4 Informed Consent Requirements***

The researcher, in addition to presenting the statement of informed consent to the subject, shall obtain the subject's signature on the statement of informed consent prior to initiating the research activity. The researcher may not be required to obtain the signature if the researcher can demonstrate that the only link to the subject's identity is the signed statement of informed consent or that there is significantly more risk to the subject if the statement is signed. The signed statement shall be submitted to the chairperson of the appropriate local research review board.

Required elements for the written consent document include:

1. A statement that participation is completely voluntary and that the participant may withdraw consent and end participation in the project at any time without penalty or prejudice (the inmate will be returned to regular assignment or activity by staff as soon as practicable);
2. Anticipated uses of the results of the research
3. A researcher may not guarantee confidentiality when the subject indicates an intent to commit future criminal conduct or harm himself/herself or someone else, or, if the subject is an inmate, indicates an intent to leave the facility without authorization.
4. A statement that participation in the research project will have no effect on the inmate participant's release date or parole eligibility.

##### **18.5.4.1 Other DOJ requirements for informed consent are congruent with current HRPP policies:**

- 28 CFR 512.16
- [AAHRPP element II.3.F.]

##### **18.5.4.2 Researcher Experience**

For research conducted within the Bureau of Prisons, the researcher must have academic preparation or experience in the area of study of the proposed research.

- 28 CFR 512.11(a)(6)
- [AAHRPP element III.1.C.]

#### **18.5.4.3 Content of research proposal**

For research conducted within the Bureau of Prisons, when submitting a research proposal, certain specified items of information must be provided by the applicant, including a statement regarding assurances and certification required by 28 CFR 46, if applicable.

- 28 CFR 512.12
- [AAHRPP element III.1.C.]

#### **18.5.4.4 PD Responsibilities**

The researcher must assume responsibility for actions of any person engaged to participate in the research project as an associate, assistant, or subcontractor to the researcher.

- 28 CFR 512.11(a)(7)
- [AAHRPP element III.2.B.]

#### **18.5.4.5 Progress Reports and Publication**

Requirements for reports of progress, and (at least annually) of findings; Publication of research results; Copyright provisions.

- 28 CFR 512.19 (Reports)
- 28 CFR 512.20 (Publication of results of research project)
- [AAHRPP element III.2.D.]

### **18.6 [Publicly Available Data and Specimens]**

## **19. Definitions**

### **A –**

**Access** –The mechanism of obtaining or using information electronically, on paper, or other medium for the purpose of performing an official function.

**Adverse Event** – Any untoward physical or psychological occurrence in a human subject participating in research. An AE can be any unfavorable or unintended event including abnormal laboratory finding, symptom or disease associated with the research or the use of a medical investigational test article.

**Agent** – Any person performing institutionally-designated activities or exercising institutionally delegated authority or responsibility.

**Anonymized** – means that data or biospecimens do not contain any identifying information and they cannot be linked to any identifiable person.

**Authorization** – A detailed document that gives covered entities permission to use protected health information for specified purposes, which are generally other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual.

**B –**

**C –**

**Children** – persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted. According to Washington state law, minors are persons under the age of 18. The general rule is that a person may consent to his/her own medical care at the age of 18. Therefore, the WSU IRB generally defines children as persons under 18 years of age. Certain statutes and case law, however, provide minors with "majority" status in some circumstances, giving them the right to consent to their own medical care. For example, for emancipated minors, Washington law enumerates certain categories of individuals who, although under the age of 18, have the right to make medical decisions on their own behalf, such as minors who are married, widowed, or divorced; minors who are parents; etc.; for mature minors, Washington law recognizes that some minors may be sufficiently "mature" to give consent to medical treatment, even though they do not qualify as "emancipated"; or certain minors seeking care for drug addiction, sexually transmitted diseases, emotional disorders, or abortion or mental health treatment. Because Washington law does not specifically address consent of children with majority status to research, the WSU IRB will review issues of consent related to enrollment of these children in research on a case- by-case basis.

Note: For research conducted in jurisdictions other than Washington, the research must comply with the laws regarding the legal age of consent in all relevant jurisdictions. The Washington State University Division of the Office of the Attorney General (AGO) will provide guidance regarding the laws in other jurisdictions.

**Clinical Trial** - Clinical trial means a research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of the interventions on biomedical or behavioral health-related outcomes.

Note: This definition differs significantly from the FDA definitions of clinical study or clinical investigation. (See below)

**Common Rule** –The Common Rule refers to the “Federal Policy for the Protection of Human Subjects” adopted by a number of federal agencies. Although the Common Rule is codified by each agency separately, the text is identical to DHHS regulations in 45 CFR 46 Subpart A. For the purposes of this document, references to the Common Rule will cite the DHHS regulations.

**Community** – the term “community” encompasses any group that is identified or self-identifies as a community (including ethnic, religious, occupational, social, or special interest group or group defined by a disease or physical condition), local community organizations and advisory boards, and/or formalized community partnerships.

**Controverted Issue** - Controverted issues are those that cause dispute or controversy among the IRB membership during a convened meeting, usually as the result of opposition to some aspect of the proposed research. Controverted issues may be resolved by continued deliberation and discussion, by seeking further clarification, or the issue may be settled by a vote. The minutes must summarize the nature of the controverted issue, the discussion points and the resolution.

**Covered entity** –The term applied to institutions that must comply with the Privacy Rule. These include health plans and health care clearinghouses.

Health care providers who conduct certain financial and administrative transactions electronically. These electronic transactions are those for which standards have been adopted by the Secretary under HIPAA, such as electronic billing and fund transfers.

## **D -**

**Dead fetus** – A fetus that exhibits neither heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, nor pulsation of the umbilical cord.

**Delivery** – Complete separation of the fetus from the woman by expulsion, extraction, or any other means.

**De-identified** – means that identifiers have been removed from data biospecimens; a code may link individual records or specimens to identifiable persons. The requirement for IRB review depends on who de-identified the data/biospecimens and who has access to the linking code.

**De-identified Information** – Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. If information is de-identified, it no longer is subject to the Privacy Rule and is exempt from HIPAA.

**Deletion** – The removal, erasing, or expunging of information or data from a record.

**Disclosure** –The release, transfer, provision of access to, or divulging in any other manner information outside of the covered entity.

## **E –**

**Engagement** – Institutions are considered “engaged” in a research project when the involvement of their employees or agents in that project includes any of the following:

1. Intervention for research purposes with any human subjects of the research by performing invasive or noninvasive procedures.
2. Intervention for research purposes with any human subject of the research by manipulating the environment.
3. Interaction for research purposes with any human subject of the research.
4. Obtaining the informed consent of human subjects for the research.
5. Obtaining for research purposes identifiable private information or identifiable biological specimens from any source for the research. In general, obtaining identifiable private information or identifiable specimens includes, but is not limited to:
  - a. observing or recording private behavior;
  - b. using, studying, or analyzing for research purposes identifiable private information or identifiable specimens provided by another institution; and
  - c. using, studying, or analyzing for research purposes identifiable private information or identifiable specimens already in the possession of the investigators.

## **F –**

**Fetus** – The product of conception from implantation until delivery [see 45 CFR 46.202(c)].

## **G –**

**Guardian** – An individual who is authorized under applicable state or local law to consent on behalf of a child to general medical care. In Washington, a “guardian” of a minor means someone with the duty and authority to act in the best interests of the minor, subject to residual parental rights and responsibilities, to make important decisions in matters having a permanent effect on the life and development of the minor and to be concerned with his/her general welfare [See MCL 330.1100(b)(6)].

Note: For research conducted in jurisdictions other than Washington, the research must comply with the laws regarding guardianship in all relevant jurisdictions. The Washington State University Division of the Office of the Attorney General (AGO) provide guidance regarding the laws in other jurisdictions.

## **H –**

**Health Information** – Any information created or received by a health care provider or health plan that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or payment for the provision of health care to an individual.

**Human subject** – means a living individual about whom an investigator (whether professional or student) is conducting research:

1. Obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or
2. Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens.

For research covered by FDA regulations (21 CFR 50 and 56), “human subject” means an individual who is or becomes a participant in a clinical investigation (as defined below), either as a recipient of the test article or as a control. A subject may be in normal health or may have a medical condition or disease. In the case of a medical device, a human subject/participant also includes any individual on whose tissue specimen an investigational device is used or tested.

Note: The terms “subject” and “participant” are used interchangeably in this document and have the same meaning.

**Human Subjects Research** –This means any activity that meets the definition of “research” and involves “human subjects” as defined by either the Common Rule or FDA regulations.

**I –**

**IDE** – An investigational device exemption in accordance with 21 CFR 812.

**Identifiable Health Information** –A subset of health information including demographic information collected from an individual.

**IND** – An investigational new drug application in accordance with 21 CFR Part 312.

Intervention includes both physical procedures by which information or biospecimens are gathered (e.g., venipuncture) and manipulations of the subject or the subject’s environment that are performed for research purposes.

**Investigational Device** – A medical device that is the subject of a clinical study designed to evaluate the effectiveness and/or safety of the device. As further stated, a device is any healthcare product that does not achieve its primary intended purpose by chemical action or by being metabolized.

**Investigational Drug** – An investigational drug for clinical research use is one for which the PI or a sponsor has filed an IND application (21 CFR Part 312) or an approved drug that is being studied for an unapproved or approved use in a controlled, randomized, or blinded clinical trial.

**Interaction** - Includes communication or interpersonal contact between investigator and subject.

**Identifiable private information** – Is private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information.

**Identifiable biospecimen** - Is a biospecimen for which the identity of the subject is or may readily

be ascertained by the investigator or associated with the biospecimen.

**Institutional Review Board (IRB)** – An IRB is a board designated by Washington State University to review, to approve the initiation of, and to conduct periodic review of research involving human subjects. The primary purpose of such review is to assure the protection of the rights and welfare of the human subjects in research. The IRB may be assigned other review functions as deemed appropriate by the VPR/DGS or the Provost of the University.

Note: In the sections that follow, the singular form “IRB” will be used to mean all IRBs registered to WSU.

**Institutional Official (IO)** – The IO is responsible for ensuring that the HRPP at Washington State University has the resources and support necessary to comply with all federal regulations and guidelines that govern human subjects research. The IO is legally authorized to represent the institution, is the signatory official for all Assurances, and assumes the obligations of the institution’s Assurance.

**J –**

**K –**

**L –**

**Legally authorized representative** – means an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject’s participation in the procedure(s) involved in the research. If there is no applicable law addressing this issue, legally authorized representative means an individual recognized by institutional policy as acceptable for providing consent in the non-research context on behalf of the prospective subject to the subject’s participation in the procedure(s) involved in the research.

**Limited Data Set** – Protected health information that excludes specific direct identifiers of the individual or of relatives, employees, or household members of an individual. A limited data set can only be used for the purposes of research, public health, or healthcare operations, and disclosed for the purpose of research.

**M –**

**Minimum Necessary** – The principle that any access should be limited to the minimum amount of information needed to accomplish the intended purpose of the use or disclosure.

**Minimal risk** – means that that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

**N –**

**Neonate** – A newborn.

**Non-Significant Risk (NSR)** – An investigational device other than a significant risk device.

**Nonviable neonate** – A neonate after delivery that, although living, is not viable.

**O –**

**P –**

**Pregnancy** – The period of time from implantation until delivery. A woman shall be assumed to be pregnant if she exhibits any of the pertinent presumptive signs of pregnancy, such as missed menses, until the results of a pregnancy test are negative or until delivery.

**Preparatory Research** – The method applied to developing or designing a research study.

**Prisoner** – Any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute; individuals detained in other facilities by virtue of statutes or commitment procedures that provide alternatives to criminal prosecution or incarceration in a penal institution; and individuals detained pending arraignment, trial, or sentencing.

Prisoner or Justice Involved Person (WSU expanded definitions, effective September 1, 2023):

- A. Individuals whose circumstances match the federal definition(s) as outlined in 45CFR46.303 (Subpart C), shown above, or other federal regulations and/or;
- B. As defined under 18 USC 3635(4), a person who has been sentenced to a term of imprisonment pursuant to a conviction for a Federal criminal offense, or a person in the custody of the Bureau of Prisons and/or;
- C. As defined under RCW 72.09.015, a person committed to the custody of the department, including but not limited to persons residing in a correctional institution or facility **and persons released from such facility on furlough, work release, or community custody**, and persons received from another state, state agency, county, federally recognized tribe, or federal jurisdiction and/or;
- D. Individuals whose circumstance do not match the federal or state definition(s) of prisoner, but whose similarly vulnerable situation indicate that these individuals deserve heightened protections as recommended by SACHRP.
  - a. These individuals may collectively be referred to as “Justice Involved”, meaning persons who are now, or who have in the past been, involved with the criminal justice system as a defendant or who have spent time in jail, prison, youth correctional facility or similar institutions and/or;
  - b. Any person who is now or has in the past been convicted or incarcerated.



The definition of minimal risk in Subpart C is different than in the rest of the federal regulations. According to 45 CFR 46.303(d), “minimal risk” is the probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons

**Privacy Act** – An Act of Congress that provides for the confidentiality of individually-identified and retrieved information about living individuals that is maintained in a system of records and permits the disclosure of records only when specifically authorized by the statute. The Act provides that the collection of information about individuals is limited to that which is legally authorized, relevant, and necessary.

**Privacy Board** – A board comprised of members of varying backgrounds and appropriate professional competencies, as necessary, to review individual’s privacy rights. It is an alternative to an IRB for privacy issues only. It cannot replace the IRB for Common Rule purposes.

**Private information** - Includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information that has been provided for specific purposes by an individual and that the individual can reasonably expect will not be made public (e.g., a medical record).

**Privacy Rule** – Provides guidance on the use of protected health information in the conduct of research. It imposes requirements on those involved in research, both individuals and institutions. “Privacy” refers to a person’s desire to control the access of others to information about him/herself. The evaluation of privacy involves consideration of how the investigator will access information from or about participants. The IRB members should know strategies to protect privacy interests relating to contact with potential participants and access to private information.

**Protected Health Information** – Individually identifiable health information transmitted or maintained electronically or in any other form or medium, except for education records or employment records, as excluded in the Privacy Rule.

**Public Observation** – The viewing and/or recording of behavior that occurs in a setting where there is no expectation of privacy. If the observation will occur in a setting where an individual may reasonably expect that no observation or recording will occur, the setting would not be considered truly public.

**Q –**

**R –**

**Related** – There is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research.

**Research (DHHS)** – The Common Rule defines research as a systematic investigation, including

research development, testing, and evaluation that is designed to develop or contribute to generalized knowledge.

For the purposes of this policy, a “systematic investigation” is an activity that involves a prospective study plan that incorporates data collection, either quantitative or qualitative, and data analysis to answer a study question. Investigations designed to develop or contribute to generalizable knowledge are those designed to draw general conclusions (i.e., knowledge gained from a study may be applied to populations outside of the specific study population), inform policy, or generalize findings.

For purposes of implementing these Standard Operating Procedures, the following activities are deemed not to be research:

1. Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.
2. Public health surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. Such activities are limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance (including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products). Such activities include those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters).
3. Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes.
4. Authorized operational activities (as determined by each agency) in support of intelligence, homeland security, defense, or other national security missions.

**Research (FDA)** - FDA regulations define Research as any experiment that involves a test article and one or more human subjects and that either must meet the requirements for prior submission to the Food and Drug Administration under section 505(i) or 520(g) of the federal Food, Drug, and Cosmetic Act, or need not meet the requirements for prior submission to the Food and Drug Administration under these sections of the Federal Food, Drug, and Cosmetic Act, but the results of which are intended to be later submitted to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit. The terms “research,” “clinical research,” “clinical study,” “study,” and “clinical investigation” are synonymous for purposes of FDA regulations [21 CFR 50.3(c), 21 CFR 56.102(c)].

Experiments that must meet the requirements for prior submission to the Food and Drug Administration under section 505(i) of the federal Food, Drug, and Cosmetic Act are those that include the use of a drug other than an approved drug in the course of medical practice [21 CFR

312.3(b)].

Experiments that must meet the requirements for prior submission to the Food and Drug Administration under section 520(g) of the Food, Drug, and Cosmetic Act are those that include any activity that evaluates the safety or effectiveness of a device [21 CFR 812.2(a)].

Any activity in which results are being submitted to or held for inspection by FDA as part of an application for a research or marketing permit is considered to be FDA-regulated research [21 CFR 50.3(c), 21 CFR 56.102(c)].

**Research Under the Auspices of Washington State University** – Research under the auspices of the institution includes research conducted at this institution, conducted by or under the direction of any employee or agent of this institution (including students) in connection with his or her institutional responsibilities, conducted by or under the direction of any employee or agent of this institution using any property or facility of this institution, or involving the use of this institution's non-public information to identify or contact human subjects.

## **S –**

**Secondary research** – means conducting research using data or biospecimens originally collected for another purpose, which may or may not have been research. The requirements for IRB review and informed consent depend on the circumstances under which the data were collected and whether the data can be linked to individuals.

**Significant Financial Interest (SFI)** – is defined by the regulation as:

- (1) A financial interest consisting of one or more of the following interests of the Investigator (and those of the Investigator's spouse and dependent children) that reasonably appears to be related to the Investigator's institutional responsibilities:
  - (i) With regard to any publicly traded entity, a significant financial interest exists if the value of any remuneration received from the entity in the twelve months preceding the disclosure and the value of any equity interest in the entity as of the date of disclosure, when aggregated, exceeds \$5,000. For purposes of this definition, remuneration includes salary and any payment for services not otherwise identified as salary (e.g., consulting fees, honoraria, paid authorship); equity interest includes any stock, stock option, or other ownership interest, as determined through reference to public prices or other reasonable measures of fair market value;
  - (ii) With regard to any non-publicly traded entity, a significant financial interest exists if the value of any remuneration received from the entity in the twelve months preceding the disclosure, when aggregated, exceeds \$5,000, or when the Investigator (or the Investigator's spouse or dependent children) holds any equity interest (e.g., stock, stock option, or other ownership interest); or
  - (iii) Intellectual property rights and interests (e.g., patents, copyrights), upon receipt of income related to such rights and interests.

**Significant Risk (SR)** – A significant risk device is an investigational device that

1. is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject; or
2. is purported or represented to be for use in supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a subject; or
3. is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health and presents a potential for serious risk to the health, safety, or welfare of a subject; or
4. otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

**Surrogate Consent** – Consent obtained from a legally authorized representative on behalf of a participant determined to lack decision-making capacity.

## **T –**

**Test Article** – Test articles covered under the FDA regulations include the following:

1. Human drugs – The primary intended use of the product is achieved through chemical action or by being metabolized by the body. A “drug” is defined as “a substance recognized by an official pharmacopoeia or formulary; a substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease; a substance (other than food) intended to affect the structure or any function of the body; a substance intended for use as a component of a medicine but not a device or a component, part or accessory of a device.”  
[\[http://www.fda.gov/Drugs/InformationOnDrugs/ucm079436.htm\]](http://www.fda.gov/Drugs/InformationOnDrugs/ucm079436.htm)
2. Medical Devices – A “device” is “an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man [sic] or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.”  
[\[http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Overview/ClassifyYourDevice/ucm051512.html\]](http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Overview/ClassifyYourDevice/ucm051512.html)
3. Biological Products – These include a wide range of products, such as vaccines, blood and blood components, allergenics, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins. Biologics can be composed of sugars, proteins, or nucleic acids or complex combinations of these substances or may be living entities, such as cells and tissues. Biologics are isolated from a variety of natural sources – human, animal, or microorganism – and may be produced by biotechnology methods and other cutting-edge

technologies. Gene-based and cellular biologics, for example, often are at the forefront of biomedical research and may be used to treat a variety of medical conditions for which no other treatments are available.

[\[http://www.fda.gov/Drugs/InformationOnDrugs/ucm079436.htm\]](http://www.fda.gov/Drugs/InformationOnDrugs/ucm079436.htm)

4. Food Additives – In its broadest sense, a “food additive” is any substance added to food. Legally, the term refers to “any substance the intended use of which results or may reasonably be expected to result – directly or indirectly – in its becoming a component or otherwise affecting the characteristics of any food.” This definition includes any substance used in the production, processing, treatment, packaging, transportation, or storage of food.
5. Color Additives – A “color additive” is any dye, pigment, or substance that, when added or applied to a food, drug, or cosmetic, or to the human body, is capable (alone or through reactions with other substances) of imparting color.  
[\[http://www.fda.gov/Food/FoodIngredientsPackaging/ucm094211.htm#foodadd\]](http://www.fda.gov/Food/FoodIngredientsPackaging/ucm094211.htm#foodadd)
6. Foods – These include dietary supplements that bear a nutrient content claim or a health claim.
7. Infant Formulas – Infant formulas are liquid foods intended for infants and that substitute for mother’s milk.

## U –

**Unexpected** – The incident, experience, or outcome is not expected (in terms of nature, severity, or frequency), given the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent documents, and the characteristics of the subject population being studied.

## V –

**Viable** – As it pertains to the neonate, it means being able, after delivery, to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration.

## W –

**Waiver of Authorization** – A means of requesting approval from an IRB or Privacy Board rather than asking each research subject for an authorization to access protected health information.

## X –

## Y –

## Z –