



THE UNIVERSITY OF
TOLEDO
1872

Department for Human Research Protections

Biomedical Institutional Review Board
Social, Behavioral and Educational Institutional Review Board

Policies and Procedures for the
Protection of Human Subjects in
Research and Investigational Activities

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**University of Toledo Department for Human Research Protections
Policy and Procedures**

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**University of Toledo
Department for Human Research Protections**

Federalwide Assurance #: 00010686

**Biomedical
Institutional Review Board**

**Social, Behavioral and Educational
Institutional Review Board**

NOTICE REGARDING UPDATES TO THESE PROCEDURES

These Policies and Procedures may be updated from time to time. The most recently updated version can be found on the [Department for Human Research Protections website](#). You should access the [website](#) to ensure that you are reviewing the most current version of these Policies and Procedures.

The official, signed copy of these Policies and Procedures are available for review during regular business hours in the Department for Human Research Protections' HSC office (Center for Creative Education, Room 0106).

Protection of Human Subjects in Research and Investigational Activities

POLICIES

I. Introduction

A. Human Subject Protections At The University of Toledo

The University of Toledo (UT) recognizes and affirms the need for academic freedom in the conduct of research, and the value of well-designed, responsible activities that involve human subjects. At the same time, the University recognizes and accepts the responsibility to assure the protection of any human subjects. The use of human subjects in research or investigational activities imposes both ethical and legal responsibilities upon the University, the principal investigator, student researchers and study staff for assuring that the rights and welfare of those subjects are adequately protected. Therefore, the principal investigator, all study personnel, and the Institution must utilize these policies and procedures to ensure that such protection occurs.

These DHRP Policies and Procedures have been prepared to help investigators and others involved in human subject research meet individual and institutional obligations with respect to human subjects. They have been developed in accord with federal regulations (45 CFR 46, 21 CFR 50, and 21 CFR 56), UT policies, human research ethical codes, and the ethical principles embodied in The Belmont Report (respect for persons, beneficence and justice).

Current law places the burden of liability for negligence or misconduct directly on the researcher and the institution. These guidelines are formulated to help protect the University, the researcher, and in the case of students, the student and principal investigator or faculty advisor, from liability by imposing minimum standards for research and required procedures for careful review of projects. Failure to follow these guidelines may cause individuals to incur personal liability for negligence and harm. Failure to follow these guidelines may also cause the University to lose federal funding, prevent individuals from receiving federal research funds, or result in a federally imposed suspension of all human research activities at UT.

The UT DHRP and associated Institutional Review Boards (IRBs) have Institutional responsibility for all ***UT Related Research***. Any ***UT Related Research*** may be undertaken only after appropriate IRB approval and may be continued only so long as that approval remains in effect (approval intervals are one year or less depending on the risk involved). Changes in a research study, or continuation of the study following adverse or untoward occurrences are also subject to IRB review and approval.

A principal investigator must refer his or her research to the IRB whenever human subjects (including medical records, tissues and other individually identifiable records) are involved, even if the research involves only a few subjects or if the investigator does not consider the subjects to be "at risk." It is the sole responsibility of the IRB not the project director, investigator, or any University official – to determine if ***research*** is exempt from ***IRB*** review. Thus, each project not specifically deemed exempt by the ***IRB*** must be submitted for ***IRB*** review, and ***human subjects*** may not be utilized until the ***research*** is approved.

- B. **Department for Human Research Protections (DHRP):** The DHRP was established to ensure the protection of the rights and welfare of human subjects, and to support the conduct of high quality and ethical human research at UT. The DHRP provides support and guidance for the operation of the two IRBs at UT: the Biomedical IRB and the Social, Behavioral and Educational IRB (SBE IRB).

The DHRP will oversee and facilitate the operation of the IRBs with project submissions and follow-up delegated to the office of the IRB that reviews the study (either the Biomedical IRB Office or the SBE IRB office).

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II. Definitions

The following definitions apply to terms used in both the Policies and Procedures. The DHRP also applies definitions provided in the federal regulations for the protection of human research subjects (45 CFR 46, and when applicable 21 CFR 50 and 56).

- A. **45 CFR 46** – refers to [Title 45, Part 46 of the Code of Federal Regulations for the Protection of Human Subjects](#). These regulations, which are issued by the federal Office for Human Research Protections under the direction of the Department for Health and Human Services, govern **Human Subject** research. In addition to other requirements, 45 CFR 46 requires that (1) institutions conducting **Human Subject** research must establish institutional review boards to prospectively review research from the vantage point of protecting the rights and safeguarding the welfare of **Human Subjects** and (2) institutions engaged in **Human Subject Research** must provide the **Office for Human Research Protections** with a **Federalwide Assurance**.
- B. **Chair Designee** means a member of the IRB designated by the IRB Chair from among the more experienced study reviewers.
- C. **Conflict of Interest** has the same meaning as used in The University of Toledo's [Conflict of Interest Policy](#).
- D. **Department for Human Research Protections (DHRP)** – The department established by UT to provide guidance to the Institutional Review Boards, researchers and study personnel for protecting the rights of human subjects, facilitating human subject research and directing compliance with regulatory and ethical guidelines.
- E. **Faculty Advisor** – The faculty advisor is the University faculty member who is responsible for providing intellectual, ethical and regulatory guidance to a student or resident research project. Faculty advisors also serve as the responsible person for regulatory compliance and following IRB procedures.
- F. **Federalwide Assurance (FWA)** – A document required by OHRP for institutions engaged in non-exempt research which states the institution's commitment to HHS that it will comply with the requirements set forth in [45 CFR 46](#) and OHRP's [Terms of Assurance](#).
- G. **Human Subject** has the same meaning as used in [45 CFR 46.102](#) [a living individual about whom an investigator (whether professional or student) conducting research obtains (1) Data through intervention or interaction with the individual, or (2) Identifiable private information].
- H. **Institution or Institutional** means The University of Toledo.
- I. **International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use Good Clinical Practice Guidance (ICH GCP Guidance)** – international ethical and scientific quality standards for designing, conducting, recording, and reporting clinical trials that involve the participation of human subjects.
- J. **Institutional Review Board (IRB)** means an institutional review board identified in the University's **Federalwide Assurance** and established by the University in accord with and for the purposes stated in these policies and procedures.
- K. **Non-Compliance** - Non-compliance means conducting research involving human subjects in a manner that disregard or violates federal regulations governing such research. This can include, but is not limited to, failure to obtain IRB approval for research involving human subjects, inadequate or non-existent procedures for informed consent, inadequate supervision in research involving experimental drugs, devices or procedures, failure to follow recommendations made

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by the IRB to insure the safety of subjects, failure to report adverse events or proposed protocol changes to the IRB, and failure to provide ongoing progress reports.

- L. **Office for Human Research Protections (“OHRP”)** – The OHRP is an administrative unit within the Department of Health and Human Services. OHRP’s responsibilities include implementation of the Regulations for the Protection of Human Subjects (**45 CFR 46**), and the provision of guidance on ethical issues in biomedical and behavioral research.
- M. **Principal Investigator** – A principal investigator is the University faculty or employee primarily responsible who is responsible for the scientific, technical and administrative conduct of the research. The principal investigator the primary responsible person for complying with regulatory requirements, following IRB procedures, and ensuring that the health and welfare of all research participants are protected in accordance with relevant ethical and regulatory guidelines.
- N. **Protocol** – A protocol is a written plan of action for a research study. The plan states what the study will do, how it will be done and why. It explains how many subjects will participate, who is eligible to participate, what study agents or interventions will be administered and how often, what tests subjects will be given and how often, and what information will be gathered.
- O. **Quorum** – A quorum is the minimum number of members that must be present at a convened IRB meeting to take an IRB vote. There are two components to a quorum – the number of members and the qualifications of the members. There must be a majority of the members present and without a conflict of interest (a member with a conflict of interest is not counted for purposes of determining a quorum). There must also be at least five members present, including one non-scientific member.
- P. **Research** has the same meaning as used in [45 CFR 46.102](#) [a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge].
- Q. **Unanticipated Problems:** Unanticipated problems, in general, include any incident, experience, or outcome that is unexpected given the research procedures that are described in the protocol-related documents and the characteristics of the subject population being studied. Unanticipated problems may be related or possibly related to participation in the research. An unanticipated problem 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.
- R. **University of Toledo Federalwide Assurance (UT FWA)** – the University’s written assurance to OHRP that the Institution will abide by the ethical principles set for the in the Belmont Report and by the Federal Regulations for the Protection of Human Subjects (**45 CFR 46**).
- S. **University of Toledo-Related Human Subject Research (UT-Related Research)** means research carried out on- or off- campus (including other states or countries) by UT faculty, students, or other employees, and any studies conducted by any investigator using UT facilities and/or UTMC patients as subjects, including patient records, biological samples, or surveys.

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III. Applicability

These policies and their associated procedures apply to all *UT-Related Research* involving *human subjects* regardless of funding status. This includes research using information or specimens from *human subjects*. This policy is therefore applicable to *research* involving *human subjects* whose physical, emotional, or behavioral condition, responses, tissues, fluids, records etc., are investigated for any purpose other than for the sole purpose of benefiting the subject as an individual. It is applicable to the use of interviews, tests, observations, and inquiries designed to elicit or obtain non-public information about individuals or groups. Student dissertation projects, independent study projects, course projects and pilot projects must follow this policy if they involve *human subjects* in *research*.

IV. Compliance Requirements for University of Toledo Related Research

All Research Conducted At The University of Toledo Shall Be In Compliance With:

A. UT FWA, The Belmont Report and Human Research Subject Regulations:

1. The University of Toledo (UT) [Federalwide Assurance](#); and the corresponding [Terms of Assurance for Protection of Human Subjects for Institutions Within The United States](#);
2. The ethical principles discussed in [The Belmont Report: Ethical Guidelines for the Protection of Human Subjects](#), namely (1) respect for persons; (2) beneficence; and (3) justice.
3. HHS Regulations For The Protection Of Human Subjects ([45 CFR 46](#));
4. FDA Regulations For The Protection Of Human Subjects ([21 CFR 50](#));
5. FDA regulations regarding Institutional Review Boards ([21 CFR 56](#));
6. All other laws and regulations applicable to human subject research, including applicable state laws and regulations

B. DHRP Policies and Procedures for the Protection of Human Subjects in Research and Investigational Activities

C. OHRP, FDA and ICH Guidance: Guidance issued by OHRP, the FDA and ICH shall be applied when appropriate and necessary for the protection of *human subjects*.

V. Basic Principles of UT-Related Research

Investigators conducting *UT-Related Research* must agree to the following basic principles:

1. Ensure all human subjects' participation is voluntary, i.e., occurs as a result of free choice, without coercion or disproportionate inducement, based upon disclosure of relevant information in a comprehensible manner.
2. Utilize adequate standards of informed consent, unless waived by the IRB.
3. Write adequate plans in the protocol for protecting the privacy of subjects and maintaining the confidentiality of identifiable subject information, including protected health information. Ensure all study personnel follow the plans.
4. Ensure the selection of subjects is based upon fair procedures and does not overburden, over utilize, or unfairly favor, or discriminate against, any particular subject pool.
5. Carefully minimize any risks to subjects, and adequately balance risks against potential benefits. Take proper precautions and make plans to deal with emergencies that may develop in the course of even seemingly routine activities.

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VI. Administration

The *DHRP* is responsible for administering these policies and related procedures, as well as overseeing the operations of the *IRB*.

VII. Educational Training

A. **General Policy:** As stated in the *Terms of The [Federalwide Assurance](#)*, research investigators and IRB members should maintain continuing knowledge of, and comply with the following:

1. Relevant human research ethical principles;
2. Relevant federal regulations;
3. Written IRB procedures;
4. State and local laws relating to human subject research; and
5. Institutional policies for the protection of human subjects

Guidance issued by OHRP and other organizations such as the FDA and the ICH shall be considered and followed by investigators and IRB members when appropriate.

B. **Oversight:** The DHRP will monitor and enforce required training.

C. **Required Training – Investigators and Study Personnel:** Prior to engaging in any *Human Subject Research*, all investigators and study personnel must complete the relevant human subjects research training modules, biomedical or social/behavioral, prior to submission to the respective IRB. The IRBs will not approve any protocol that proposes to utilize study personnel who have not completed the required training.

1. **General Requirements:** All study personnel must understand and accept the responsibility to comply with the standards and requirements stipulated in the following documents:
 - a) [UT Federalwide Assurance](#) of Compliance with DHHS Regulations For Protection of Human Research Subjects (FWA);
 - b) OHRP’s [Terms of the Federalwide Assurance](#); and
 - c) “[The Belmont Report](#) – Ethical Principles and Guidelines for The Protection of Human Subjects of Research”
2. **Internet Based Training for Researchers:** Study personnel must complete the appropriate CITI Training modules via the Internet. Instructions for the training module(s) are listed on the [UT Human Subjects Research Training](#) web page.
3. **HIPAA Training:** Any study personnel who interact with patients or have access to protected health information (PHI) must complete the UT HIPAA Privacy/Security Rule Training through the UT Privacy Office.

Instructions for obtaining access to the University’s HIPAA training are listed on the [UT Human Subjects Research Training](#) page.
4. **Other Training:** The IRB may require a researcher to complete additional or remedial training if the IRB finds that circumstances indicate the training is necessary to fulfill the University’s obligations under the terms of the UT [Federalwide Assurance](#) or to ensure proper protection of *human subjects*.

D. **Required Training – IRB Members:** IRB Members must complete an orientation and the following training upon being appointed to their position.

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1. **General Requirements:** All IRB Members must complete:
 - a) the **General Requirements for Study Personnel** (section C-1 above), and
 - b) their respective CITI IRB Member training modules, either biomedical or social/behavioral. Instructions for accessing the CITI modules can be found on the [UT Human Subjects Research Training](#) page.
2. **Biomedical IRB Members:** All Biomedical IRB Members must complete the UT HIPAA Privacy/Security Rule Training through the UT Privacy Office. Instructions for obtaining access to the University's HIPAA training are also listed on the [UT Human Subjects Research Training](#) page.

VIII. IRB Member Conflict of Interest

A. General Policy:

1. IRB Members shall comply with HHS regulations at [45 CFR 46.107\(e\)](#) that stipulate that *no IRB member may participate in the IRB's initial or continuing review of a project in which the member has a conflicting interest, except to provide information requested by the IRB. Except when requested by the IRB to be present to provide information, IRB members should absent themselves from the meeting room when the IRB reviews research in which they have a conflicting interest, and such should be noted in the IRB meeting minutes.*
2. Each IRB member shall review the UT's Conflict of Interest Policy and sign a certificate of acknowledgment. The certificate must be submitted the **IRB** office.

B. Declaration of Conflict: An IRB who has conflict of interest as defined by UT's Conflict of Interest Policy should declare such conflict to the IRB chair at anytime prior to the review of the study for which the member has a conflicting interest.

C. Recusal from Voting: An IRB member with a conflict of interest must recuse himself or herself from voting. Such recusal shall be recorded in the meeting minutes. The recused member shall not be counted for purposes of determining a *quorum*.

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PROCEDURES

These Procedures describe the required processes for obtaining institutionally and federally required approval to conduct *UT-Related Human Subject Research*.

- I. **Definitions.** Words that appear in bold, italicized text are defined in Section II of the Policies (see page 3 of this document).
- II. **Eligibility to Conduct Human Subject Research**
 - A. **Principal Investigator:** Any *research* involving *human subjects* must be under the supervision of a qualified UT faculty member at or above the level of instructor, or qualified staff member of an equivalent level.
 - B. **Student Research and Resident Fellow Projects:** Student and resident research projects will be reviewed using the same criteria as for any other project. Students and residents may be listed as either study personnel or the student principal investigator. A faculty member must be listed as the principal investigator or faculty advisor.
- III. **General Requirement for Review of Human Subject Research**
 - A. **Responsibility for Review of Research**
 1. **Institutional Review Board (IRB):** The requirement for *IRB* review and approval of research involving *human subjects* is part of *IRB* Policy and Procedures and is required by federal regulations at [45 CFR 46](#). It is the prerogative of the *IRB* to determine whether research is *human subject research*. The *IRB* has primary responsibility for review of *human subject research*.
 2. **University Authority:** Although other University authority may prohibit a project that is approved by the IRB, University authority may not approve a project that is not approved by the IRB. Similarly, the President or other University authority may impose stricter limitations on the conduct of research than the IRB; however, no limitation placed by the IRB may be relaxed or overruled. ([45 CFR 46.112](#))
 - B. **Prior Review of New Research:** Federal regulations, University policy, and ethical guidelines require IRB review prior to beginning any research on *human subjects*. There is no emergency exception for beginning research without prior IRB review. Nothing in these procedures is intended to limit the authority of a physician to provide emergency medical care (see subsection 2 below), to the extent the physician is permitted to do so under applicable federal, state, or local law.
 1. **No Retrospective Approval:** The IRB will not retrospectively approve *human subject research* that begins or occurs without IRB approval, or continues beyond the approval period. Researchers who obtain data through research without current IRB approval shall not use the data in a manner that represents the researcher had IRB approval to conduct the research.
 2. **Emergency Medical Care:** The patient may not be considered a research subject under [45 CFR Part 46](#) when emergency medical care is initiated without prior IRB review and approval. Such emergency care may not be claimed as research, nor may any data regarding such care be included in any report of a prospectively conceived research activity.

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C. Prior Review of Changes to Research:

1. **Prior Approval of Changes:** Any changes to a research protocol, study documents or data collection tools that require IRB approval must be reviewed and approved by the IRB prior to implementing changes. Examples of changes that must be approved by the IRB include, but are not limited to, research methods, data collection tools, change in study personnel, informed consent forms and recruitment materials.
2. **Emergency Situations:** Changes may be made to a research protocol without prior review and approval only under federal guidelines regarding the best interest of the subject in emergency situations such as in clinical research. All emergency changes to a protocol must be reported to the IRB within 5 business days.

IV. IRB Membership and Responsibilities

A. **IRB Membership:** *University* faculty, *University* staff and members of the community are invited to serve on one of the two *University IRBs*. Members with varied expertise and perspectives are needed to enable the *IRB* to conduct thorough reviews of the research and fulfill regulatory membership requirements.

1. **Composition of the IRBs:** The composition of each *IRB* shall be in compliance with [45 CFR 46.107](#), which requires:
 - a) at least five members with varying backgrounds and professional competence appropriate for the type of research reviewed by the IRB,
 - b) at least one member whose primary concerns are scientific areas,
 - c) at least one member whose primary concerns are non-scientific areas, and
 - d) at least one member who is not otherwise affiliated with the institution, or a member of the immediate family member of an affiliated individual.

Every nondiscriminatory effort will be made to ensure that no IRB consists entirely of men or entirely of women, including the institution's consideration of qualified persons of both sexes, so long as no selection is made on the basis of gender. No IRB may consist entirely of members of one profession [45 CFR 46.107(b)].

2. **Qualifications of Chair:** The *IRB* chair should have, prior to appointment, a thorough working knowledge of federal regulations for the protection of human subjects, the Belmont Report, the University's Federalwide Assurance, Terms of the Federalwide Assurance IRB Policies and Procedures, as well as appropriate federal, state and local regulations and laws.
3. **Alternate IRB Members:** An IRB alternate member is a member of the IRB who may serve in the absence of a designated, primary member. Use of an alternate member results in two members for one IRB position. Only one member (either the primary or alternate) for each IRB position may participate in IRB business at one time. The IRB may not record a vote for both a primary and alternate member.

Alternate members' qualifications should be comparable to the corresponding primary member's qualifications to ensure that regulatory requirements for IRB composition are met. An alternate for a non-affiliated member should also be unaffiliated with the University. Alternates for scientific members should have expertise in the same or very similar area as the primary member. Alternates for non-scientific members should also be considered non-scientific.

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4. Appointment of Members:

- a) **Biomedical IRB:** The President of the University or the Provost of the Health Science Campus will appoint members and alternates to serve on the Biomedical *IRB* and shall name the chair of the *IRB*. Recommendations for appointments and re-appointments of individuals other than the chair may be made by the chair, vice-chair or another interested person.
 - b) **Social, Behavioral and Educational IRB (SBE IRB):** The President of the *University* or Provost of the Main Campus will appoint members to serve on the SBE *IRB*. Recommendations for appointments and re-appointments of individuals other than the chair may be made by the chair or vice-chair of the SBE *IRB*.
 - c) **IRB Alternate Members:** Any IRB member may nominate an alternate member for his or her position. The chair, vice-chair or another interested person may also nominate an alternate member for a specific IRB member.
5. **Term of Service:** Terms of members will be three years and will be staggered so that 1/3 of the members will be newly appointed or reappointed each year. There is no limit on the number of terms a member may serve. Members may be removed from the board through written notification from the President or Provost.
6. **Non-IRB Consultants:** In addition to regular members, the IRB may utilize outside experts as needed for adequate review of project. These may vary, except: (a) for FDA related drug studies, two persons licensed to prescribe the drugs must be included in the review process; and (b) when a project involves vulnerable subjects (e.g. prisoners, children or mentally disabled) who will be at greater than minimal risk, a person will be included whose primary concern is the welfare of such subjects.

B. Responsibilities of IRB Members

1. **IRB Member Responsibilities.** IRB membership involves attending one regular meeting per month, and reviewing study proposals prior to the meeting. Members may also be asked to attend an emergency meeting from time to time. IRB members should be prepared to devote several hours per month in preparation for and to attend the IRB meeting. Specific responsibilities of members include:
 - a) **Educational Training:** Complete the required IRB member education [See Policies, Section VII] Develop an understanding of the ethical principles and federal regulations for the protection of research participants. Participate in continued education through workshops, and reviewing current literature in the field, and education presented at IRB meetings.
 - b) **Review and Evaluate Proposed Research:** Contribute to the institution's human research protection program by participating in the review and evaluation of new research proposals and ongoing research investigations. Conduct a thorough review of study materials when appointed as a primary reviewer for a study and be prepared to summarize the study, critique the research and make a recommendation to the board regarding approval.
 - c) **Attend IRB Meetings:** Attend scheduled IRB meetings prepared to discuss proposals and items on the agenda within the member's realm of expertise.

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V. Application Requirements For IRB Review of Research

A. **Submission Deadlines:** Submission deadlines for review of convened research will be set by each IRB. Deadlines may be altered to accommodate holidays and departmental necessity. A schedule of submission deadlines and IRB meeting dates is available on the DHRP web page, or by calling the DHRP or IRB offices.

1. **Biomedical IRB:** Generally, the deadline for the Biomedical IRB is on Monday, three (3) weeks prior to the IRB meeting.
2. **SBE IRB:** For the SBE IRB, the deadline is generally two (2) weeks prior to the IRB meeting.

B. **Application Content for Research Requiring Convened Review by the IRB**

1. **General Requirements:** The complete list of submission requirements is listed in the corresponding IRB application that is posted on each IRB's website. IRB applications that do not meet submission requirements, are incomplete or are improperly completed will be returned to the applicant. This could result in a delay in IRB review depending on the submission deadline. Items that must be submitted include, but are not limited to:

- a) An IRB application;
- b) A complete research protocol;
- c) A complete informed consent form(s);
- d) A complete assent form(s) when minors or others with limited comprehension are potential research subjects;
- e) The most current version of the investigator's brochure(s);
- f) All research data collection tools (surveys, questionnaires, etc.);
- g) All recruitment material or information to be given to subjects or potential subjects;
- h) **Human subject** training verification for any study personnel who have not previously submitted verification of training;
- i) Any additional information pertinent to the study that will assist the IRB in making the determinations set forth in these procedures;
- j) UT conflict of interest disclosure form;
- k) If research will be conducted at a non-UT site, *current IRB approval letters from sites with IRBs, or permission letters on official letterhead from sites without an IRB; and
** a "current" IRB approval letter is one that demonstrates compliance with the site's continuing review requirements, which must require review no less than annually*
- l) Any other document(s) listed on the IRB application.

These requirements may be updated by the DHRP or IRB as necessary to conduct IRB business.

2. **Department of Health and Human Services (HHS) Trials:** The IRB must receive and review a copy of the HHS-approved sample informed consent document and the complete HHS-approved protocol for all HHS-Supported Multi-Center Clinical Trials, unless the document or protocol does not exist.

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C. Application Requirements for Convened Continuing Review

1. Submission of Study Documents and Information For Continuing Review:

Principal investigators must submit all current study related documents and report the progress of the study to the IRB through the Continuing Review Application.

- a) **Required Documents:** The following items must be submitted to the IRB at the time the investigator applies for continued approval of a research study:
- (1) A Continuing Review Application (see contents in section b, below);
 - (2) A complete up-to-date research protocol;
 - (3) A complete informed consent form(s);
 - (4) A complete assent form(s) when minors or others with limited comprehension are potential research subjects;
 - (5) The most current version of the investigator's brochure(s);
 - (6) All research data collection tools (surveys, questionnaires, etc.);
 - (7) All recruitment material or information to be given to subjects or potential subjects;
 - (8) Any additional information pertinent to the study that will assist the IRB in making the determinations set forth in these procedures;
 - (9) UT conflict of interest disclosure form with dated signature; and
 - (10) If research will be conducted at a non-UT site, *current IRB approval letters from sites with IRBs, or permission letters on official letterhead from sites without an IRB;

** a "current" IRB approval letter is one that demonstrates compliance with the site's continuing review requirements, which must be no less than annually to comply with federal regulations*

- b) **Contents of Continuing Review Application:** Principal investigators must provide the following information and data to the **IRB**:
- (1) General study information: study title, name of principal investigator; contact information;
 - (2) Names of study personnel and **human subject** training status;
 - (3) Study funding status;
 - (4) Status of study, e.g. recruitment/enrollment continues; accrual complete/research intervention continues; long-term follow-up, data analysis only/data collection complete
 - (5) The number of subjects approved and actually enrolled;
 - (6) Subject activity status, including the number of subjects who are active, in follow up, completed, withdrawn, and deceased;
 - (7) A summary of unanticipated problems and subject withdrawals;
 - (8) Summary of study: purpose, methods, procedures, progress;
 - (9) Intervention information;
 - (10) Summary of recent literature;
 - (11) Any requested proposed amendments;
 - (12) Any other information requested by the **IRB** on the continuing review application or through oral or written communication.

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2. **Investigator Assurance:** At the time of continuing review, principal investigators must re-affirm their assurance of compliance and agreement to comply with investigator's responsibilities by signing where indicated on the Continuing Review Application.

VI. IRB Review of Research

A. Determination of Level of Review

1. **Assignment of Category:** *Human subject research* applications and protocols are reviewed by the DHRP or the IRB office staff under the regulations set forth in [45 CFR 46](#) and placed into one of three categories: convened review, expedited review or exempt. The DHRP may also determine that a certain application is not *human subject research* under the definitions set forth in [45 CFR 46.102](#). It is the prerogative of the DHRP and IRB to determine whether proposed research is *human subject research* and which category of review is appropriate for the research.
2. **Exempt Determination:** Only *human subject research* that is designated exempt by the *IRB* is exempt from *IRB* review. Investigators may not make an independent determination that their research proposal is exempt.
3. **Discretionary Elevation of Level of Review:** Research that qualifies for exempt review may be reviewed by the *IRB* under expedited or convened review at the discretion of the *IRB* chair. Research that qualifies for expedited review may be reviewed by the *IRB* under convened review at the discretion of the *IRB* chair.

B. General Guidance Relevant to Initial and Continuing Review: In accordance with [45 CFR 46.108\(b\)](#), initial and continuing reviews of research must be conducted by the IRB at convened meetings with a *quorum* of members present, except where expedited review is appropriate under [45 CFR 46.110\(b\)\(1\)](#). Permissible categories of research that may be expedited are listed in the [Federal Register of November 9, 1998](#) (63 FR 60364-60367) (See [Appendix B](#)). The IRB must make the findings required by [45 CFR 46.111](#) prior to approving *research*.

C. Expedited Review Of Research: Research that is eligible for expedited review under [federal guidelines](#) may be reviewed under the expedited review procedures set forth in [45 CFR 46.110](#). At the discretion of the IRB chair, research that is eligible for expedited review may be reviewed under the convened review procedures.

1. **IRB Members Authorized To Conduct Expedited Review of Research Proposals:** The IRB Chair and any chair-designated IRB member from among experienced reviewers may conduct expedited review of research. A letter from the IRB Chair designating an IRB member's authority to conduct expedited reviews shall be placed in the IRB member's file in the IRB office.
2. **Required Findings:** In addition to the findings required by [45 CFR 46.111](#), approval of research under the expedited review procedure requires that the Chair or Chair Designee find and document:
 - a) The research activities involve no more than minimal risk;
 - b) The research is within a permissible category justifying expedited review authorized by [45 CFR 46.110](#). The reviewer shall document the specific category;
 - c) Identification of subjects and their response, or collected data, will not reasonably place them at risk of criminal or civil liability or be damaging to

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them (e.g. financial standing, insurability, reputation) 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; and

- d) The informed consent form is adequate based on federal regulatory guidelines.
- 3. **Authority of Reviewer:** In reviewing the research, the reviewers 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 by the convened IRB.
- 4. **Approval Period:** The approval of expedited research shall be valid for one year from the date of review unless new information is obtained (e.g. serious unexpected events) and the chair determines that the study should be reviewed by the full board.
- 5. **Reporting Expedited Actions To The IRB:** Research proposals approved under the expedited review procedure shall be placed on the IRB agenda of the next IRB meeting. The agenda shall list the title of the study, the name of the principal investigator, the category of expedited review and the IRB file number. The chair shall call these items to the attention of the board and allow time for any questions or discussion by the IRB. The full IRB file for these studies will be available for inspection by IRB members at the convened meeting or in the IRB office.

D. Convened Review of Research

1. Process for Initial Convened Review of Research

- a) **IRB File Assignment:** New applications for convened review are logged into the IRB Database and assigned an IRB number. An IRB research file is created for each new study. The study is then entered onto the agenda for the IRB meeting at which the study will be reviewed.
- b) **Primary Reviewer System:** Primary reviewer(s) are required to conduct an in-depth review of all documents distributed to them. All other IRB members will receive and should review at a minimum a protocol summary (of sufficient detail to make the determinations required under [45 CFR 46.111](#)), the informed consent document, and any recruitment materials. The complete set of documents is available to all members for review.

(1) Documents Distributed to Primary Reviewers:

- (a) Primary reviewer worksheet
- (b) IRB Application
- (c) Full protocol
- (d) Proposed informed consent form
- (e) Any recruitment materials, including a written transcript of any audio or video advertisements
- (f) Any relevant grant application(s)
- (g) Investigator's brochure (if applicable)

(2) Documents Distributed to Each IRB Member:

- (a) All documents distributed to the primary reviewers are distributed to IRB members via the University's secured computer network, except for grant applications and investigator's brochures, which are available in the IRB office.

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- (b) Copies of completed primary reviewer worksheets are distributed to IRB members via the University's secured computer network.

2. IRB Voting and Actions:

- a) **Assurance of Minimized and Reasonable Risk:** Prior to approving any research project, the IRB must assure, regardless of category, that (a) risks to subjects are minimized, and (b) that risks are reasonable in relation to any anticipated benefits.
- b) **Voting:** Voting at a convened **IRB** meeting will occur only if a **quorum** of **IRB** members are present. Should the **quorum** fail during a meeting (e.g., by recusal of members with conflicting interests, early departures, or absence of a non-scientist member), the IRB may not vote unless a **quorum** can be restored. Voting may not occur if a member with a conflict-of-interest is present or if members have not had time to adequately discuss the research.

(1) **Voting Options:** A member has five options when voting:

- (a) **Approve As Submitted:** A member shall vote to approve a study when the member approves of the study as presented to the IRB.
- (b) **Approve With Minor Modifications:** A member shall vote to approve a study with minor modifications when the board has concurred on explicit simple minor revisions to be reviewed by the chair or chair designee, and the member agrees that the study may be approved after completion of those revisions.
- (c) **Not Approve:** A member shall vote to not approve a study when the member finds that there are a substantial number of significant concerns, questions or problems with the study that cannot be addressed with modifications.
- (d) **Defer:** A member shall vote to defer a study for review at a later meeting when the member finds that there are a substantial number of significant problems with the study or consent form, or if there is a lack of adequate information provided, and that these issues have the potential for being adequately addressed with modifications.
- (e) **Abstain:** A member shall abstain from voting when the member feels that he or she should not vote on the study. Members who miss a portion of IRB deliberations or do not understand the study or the issues may abstain from voting. A member who abstains will be included for purposes of determining whether a quorum is present. Members who choose to abstain shall not have a conflict of interest.
- (f) **Recuse:** A member shall recuse himself or herself from voting when the member has a conflict of interest. A member with a conflict-of-interest may be in the meeting room for presentation of a research project but must leave the room during deliberation and voting.

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- c) **IRB Actions:** Following IRB deliberations, the IRB chair shall take a vote of the IRB members. A successful vote requires a majority vote of the quorum of members or their alternates (an alternate member may not vote if the regular member votes). The following actions may be taken:
 - (1) Approve
 - (2) Approve With Minor Modifications
 - (3) Defer
 - (4) Not Approve
 - (5) Table: A study should be tabled when there is a lack of appropriate expertise in attendance; a lack of sufficient information to conduct an adequate review; a lack of time; or loss of a quorum.
- d) **Review of Investigator's Response to Request for Minor Modifications**

When the IRB approves a study with minor modifications, the IRB Chair, or chair designated IRB member shall review an investigator's response to the IRB letter requesting specific minor clarifications or changes. If the investigator makes all requested clarifications or changes, the IRB Chair or chair designee shall approve the research.

If a satisfactory response is not received, the investigator shall be notified and the study shall be deferred until the next IRB meeting. The IRB will be notified at the next meeting that a satisfactory response was not received from the investigator. The investigator may be invited to the meeting to discuss the study with the board, provided the investigator leaves the meeting prior to any deliberations or voting by the board.
- e) **University Official Action:** University officials may disapprove research that has been approved by the IRB, but they may not approve research that has not been approved by the IRB.

E. Continuing Review Of Research (Convened and Expedited Review Research)

- 1. **General Requirement for Continuing Review:** Except for research protocols determined to be exempt by the *IRB*, all *human subject research* is subject to continuing review at intervals determined by the *IRB* based on the risk to study subjects. Federal regulations require continuing review of research at appropriate intervals based on the degree of risk to subjects, and no less than annually. Extensions of approval periods are prohibited.
 - a) **Convened Review Research:** The appropriate length of approval is determined by the convened IRB using the procedures described below.
 - b) **Expedited Review Research:** Only research involving no more than minimal risk to subjects is eligible for expedited review. Therefore, the approval period for expedited review research is generally one year, unless there are concerns regarding the primary investigator's experience, qualifications, or previous non-compliance.
 - c) **Exempt Research:** Continuing review is not required for research classified as exempt from IRB review. However, any change to a study's procedures that could elevate the review classification to expedited or convened must be reviewed by the IRB.

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2. **Procedures For Determining Frequency Of IRB Review:** During the initial and each continuing review (or as otherwise warranted), the IRB will plan for continuing review at intervals appropriate to the degree of risk, but not less than once per year.
 - a) **Primary Reviewer Recommendation of Review Frequency:** When reviewing a more than minimal risk study, the primary reviewer(s) of a study shall make a recommendation to the IRB regarding the frequency of review of the study based on the procedures listed below. Research must be reviewed at least annually.
 - b) **Considerations for Determining Approval Period:**
 - (1) **Factors to Consider:** In determining which projects require review more often than annually, IRB members shall consider:
 - (a) the degree of risk to subjects and any minimization of those risks;
 - (b) more than minimal risk studies using vulnerable populations;
 - (c) the experience and qualifications of the primary investigator;
 - (d) any previous non-compliance by the primary investigator or study personnel;
 - (e) for FDA regulated studies, the trial phase assigned by the FDA
 - (2) **Specific Types of Research Requiring Review More Frequently Than Annually:** The following categories of research should be approved for less than one year.
 - (1) Phase I Clinical Trials. The IRB approval period shall be either:
 - (a) not more than six months, or
 - (b) not more than six months after the first subject is enrolled or one year, whichever date occurs first.
 - (2) More than minimal risk research involving a vulnerable population with no prospect of direct benefit to the individual participants.
3. **Review of Amendments Do Not Effect Continuing Review Date:** Review of a change in a protocol ordinarily does not alter the date by which continuing review must occur. This is because continuing review requires full review of the protocol.
4. **Determining Approval Period During Continuing Review:** The IRB shall make a new determination regarding the time period for IRB approval during continuing review. In addition to factors listed above, IRB members shall consider unanticipated problems, adverse events, available information regarding withdrawal of subjects, investigator non-compliance or misconduct, and any other information related to risks associated with the research.
5. **Notifying Investigators:** Principal investigators are notified of the expiration date of IRB approval, as well as any limitations of approval, in the initial and continuing review approval letters. Reminder notices may be sent by the DHRP or IRB as a courtesy to investigators, but should not be relied upon exclusively. Investigators are responsible for tracking approval dates and expiration of approval, and applying for continuing review allowing ample time for the IRB process (two months prior to expiration is recommended for convened studies).

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6. **Authority to Reduce Approval Period:** The IRB may reduce the time period of approval at any time during the approval period when warranted based on risk to subjects, investigator non-compliance or misconduct, or any other factor that could jeopardize the health or welfare of a study subject.
7. **Continuing Review by the IRB:**
 - a) **Criteria For Continued Approval of Research:** The IRB uses the same criteria for approval during continuing review of research as is used for initial approval of research (see [45 CFR 46.111](#)).
 - b) **Documents and Information Distributed to Members:** In conducting continuing review of research not eligible for expedited review, all IRB members will receive and review at a minimum a protocol summary, informed consent form, and status report on the progress of the research.
 - c) **Review Process:** The IRB will follow the same process detailed in the explanation of the initial review of research, except that a progress report must also be reviewed.

Research reviewed under the expedited procedure during the last IRB review (initial or continuing) may undergo expedited continuing review if the research continues to qualify for expedited review. The primary reviewer or an individual authorized to make the determination that review of the research may be expedited must determine, that the research continues to qualify for expedited review.

- d) **Calculation of Approval Period and Expiration Date.** The expiration date of research shall be calculated as follows:
 - (1) Convened Review - For research receiving full board review, the approval period is calculated from the date of the IRB meeting during which the research was reviewed.
 - (2) Expedited Review – Expiration of expedited studies are calculated from the date the IRB Chair or Chair Designee reviewed the research.
- F. **Verification of No Material Changes:** The IRB will consider whether verification from sources other than the investigator that no material changes have occurred since previous IRB review. Examples of when the IRB may require verification from other sources include:
1. **Pattern of Submitting Incorrect Versions of Required Documents:** The investigator or responsible study coordinator has a pattern of submitting the wrong version of documents that the IRB must review such as the protocol or consent document;
 2. **History of Late Reporting of Adverse Events:** The principal investigator has a history of late notification to the IRB of adverse events or unanticipated problems;
 3. **Previous Late Reporting of Changes in Research:** The IRB has knowledge that the principal investigator previously implemented changes to any human subject research (other than emergency changes solely for the protection of study subjects) without prior approval from the IRB; or
 4. **Report of Changes to Research:** The IRB receives a report from a third party that the research has deviated from the IRB approved protocol.

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- G. IRB Observation of Informed Consent Process:** When deemed necessary by the IRB chair or the IRB members, the IRB will exercise its authority to observe or have a third party observe the informed consent process or the research [[45 CFR 46.109\(e\)](#)]. This determination may be made during initial review, continuing review, following a report of an adverse or unanticipated event, following a report of investigator non-compliance, or at random as part of the IRB's compliance oversight responsibilities.
- H. Emergency Review of Convened Research**
1. **Emergency Meeting:** In exceptional circumstances, the IRB chair may call an emergency meeting of the **IRB** at his or her discretion to review a study or change to a research protocol. When requesting emergency review of research, the applicant should set forth in writing why an emergency meeting is justified. Standard submission requirements, other than submission deadlines, apply to emergency review of research. An emergency meeting will only be held if a quorum of the members is able to attend the emergency meeting.
 2. **Procedure for Review:** Emergency review of research shall follow the same procedures as for the regular review of research, except that **IRB** procedures that are not a federal or state regulatory requirement may be altered to the extent necessary to complete review of the research under the circumstances.
- I. Research Exempt from IRB Review**
1. **Exempt Categories:** Research activities involving *human subjects* that are exempt from IRB review are identified in 45 [CFR 46.101\(b\)](#). None of the exemptions apply to research involving prisoners, fetuses, pregnant women, or human in vitro fertilization. Neither the University nor the IRBs may create a new category of exempt research.
 2. **Authority to Determine That Research Is Exempt:**
 - a) **Authorized Individuals:** A determination that research is exempt under [45 CFR 46.101\(b\)](#) may be made by the following:
 - (1) The **IRB** Chair, vice chair or chair designee
 - (2) The DHRP Director of Regulatory Compliance
 - b) **Unauthorized Individuals:** **OHRP** advises that investigators should not have the authority to make an independent determination that research involving *human subjects* is exempt. Therefore, investigators must check with the **IRB** or other designated authorities concerning the status of proposed research or changes in ongoing research prior to engaging in the research.
- J. Reporting IRB Actions To Investigators:** Investigators will generally receive written notice of the action taken by the **IRB** in regard to their protocol. When the application corresponds to a student research project, the student investigator will also be notified.
1. **IRB Approval of Research:** Written notification from the **IRB** to the investigator gives the investigator IRB approval to conduct the proposed research as presented to the IRB. No involvement of *human subjects* (including tissues, data and other activities under the realm of *humans subject research*) is permitted before such approval.

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2. IRB Request for Modifications Prior To Approval

- a) **Convened Review Research:** The IRB staff will send a letter to the principal investigator or study coordinator with specific requests for modifications. When the study is a student research project, the student investigator will be contacted in addition to the primary investigator.
- b) **Expedited Review Research:** The IRB chair or chair-designated reviewer will contact the principal investigator or study coordinator with requested modifications or changes.

3. **IRB Disapproval of a Research Study:** The IRB will send written notification to the principal investigator, and the student research for student projects, when the IRB has disapproved a study following convened review.

K. Reporting IRB Actions To University Officials

Each IRB office will send a finalized copy of monthly IRB meeting minutes, no less than quarterly, to the President of the University, each respective Provost or Provost designee and the Vice President of Research Administration.

L. IRB Information Regarding Student Research; Thesis and Dissertation Projects; Instructional Projects

1. **Thesis and Dissertation Projects:** At the university level, a thesis or dissertation involving *human subjects* is not considered approved until the **IRB** has given approval relative to the use of those subjects. The appropriate faculty advisor or committee(s), as determined by departmental or college policies, must approve thesis and dissertation projects before submission to an **IRB** for review. In addition, any other required approvals (e.g., departmental, college, University or outside agency) should be secured prior to submission and copies of those approvals appended to the research application.
2. **Instructional Projects Using Human Subjects:** UT recognizes the need for diverse instructional projects utilizing human beings. However, the University makes no exception to the principle that there is always an underlying responsibility for the protection of privacy, dignity, and welfare. When comparing instructional projects and research projects, the difference lies not in the principles of sound and ethical practice, but in the focus of responsibility for monitoring compliance with those concerns.
 - a) **Exempt Projects:** In a number of departments, it is customary for undergraduate courses to incorporate small projects that have many of the characteristics of research, and involve using other persons as project resources. The usual purpose of these projects is to provide an opportunity for students to develop familiarity with the means of investigation customary to the various disciplines. These projects teach the development of student knowledge and skills. Collected data is not used for research purposes. To the extent that regular courses involve projects with this intention, which would not later be used as part of a research project, and that do not put persons at risk, such projects do not meet the definition of *human subject research* and therefore do not need to be submitted to the **IRB** for approval. However, participation in such projects should be voluntary and based upon appropriate informed consent.
 - b) **Non-Exempt Projects:** The following are not exempt from **IRB** review: internships, research practica, independent study, independent research, honors projects, thesis, dissertation, and other formal research projects of

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undergraduate students, graduate students, faculty and staff. In addition, course projects that are classified by [45 CFR 46](#) and these Procedures as requiring convened review must also be reviewed by the **IRB**.

M. Reporting Research Issues To The IRB, University Officials And Federal Authorities:

1. **Reportable Event:** The following events must be promptly reported to the **IRB** members, **Institutional** Officials, any federal Department or Agency head, and **OHRP** when required by regulation:
 - a) Any unanticipated problems involving risks to subjects or others (hereinafter referred to as *unanticipated problems*)
 - b) Any serious or continuing noncompliance with 45 CFR Part 46 or the requirements or determinations of the IRB; and
 - c) Any suspension or termination of IRB approval.
2. **Procedures and operational details:**
 - a) Upon receipt of information indicating a potentially Reportable Event, the DHRP shall promptly conduct any investigation necessary to compile a complete report of the potentially Reportable Event. The completed report will be submitted to the Vice President for Research Administration for review. The IRB Chair or Vice President for Research Administration may call a meeting of appropriate individuals, or designate a member of the DHRP to promptly conduct further investigation.
 - b) Upon completion of the investigation, the Vice President for Research Administration shall determine if the occurrence constitutes a Reportable Event and shall notify the Signatory Official, the DHRP Director of Operations, DHRP Director of Regulatory Compliance and the appropriate IRB Chair of this decision.
 - c) Reports shall be made to OHRP Institutional Officials, any federal Department or Agency head, and OHRP no later than seven (7) business days after a determination is made that the event is considered a reportable event.
 - d) Reportable Events shall be placed on the IRB agenda of the next IRB meeting and reported to the IRB members by the IRB Chair at the meeting.
 - e) The UT President, appropriate Provost (as determined by the primary investigator's department), Dean of the primary investigator's department, OHRP, and if applicable, the FDA shall be promptly notified in writing of OHRP or FDA reportable events.

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VII. IRB Operations and Record Keeping

A. Responsibility For Maintenance of Records: All records, files and materials of the *IRB* will be maintained through the *DHRP*, under the direction of the *DHRP's* Director of Operations.

B. IRB Records and Documentation

1. **Contents of IRB Research Files.** The IRB that reviews the study shall maintain the file for the project. IRB research files shall contain the following:
 - a) All information stipulated by federal regulations at [45 CFR 46.115\(a\)\(1\), \(3\), \(4\) and \(7\)](#):
 - (1) Copies of all research proposals reviewed, scientific evaluations, if any, that accompany the proposals, approved sample consent documents, progress reports submitted by investigators, and reports of injuries to subjects,
 - (2) Records of continuing review activities,
 - (3) Copies of all correspondence between the IRB and the investigators,
 - (4) Statements of significant new findings provided to subjects, as required by [§46.116\(b\)\(5\)](#);
 - b) Completed IRB forms (e.g. applications, requests for amendments, adverse event reports, final reports);
 - c) IRB approval memorandums; and
 - d) The following additional items, when applicable:
 - (1) Grant information
 - (2) Clinical trial agreement
 - (3) Conflict of interest forms
 - (4) Investigator Brochure
 - (5) Sponsor generated amendment information
 - (6) UT IRB approved Authorization for Use and Disclosure of Protected Health Information (PHI) Forms (if not included in consent form)
 - (7) UT IRB approved assent forms
 - (8) Med Watch forms (FDA safety information and adverse event reporting)
 - (9) Sponsor safety updates and sponsor adverse event information
 - (10) Data Safety Monitoring Board (DSMB) reports and updates
 - e) Information regarding research at non-UT sites, when applicable:
 - (1) Institutional or site permission letters from non-UT sites
 - (2) IRB Approval Memos and Approval Consent/Assent Authorization Forms from non-UT Sites
 - (3) Correspondence from non-UT sites
2. **Minutes of IRB Meetings.** Minutes of IRB meetings will be maintained in the office of the IRB that generated the minutes.

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- a) **General Content of Minutes:** Minutes of IRB meetings shall be in conformance with [45 CFR 46.115](#), which requires
 - (1) sufficient detail to show attendance at meetings;
 - (2) actions taken by the IRB; the vote on these actions including the number of members voting for, against, and abstaining;
 - (3) the basis for requiring changes in or disapproving research; and a written summary of the discussion of controverted issues and their resolution.
 - b) **Risk and Approval Period:** IRB minutes shall contain documentation regarding risk and approval period as described in these procedures.
 - c) **Other Content:** IRB minutes shall document specific findings required by federal regulations as described below (“IRB Documentation of Other Specific Findings”).
3. **IRB Documentation of Other Specific Findings:** When federal regulations require specific findings by the IRB, the IRB shall make and document such findings.
- a) **General Policy:** For research reviewed through the convened or expedited review process, when applicable, the IRB shall document its findings regarding alternative consent procedures; waiver of signed consent; research involving pregnant women, human fetuses, or neonates, research involving prisoners; and research involving children.
 - (1) **Convened Review:** All required findings should be fully documented in the minutes of the IRB meeting, including protocol-specific information justifying each IRB finding.
 - (2) **Expedited Review:** The IRB Chair or chair-designated reviewer should document all required findings and file such documentation in the IRB study file.
 - b) **Alternative Consent Procedures**
 - (1) **General Requirement for Altered Consent:** The IRB shall make and document the findings required by [45 CFR 46.116\(d\)](#) ([See Appendix C](#)) when approving a consent procedure which does not include, or which alters, some or all of the required elements of informed consent or when waiving the requirement to obtain informed consent.
 - (2) **IRB Documentation:** When approving such a waiver for research reviewed by the convened IRB, these findings should be documented in the minutes of the IRB meeting, including protocol-specific information justifying each IRB finding.
 - c) **Waiver of Obtaining a Signed Consent Form:** The IRB shall make and document the findings required by [45 CFR 46.117\(c\)](#) when approving a procedure which waives the requirement for obtaining a signed consent form.
 - d) **Research Involving Pregnant Women, Human Fetuses, or Neonates:** The IRB shall make and document the findings required by [45 CFR 46.204-207](#) when approving research involving pregnant women, human fetuses, or neonates.

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- e) **Research Involving Prisoners:** The IRB shall make and document the findings required by [45 CFR 46.305-306](#) when approving research involving prisoners.
 - f) **Research Involving Children:** The IRB shall make and document the findings required by [45 CFR 46.404-407](#) when approving research involving children.
4. **Documentation of Risk and Approval Period.** The IRB must determine which protocols require continuing review more often than annually, as appropriate to the degree of risk [see [45 CFR 46.103\(b\)\(4\)](#) and [46.109\(e\)](#)]. IRB minutes must clearly reflect these determinations regarding risk and approval period.
5. **Retention of IRB Records.** IRB records shall be retained for at least 3 years.
Retention of investigators' research records is discussed in section III-B, above.

VIII. Investigator Responsibilities

Although investigators and research staff are responsible for complying with all DHRP Policies and Procedures, the following outlines major responsibilities that each investigator must understand and agree to prior to engaging in *UT Related Human Subject Research*.

A. Primary Investigators

1. **Comply With Regulatory Authority, Ethical Standards and DHRP/IRB Policies and Procedures**
 - a) **Compliance with Regulatory and Ethical Standards for Conducting Human Subject Research.** Applicable regulatory and ethical standards are listed in the Policies Section IV of this document (*Compliance Requirements*).
 - b) **Compliance With UT DHRP Research Policies and Procedures:** All investigators and study staff participating in *research* involving *human subjects* must familiarize themselves and agree to comply with DHRP Policies and Procedures. These Policies and Procedures were written based on federal regulatory guidance provided by OHRP and contain requirements based on both federal and state laws and regulations.
2. **Obtain IRB Approval Before Starting Research.** Researchers must obtain IRB approval to conduct *human subject research* prior to beginning any research activity. A determination that *human subject research* is exempt from *IRB* review may only be made by the IRB or DHRP staff.
3. **Obtain and Document Informed Consent:** Unless the *IRB* has granted a waiver of all or some of the consent process, the investigator or his/her representative must explain the nature of the study to the subject, or the subject's legally authorized representative and answer all questions regarding the study. Prior to any study-related screening procedures being performed on the subject, the *IRB* approved informed consent form must be reviewed, signed and dated by the subject, or the subject's legally authorized representative, and the person who administered the informed consent. A copy of the informed consent form must be given to the subject, a copy placed in the subject's medical record if the subject is a patient, and the original shall be placed in the investigator's file. A dated entry must also be made in the patient/subject's medical record to confirm that informed consent was obtained prior to any study-related procedures and that the subject received a signed copy.

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4. **Protect Confidentiality.** Breach of confidentiality is a risk to subjects that has the potential to cause significant harm. The principal investigator and all research staff are responsible for protecting the confidentiality of research subjects and all research records. The principal investigator must have sound plans written into the study protocol for ensuring confidentiality. The IRB is especially concerned with confidentiality and will not approve studies that do not have adequate confidentiality protections in place for subjects.
5. **Report Any Injury or Unanticipated Problem or Adverse Event Involving Risk To Subjects According Within The Time Required By IRB Procedures.** The principal investigator must notify the IRB of any injury or unanticipated event involving risk to subjects. The required timeline for reporting unanticipated events ranges from 24 hours to 30 days, depending on the severity of the event. Fatal or life threatening events, regardless of whether related to the research, must be reported within 24 hours. Most other events must be reported within 5 days. Events that are not serious or are definitely unrelated to the study must be reported within 30 days.
6. **Report When UT Research Subjects Are Admitted Into Other Institutions For Research Purposes.** Investigators will advise the UT IRB, Research & Sponsored Programs/Administration and the appropriate officials of other institutions of the intent to admit *human subjects* into another institution (e.g., into another hospital) who are involved in research protocols. When such admissions are a planned part of DHHS-supported research, those institutions must possess an applicable Human Research Federalwide Assurance prior to involvement of such persons as *human subjects* in those research protocols at those institutions.
7. **Obtain Approval To Continue Research Prior to Expiration of IRB Approval.** IRB approval must be maintained throughout the performance of all research activities including data collection and analysis. IRB approval expires on the date designated by the IRB at the time of initial review. Federal regulations limit approval periods to one year or less depending on the degree of risk to subjects. Federal administrators prohibit extensions of approval periods without continuing IRB review. It is the responsibility of the Principal Investigator to have a reminder system in place to initiate continuing review, allowing ample time for the IRB review process. If IRB approval has expired, research activities must stop, unless stopping would harm the subject, and no new subjects may be enrolled in the study until IRB review and approval has been obtained.
8. **Comply With HIPAA Requirements Including HIPAA Training When Research Involves Protected Health Information (PHI).** Comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) when research involves protected health information. Regulations require that all researchers be trained on HIPAA regulations and measures for compliance. Principal investigators must assure that all key personnel involved in the research, especially personnel with data access and patient contact, have completed the *IRB* required HIPAA training for researchers. If consent or authorization is revoked by a subject, it is the responsibility of the P.I. to obtain the required signed document(s) and submit these to UT's Health Information Management Department as required by institutional policy in compliance with the HIPAA Privacy Rule ([45 CFR 164](#)).
9. **Submit A Final Report Upon Completion Of Research.** Principal investigators must submit a Final Report (IRB Form) to notify the IRB that the investigator's study has terminated and report general information to the IRB such as the number of subjects

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involved, the duration of subject involvement, serious adverse events and a summary of the project results. The IRB must be review and approve the Final Report.

10. **Retain Research Records For The Applicable Time Period:** The length of time that research records must be maintained by the principal investigator depend on a number of factors. The IRB requirement is three (3) years, however, other authorities require longer retention periods. Principal investigators are responsible for determining how long their research records and consent forms must be retained. Records should be retained for the longest applicable period.
- a) **IRB Requirement:** For purposes of IRB requirements, principal investigators must maintain study records for three (3) years following the expiration of IRB approval.
 - b) **Regulatory and Institutional Requirements:** Although it is beyond the scope of the DHRP to provide advice on authority outside of the DHRP, investigators should consider the following when determining applicable retention periods:
 - (1) State of Ohio rules and regulations,
 - (2) HIPAA Privacy Rule,
 - (3) Institutional Requirements,
 - (4) Sponsor Requirements, e.g. Clinical Trial Agreement,
 - (5) FDA Regulations,
 - (6) *ICH GCP Guidance* (Applies to FDA Regulated Research), and
 - (7) Other laws, regulations or guidance applicable to the research.

B. Student Investigators; Research Conducted by Interns and Residents: Students, interns and residents conducting human subject research share the same responsibilities as primary investigators when conducting human subject research. They must comply with the same *University* and *DHRP* Policies and Procedures when conducting *human subject research*, including obtaining and maintaining approval for research projects. Students, interns and residents are advised to contact the *IRB* directly with questions related to the IRB process.

IX. Research Conducted Off-Campus or With a Non-UT Researcher

Principal investigators planning to conduct *human subject research* at sites other than UT or with non-UT investigators must meet certain requirements of the *DHRP* and *IRB*. Requirements for conducting off-campus research range from a simple letter of permission from the site to a formal dual-review process.

A. Investigator Responsibilities

- 1. **Compliance with *UT Federalwide Assurance*:**
- 2. **Submit Written Description of Off-Campus Research to the IRB:** A principal investigator must submit a written description of the non-UT institution's involvement and of any non-UT investigator's or study personnel's participation to the IRB office prior to beginning any research activity. The description shall also include the following information:
 - a) All research sites, including (1) the address of non-UT sites, and (2) Whether the site holds a *Federalwide Assurance*
 - b) All research staff, including (1) institutional affiliations of each person, and (2) title and address of each person

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3. **Additional Prerequisites:** The **IRB** will notify the principal investigator of any additional requirements that must be met prior to beginning the research. The principal investigator is responsible for completing those requirements prior to beginning the research. Examples of prerequisites include, but are not limited to:
 - a) A letter of permission from a non-assured research site when all investigators are UT faculty, staff or students, or
 - b) Full UT IRB application, review and approval in addition to IRB review by an assured research site.
 - c) Execution of an individual investigator agreement drafted by the DHRP for research conducted at a non-assured site in collaboration with an investigator who is not a UT faculty, staff or student member.

B. Collaborative Research With Researchers or Institutions That Are Not Federally Assured

1. General Requirements

- a) The research is being conducted under the direction and supervision of a principal investigator from UT (the assured institution)
- b) The collaborating institution or investigator does not hold an **FWA** (hereafter referred to as *non-assured institutions*) and does not routinely conduct human subjects research.
- c) Extension of UT's **FWA** to Cover Collaborating Individual Investigators

2. Types of Collaborations: *UT Related Research* may involve one of two types of collaborating individual investigators: collaborating independent investigator, or a collaborating institutional investigator.

- a) A collaborating independent investigator is:
 - (1) not otherwise an employee or agent of UT;
 - (2) conducting collaborative research activities outside the facilities of UT; and
 - (3) not acting as an employee of any institution with respect to his or her involvement in the ***UT-Related Research***.
- b) A collaborating institutional investigator is:
 - (1) not otherwise an employee or agent of UT;
 - (2) conducting collaborative research activities outside of UT facilities;
 - (3) acting as an employee or agent of a non-assured institution with respect to his or her involvement in the research being conducted by UT (the assured institution); and
 - (4) employed by, or acting as an agent of, a non-assured institution that does not routinely conduct human subjects research.

C. Research Conducted In Collaboration With A Federally Assured Institution

Research conducted in collaboration with external federally assured institutions shall be documented through an **IRB** agreement approved by the **DHRP** and signed by the signatory official or official's designee. Collaborative research includes:

1. Reliance on an external IRB holding an FWA
2. An external institution relying on a UT IRB for review of a protocol

The UT principal investigator should contact the IRB to initiate the IRB agreement process.

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X. IRB Compliance Activities

- A. **IRB Compliance Monitoring and Corrective Action.** The *DHRP* is responsible for coordinating and supporting *IRB* compliance monitoring and corrective action. Compliance monitoring activities will be conducted by each UT IRB at least monthly.
1. **Non-Compliance Reporting.** Any person or entity may report suspected or confirmed *Non-Compliance*. Mechanisms for reporting include:
 - a) Written notice to the IRB or DHRP. This may be submitted anonymously.
 - b) Electronic Mail Notification to the IRB
 - (1) The Biomedical IRB at IRB.Biomed@utoledo.edu
 - (2) The SBE IRB at IRB.SBE@utoledo.edu
 - c) Anonymous Reporting through Ethics Point
 2. **Compliance Support Visits – Random Compliance Monitoring:** The DHRP and IRB shall select human research studies at random to review for regulatory and institutional compliance. These visits shall be conducted in a manner that offers compliance support to investigators. When substantial non-compliance (serious or continuing) is found during a Compliance Support Visit, the person in charge of the visit shall submit a report of non-compliance to the DHRP and follow the Compliance Oversight Review and Evaluation Process described in section XVI-B, below.
 3. **Compliance Oversight Review and Evaluation (CORE) Process – For Cause Compliance Investigations:** The DHRP is responsible, together with the IRB, for Compliance Oversight. In those instances where there are concerns regarding non-compliance with regulatory, institutional or IRB policies or procedures, the DHRP and the IRB will take the actions described in these procedures. These procedures apply to all research activities of faculty, staff, students and others involved in human subject research at the University.
 - a) **Investigation by DHRP.** Following a report of non-compliance, the DHRP shall conduct an investigation and issue a written report to the members of the corresponding IRB.
 - (1) **Committee Formation.** The CORE Committee shall consist of at least three persons. The IRB Chair of the corresponding IRB will serve as the chair of the CORE Committee. At least two CORE Committee members shall be selected from the list of eligible primary members.
 - (a) Primary CORE Committee members may include:
 - (i) IRB Chair(s)
 - (ii) DHRP Director of Operations
 - (iii) DHRP Director of Regulatory Compliance
 - (b) The following individuals may also be included on the CORE committee:
 - (i) IRB Vice-Chair(s)
 - (ii) IRB Chair Designee(s)
 - (iii) Departmental representative(s)
 - (iv) UT legal counsel member(s)

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- (2) **Committee Meeting With Investigator:** The DHRP shall send a written request to the researcher for a personal meeting with the CORE Committee. The written request shall provide a list of any initial documents or information requested by the committee, notify the researcher that he or she should provide any additional documents that would aid the committee in the investigation, and provide a deadline for submission of the documents. If the committee discovers during or after the meeting that additional documents are needed, the committee shall promptly request the documents from the researcher.
- (3) **Additional Meetings:** If deemed necessary, the DHRP shall make a written request for a meeting between any other person with relevant factual knowledge of the alleged non-compliance.
- (4) **Data Analysis and Preparation of CORE Committee Report:** The CORE Committee shall conduct an analysis of the information gathered and presented to the Committee and draft a report for review by IRB members.

(a) Contents of Report:

- (i) Describe the allegations or indications of non-compliance, protocol deviations or protocol violations;
 - (ii) Document the results of investigations as established in the DHRP records regarding study approvals and the potential non-compliance, including any additional findings of non-compliance;
 - (iii) Report on the responses (written and oral) from investigators and any other individuals regarding the allegations or indications of non-compliance and any documentation submitted by or obtained from the researcher;
 - (iv) Summarize any relevant IRB records (e.g. IRB application) pertaining to the study and explain any deviation or non-compliance; and
 - (v) Suggest a corrective action plan for review by the relevant IRB if the investigation confirms any non-compliance.
- (5) **Report of Findings:** The CORE Committee shall submit the completed committee report to the relevant IRB and the Vice President for Research Administration.
 - (6) **Continuing Oversight:** The CORE Committee shall develop a plan for continuing oversight review and re-evaluation procedures if deemed appropriate by the CORE Committee.

b) IRB Review of Alleged Non-Compliance

- (1) **Review and Determination of Corrective Action.** The convened IRB will review the report and make an independent determination of whether there was a substantive (serious or continuing) non-compliance and if so:

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- (a) Whether any sanctions should be instituted and what they should be; and
 - (b) What other corrective action, including education, should be instituted.
- (2) **Ad-Hoc Review.** The report may be referred to an ad hoc committee for further study and reporting back to the convened IRB.
- (3) **IRB Sanctions and Corrective Action.** Actions that may be taken by the IRB may include, but are not limited to the following:
- (a) Dismissal of the complaint as unjustified;
 - (b) A suspension of the study if the IRB concludes a protocol violation has occurred. If the violations are found to be serious in nature, the committee may elect to audit or suspend and audit all of the investigator's protocols;
 - (c) Termination of approval for the protocol if the IRB concludes a protocol violation is serious or continuing;
 - (d) A written notification defining the misconduct to the Vice President for Research Administration and the Institutional Signatory Official (UT President);
 - (e) A written notification of the findings to the Investigator, with copies to the researcher's Chair, Dean, and Vice President of Research;
 - (f) Additional or remedial training or education;
 - (g) Increased reporting by the researcher of his or her human subject research activities;
 - (h) Temporary or permanent restrictions on research practice, such as limiting privileges to minimal risk or supervised research projects;
 - (i) Termination of approval of one or more of the researcher's studies;
 - (j) Designating all or part of the research data as "not IRB approved."
- c) **Determination Letter to Investigator:** An IRB Notice of Action will be communicated in writing to the researcher.
- d) **Reporting to Institutional Officials and OHRP:** If the IRB finds that there were (a) unanticipated problems involving risk to subjects, or (b) serious or continuing non-compliance, the IRB shall report the occurrence to the appropriate institutional official(s) including the signatory official (UT President) and OHRP.
- e) **Institutional Review:** The University of Toledo retains the right to review the findings and take additional corrective action, but may not prevent reporting to the OHRP or reverse any sanction on an individual investigator that has been imposed by the convened IRB.

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f) **Investigator's Right of Appeal**

(1) **Purpose and Grounds for Appeal:** The purpose of an appeal is to give the researcher an opportunity to request reconsideration of the IRB's decisions under certain limited circumstances. Grounds for appeal are limited to:

- (a) new information not reasonably available during the investigation;
- (b) material failure to follow these policies and procedures;
- (c) the decision of the board is clearly erroneous; or
- (d) sanction exceeds the severity of the violations.

No other grounds will be considered.

(2) **Process:** The Investigator has the option to appeal the committee's decision if he/she disagrees with the findings and subsequent requirement(s). Appeals must be in writing, state the reason or reasons for appeal, and include any information that the researcher would like the appeals committee to consider. The written notice of appeal must be signed and dated by the investigator, and sent to the DHRP Director of Operations and the IRB Chair. The appeal must be received within 14 days of the date of the IRB Notice of Action. Information that was reasonably available during the initial investigation and not submitted to the CORE Committee in the initial investigation will not be considered on appeal. Decisions of the CORE Committee will become final if a notice of appeal is not received within 14 days of the IRB Notice of Action.

(3) **Appeals Committee:** The Appeals Committee shall be comprised of three individuals appointed by the Vice President for Research Administration. Appointees shall not have served on the CORE Committee for the initial investigation. The Vice President for Research Administration may serve as a member of the Appeals Committee.

The Appeals Committee will review the written statement of appeal by the researcher and make a recommendation as to whether the CORE Committee should reconsider any aspect of its decisions based on the grounds outlined above. In reaching this recommendation, the Appeals Committee may seek a response from the CORE Committee. The Appeals Committee shall complete its review within 60 days.

B. **Suspension or Termination of Research:** The *IRB* has the authority to suspend or terminate approval of research that is not conducted in accordance with the regulatory, ethical, *IRB* and institutional requirements outlined in *IRB* Policies and Procedures or that has been associated with unexpected risk or harm to subjects (see [45 CFR 46.113](#)). Furthermore, any such unexpected risk or harm, suspension or termination will be reported to *OHRP* or the FDA if required by federal authority. *University* officials may also suspend or terminate approval of research under applicable *University* policies.

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APPENDIX A: 45 CFR 46.111

45 CFR §46.111 Criteria for IRB approval of research.

(a) In order to approve research covered by this policy the IRB shall determine that all of the following requirements are satisfied:

(1) Risks to subjects are minimized: (i) By using procedures which are consistent with sound research design and which 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 involving vulnerable populations, such as children, prisoners, pregnant women, mentally disabled persons, 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 §46.116.

(5) Informed consent will be appropriately documented, in accordance with, and to the extent required by §46.117.

(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.

(b) 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, additional safeguards have been included in the study to protect the rights and welfare of these subjects.

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APPENDIX B:

Categories of Research That May Be Reviewed by the IRB through an Expedited Review Procedure¹

Source: 63 FR 60364-60367, November 9, 1998.

Applicability

(A) Research activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the following categories, may be reviewed by the IRB through the expedited review procedure authorized by 45 CFR 46.110 and 21 CFR 56.110. The activities listed 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.

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

(C) 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.

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

(E) IRBs are reminded that the standard requirements for informed consent (or its waiver, alteration, or exception) apply regardless of the type of review--expedited or convened--utilized by the IRB.

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

Research Categories

(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 children², 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.

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(3) Prospective collection of biological specimens for research purposes by noninvasive means.

Examples: (a) hair and nail clippings in a nondisfiguring 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 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 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.)

(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.

(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.

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1 An expedited review procedure consists of a review of research involving human subjects by the IRB chairperson or by one or more experienced reviewers designated by the chairperson from among members of the IRB in accordance with the requirements set forth in 45 CFR 46.110.

2 Children are defined in the HHS regulations as "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." 45 CFR 46.402(a).

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APPENDIX C:
Findings The IRB Must Make And Document To Approve An Alternative Consent Procedure – 46
CFR 46.116

Please visit the “Regulations” web page at <http://www.hhs.gov/ohrp> for the most recent version of this regulation.

Code of Federal Regulations
TITLE 45 PUBLIC WELFARE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
PART 46 PROTECTION OF HUMAN SUBJECTS

* * *

Revised June 23, 2005
Effective June 23, 2005

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46.116 (d). An IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent set forth in this section, or waive the requirements to obtain informed consent provided the IRB finds and documents that:

- (1) The research involves no more than minimal risk to the subjects;
- (2) The waiver or alteration will not adversely affect the rights and welfare of the subjects;
- (3) The research could not practicably be carried out without the waiver or alteration; and
- (4) Whenever appropriate, the subjects will be provided with additional pertinent information after participation.