

University of North Carolina Greensboro  
**Procedures for Human Research  
Protection**



**UNCG**

Revised 2025

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## 1. Mission

The University of North Carolina at Greensboro (UNCG) fosters a research environment that promotes respect for the rights and welfare of individuals recruited for, or participating in, research conducted by or under the auspices of the University. In the review and conduct of research, actions by UNCG will be guided by the principles (respect for persons, beneficence, and justice) set forth in the *Ethical Principles and Guidelines for the Protection of Human Participants of Research* (often referred to as the Belmont Report) and, for all federally funded research, will be performed in accordance with the Department of Health and Human Services (DHHS) policy, and regulations of 45 CFR 46 (also known as the “Common Rule”). The actions of UNCG will also conform to all other applicable federal, State, and local laws and regulations.

The University maintains an Institutional Review Board (IRB) to review research protocols involving human participants and to evaluate both risk and the protection against risk for participants. It is the function of the IRB to 1) determine and certify that all projects reviewed by the IRB that are externally funded by a federal agency, conform to the policies and procedures in this document and the regulations and policies set forth under the Common Rule regarding the health, welfare, safety, rights, and privileges of human participants; 2) for all research (herein, federally funded, non-federally funded and unfunded) research, assist investigators in complying with federal and state regulations; 3) for all research, ensure that research meets the universities ethical standard of “academic freedom” to which the university is committed; and 4) for all research, apply all sup- parts, as well as 46.111 and 46.116, for studies qualifying for expedited and full committee review.

### 1.1 Introduction

The UNCG *Procedures for Human Research Protection* details policies and regulations governing research with human participants, and the requirements for submitting research protocols for review by the UNCG Institutional Review Board for federally and non-federally funded research (externally funded research) and for unfunded research. These procedures are reviewed and revised if necessary, annually each Fall semester.

UNCG is guided by the ethical principles regarding all research involving humans as set forth in the report of the National Commission for the Protection of Human Participants of Biomedical and Behavioral Research titled *Ethical Principles and Guidelines for the Protection of Human Participants of Research*, often referred to as the Belmont Report, (National Commissions for the Protection of Human Participants of Biomedical and Behavioral Research, April 1979).

All institutional and non-institutional sites where research for UNCG is performed, domestic or foreign, will be obligated to conform to ethical principles which are at least equivalent to those of UNCG, as cited in the previous paragraph or as may be determined by the Department of Health and Human Services (DHHS) Secretary.

In many cases, procedures required by UNCG are identical to those required or recommended by various federal agencies including the Office of Human Research Protections.

### 1.2 Ethical Principles: The Belmont Report

#### The Belmont Report

It is the duty of the UNCG IRB to review and make decisions regarding all protocols, regardless of funding, for research involving human participants. The primary responsibility of the IRB is the protection of research participants from undue risk and from deprivation of personal rights and dignity. This protection is best assured by consideration of **three principles**, which are the touchstones of ethical research:

- (1) that voluntary participation by the research participants, indicated by free and informed consent, is assured,
- (2) that an appropriate balance exists between the potential benefits of the research to the participants or to society and the risks assumed by the participants, and
- (3) that there are fair procedures and outcomes in the selection of research participants.

These principles are referred to as **respect for persons, beneficence, and justice**.

### **Respect for Persons: Voluntary Participation and Informed Consent.**

One of the most important elements in any research involving human research participants is the assurance of voluntary informed consent. Any person who is to be a research participant, whether that research is designed for his/her own direct benefit or for the advancement of scientific knowledge in general, must understand as completely as possible what is to be done and the associated potential risks and benefits. The person must give his/her consent freely, without pressure or inappropriate inducement. The IRB at UNCG strives to ensure voluntary informed consent of research participants through careful review of the recruitment and consent processes, and of the consent form or information sheet to be used with participants.

The informed consent concept is extended to those studies in which participants are not able to give personal consent for themselves. In such cases, the consent document is addressed to those who have been designated as responsible for the research participants' well-being (e.g., parents of children). The IRB's concern is to verify that the consent process and document are likely to assist these persons in making informed decisions which are in the best interest of the research participants. The capacity for truly informed and voluntary participation in research varies widely among study populations. At one extreme, there may be ample understanding and manifest freedom from coercion; at the other, there may be degrees of understanding and freedom that affect the consent of potential participants. The IRB must exercise special care when considering participants whose ability to give free and informed consent may be compromised in any way.

### **Beneficence: The Risk-Benefit Ratio.**

The IRB is charged with deciding, for any proposed activity which falls under its jurisdiction, whether: "The risks to the participant are so outweighed by the sum of the benefit to the participant and the importance of the knowledge to be gained as to warrant a decision to allow the subject to accept (those) risks" (Federal Register, May 30, 1974).

Assessment of the risk/benefit relation is a complex task. Risks of injury or discomfort to the individual can be physical, psychological, and/or social. There can be potential benefits to the individual, to a group to which the individual belongs, and/or to society. When reviewing applications, the IRB must carefully assess the types and degrees of both risks and benefits for a given participant population, as well as the investigator's communication of these risks and benefits

in the consent process and form. While the IRB is not charged with reviewing scientific design per se, it must sometimes clarify design-related issues to properly assess the risk/benefit ratio. If a study design does not seem adequate to attain the stated aim of the investigation, then no benefit can be anticipated from conducting the study, and there is no justification for placing any research participant at risk, however minimal. Thus, the design of the study must be sound, and the nature and likelihood of all risks and benefits must be made clear in any application to the IRB.

**Justice: The Fair Selection of Research Participants.**

Both the risks and the potential benefits of research should be spread fairly among potential individual research participants and groups of individuals participating in research. Study design and selection of participants should avoid bias for or against particular social, racial, sexual, or ethnic groups.

**Sharing Research Risks.** The guiding principle in the ethical selection of research participant groups is that any risks of the research should fall upon the groups that might benefit from the research. If the results of a risky protocol might benefit the general population, it would be unethical to focus participant recruitment on vulnerable or disadvantaged groups (e.g., institutionalized people or prisoners, patients at free clinics primarily patronized by people unable to afford other medical care) simply because they are easily accessible or can be persuaded to participate. An undue share of research risks should not also burden groups already burdened by other factors. Rather, attempts should be made to include a fair sampling of the groups that might benefit from the study. When research involves persons whose autonomy is compromised, it is expected that the research bear some direct relationship to the conditions or circumstances of the research participant population. In addition, groups fully able to consider research risks and informed consent should be asked to face research risks before more vulnerable populations.

**Sharing Research Benefits.** In recent years, increasing attention has been paid to the rights of various groups to be included in research. In addition, researchers, ethicists, and public officials have recognized that because many clinical trials focus primarily on White middle-class research participant groups, the results of some trials have been of questionable value for members of other social, racial, sexual, and ethnic groups. As a result, both the National Institutes of Health and the Food and Drug Administration now require that study design include as broad a range of research participants as feasible, and data be analyzed to uncover responses that differ between groups. Whereas women of child-bearing potential and pregnant and nursing women previously were routinely excluded from new drug trials, it is now required that whenever possible these women be asked to make their own choices after being fully informed of the risks of the research.

## **2. Definitions**

**Human Participant Research** – For the purposes of this policy research involving “human participant research” is defined as an activity that meets the definition of “research” and involves “human participants” as defined by 45 CFR 46.102(d)&(f).

**Research** – a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this definition may be funded or unfunded or may be conducted as a component of another program not usually

considered research. For example, demonstration and service programs may include evaluation components, which constitute research activities under this definition. For purposes of this part, the following activities are deemed not to be research:

- (1) Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.
- (2) Public surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. Such activities are limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance (including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products). Such activities include those associated with providing timely situational awareness and priority settings during an event or crisis that threatens public health (including natural or man-made disasters).
- (3) Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes.
- (4) Authorized operational activities (as determined by each agency) in support of intelligence, homeland security, defense, or other national security missions.

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

**Human participant** – For all federally funded research subject to pre-2018 requirements: a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention<sup>1</sup> or interaction<sup>2</sup> with the individual, or identifiable private information<sup>3</sup>.

**Human participant** – For all federally and non-federally funded research subject to 2018 or hybrid requirements: a living individual about whom an investigator (whether professional or student) conducting research obtains:”

1. Information or biospecimens through intervention or interaction with individual, and uses, studies, or analyzes the information or biospecimens; or

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<sup>1</sup> Intervention includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the participant or the subject's environment that are performed for research purposes.

<sup>2</sup> Interaction includes communication or interpersonal contact between investigator and subject.

<sup>3</sup> Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a

2. Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens

**IRB** – an Institutional Review Board established in accord with and for the purposes expressed in this policy.

**IRB approval** – the determination of the IRB that the research has been reviewed and may be conducted at an institution within the constraints set forth by the IRB and by other institutional and Federal requirements.

**Identifiable information** –

1. For all research subject to pre-2018 requirements: Information by which the identity of the human subjects is or may readily be ascertained by the investigator or readily be associated with the information
2. For all research subject to 2018 or hybrid requirements: Information or a biospecimen for which the identity of the human subject is or may readily be ascertained by the investigator or readily be associated with the information

**Identifiable Private Information** – private information for which the identity of the human subject is or may readily be ascertained by the investigator or associated with the information

**Identifiable Biospecimen** – a biospecimen for which the identity of the human subject is or may readily be ascertained by the investigator or associated with the biospecimen.

**Legally Authorized Representative (LAR)** – An individual, judicial, or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research.

- **For research NOT subject to FDA regulations and NOT subject to 2018 requirements:** Where there is no applicable law addressing this issue, legally authorized representative means an individual recognized by institutional policy as acceptable for providing consent in the non-research context on behalf of the prospective human subject to the human subject's participation in the procedure(s) involved in the research.

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

**Certification** - the official notification by the institution to the supporting Department or Agency, in accordance with the requirements of this policy, that a research project or activity involving human participants has been reviewed and approved by an IRB in accordance with an approved assurance.

**Clinical Trial** – a research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of the interventions on biomedical or behavioral health-related outcomes.

**Moderate Exercise** – When evaluating participant safety during exercise testing or training, intensity (how hard the activity is—whether it is mild, moderate, or vigorous) is not and should not be the primary issue. The primary issue is the level of cardiovascular, cerebrovascular, or musculoskeletal risk to be experienced by the person who is going to engage in a given intensity of exercise. The most important aspect of keeping individuals safe is to screen them properly prior to exercise participation. Some individuals who possess high levels of fitness along with satisfactory health histories and no serious personal risk factors can participate in very high intensity exercise testing or training and are at minimal risk for a serious medical event as a result of this activity. Their risk as associated with testing or training is close to the risk present in normal, everyday activities. This is in comparison to other individuals who have significant heart disease with symptoms and who should not participate in even mild/moderate exercise testing or training without American College of Sports Medicine (ACSM) certified personnel (or other properly certified personnel) directly supervising all aspects of the activity with a physician in close proximity.

**Agent of the University** – is anyone who has proper authority to make official representations on behalf of the University and/or bind the university to agreements.

**Engaged in Research** – when an UNCG employee or agent either intervene or interact with living individuals for research purposes or obtain individually identifiable private information for research purposes.

### **3. Institutional Authority**

The Chancellor of UNCG has designated the Vice Chancellor for Research and Engagement as the Institutional Official. The Director of the Office of Research Integrity is supported by the Vice Chancellor, and both are responsible for carrying out the University’s human research protections program.

The UNCG IRB has jurisdiction over all human participant research (as defined above), conducted under the auspices of UNCG. Research under the auspices of UNCG includes research conducted at UNCG, conducted by or under the direction of any employee or agent of UNCG (including students) in connection with his or her institutional responsibilities, conducted by or under the direction of any employee or agent of UNCG using any property or facility of UNCG, or involving the use of UNCG’s non-public information to identify or contact human participants.

#### **3.1 Assurance of Compliance**

UNCG holds a Federal-wide Assurance (FWA; Number 00000216). A FWA is an assurance of compliance with the federal regulations for the protection of human participants in research that is federally funded. The FWA is also approved by OHRP for Federal-wide use, which means that other departments and agencies that have adopted the Federal Policy for the Protection of Human Subjects (also known as the Common Rule) may rely upon the FWA for the research that they conduct or support.

### **3.2 UNCG ORCI**

The UNCG ORCI reports directly to the Director of the Office of Research Integrity (“Director”) and is supervised by the Vice Chancellor for Research and Engagement. The Vice Chancellor for Research and Engagement is the Institutional Official and the Signatory Official on the Federal-wide Assurance. The Director has expert knowledge in regulatory issues regarding human participants and has delegated authority for some signatory privileges on behalf of the Institutional Official. The Director supervises the Assistant Director who serves as the Human Protections Administrator, the primary point of contact and reviewer at UNCG for the Office for Human Research Protections, and the Department of Health and Human Services.

This office is staffed by other appropriate and knowledgeable individuals whose duties and responsibilities are found in their respective job descriptions, and whose performance is evaluated on an annual basis by the Director and Assistant Director in accordance with UNCG Human Resource Standards.

### **3.3 North Carolina Law**

UNCG and the UNCG IRB rely on the guidance of University Counsel for the interpretation and application of North Carolina law and the laws of any other jurisdiction where research is conducted as they apply to human participants research. University Counsel has indicated that currently there are no specific state laws that apply directly/solely to research.

## **4. UNCG Institutional Review Board**

The UNCG IRB is an administrative body established to protect the rights and welfare of human research participants recruited to participate in research activities conducted under the auspices of this institution.

The Director of ORCI and Vice Chancellor for Research and Engagement will review the activity of the IRB on a regular basis and determine the appropriate number of IRBs for the institution.

### **4.1 Authority of the IRB**

The UNCG IRB reviews all research conducted under the auspices of UNCG and has the authority to approve, require modifications in, or disapprove such research. The IRB is required to ensure that appropriate safeguards exist to protect the rights and welfare of research participants [45 CFR 46.111]. In fulfilling these responsibilities, the IRB is expected to review all research documents and activities that bear directly on the rights and welfare of potential participants in proposed research. The research protocol and consent/assent document(s) are examples of information/materials that the IRB should review. The IRB should also review the methods and materials that investigators propose to use to recruit participants.

Before any human participant is involved in research conducted under the auspices of UNCG, the UNCG IRB will consider:

1. the potential risks to participants
2. the anticipated benefits to participants, others, and society

3. the importance of the knowledge that may reasonably be expected to result from the research
4. the informed consent process to be employed

The IRB has the authority to suspend, place restrictions on, or terminate approval of research activities that fall under its jurisdiction that are not being conducted in accordance with IRB requirements or that have been associated with unexpected adverse events. The IRB has the authority to observe or have a third party observe the consent process and/or the research procedures.

#### **4.2 Jurisdiction of the IRB**

The IRB jurisdiction extends to ALL research (funded and not funded) involving human participants conducted at UNCG, as well as research conducted elsewhere by UNCG faculty, staff, and students.

If an IRB chair, member, or staff person feels that the IRB has been unduly influenced by any party, they can make a confidential report to the ORCI Director or the Vice Chancellor for Research and Engagement, depending on the circumstances. The institution will conduct a thorough investigation and corrective action will be taken to prevent additional occurrences.

#### **4.3 IRB Relationships**

The IRB functions independently of, but in coordination with, other institutional regulatory committees. The IRB, however, makes its independent determination whether to approve or disapprove a protocol based upon whether human participants are adequately protected. The IRB has review jurisdiction over all research involving human participants conducted, supported, or otherwise under regulations from any federal department or agency that has adopted the human participants regulations.

The Research Advisory Council (RAC) ensures a dialogue is maintained between the various compliance entities at the University. The committee will act in an advisory capacity to the Vice Chancellor for Research and Engagement, monitoring the effectiveness of existing integrity programs, developing new or revised policies as changes in requirements occur, and disseminating updated compliance information to the research community.

Institutional officials may NOT approve research if it has been disapproved by the IRB.

**Relationships with other institutions:** UNCG may choose, on a case-by-case basis, to provide human research protection oversight for another institution or allow that institution to provide oversight over a study at UNCG. For the University to provide this oversight, a formal relationship must be established between the University and the other institution through a reliance agreement. This relationship must be formalized before the University will accept any human research proposals from the other institution.

For nonexempt research involving human subjects covered by the Common Rule that takes place at an institution where oversight is conducted by an IRB entity that is not the UNCG IRB, UNCG and the organization operating the IRB shall document UNCG's reliance on the

other IRB entity for oversight of the research and the responsibilities that each entity will undertake to ensure compliance with the requirements of this policy (e.g., in a written agreement between UNCG and the other institution's IRB, by implementation of an institution-wide policy directive providing the allocation of responsibilities between UNCG and an IRB that is not affiliated with UNCG, or as set forth in a research protocol).

For exempt research involving human subjects that takes place at another institution where oversight is conducted by an IRB entity that is not operated by UNCG, UNCG may choose to accept the exemption determination from the other institution. The IRB will provide the UNCG researcher with a letter stating that the UNCG IRB accepts this exempt determination. To be considered, all procedures that the UNCG researcher completes must have been reviewed and approved by the collaborating IRB. There can be no differences. This is considered to be UNCG relying on the collaborating institution's IRB but without an executed reliance agreement. If the Acceptance Letter does not suffice, exempt research reliance agreements may be considered and must provide additional justification and/or rationale for the reliance and must be approved by the UNCG Director of Research Integrity or the Institutional Official. The reliance agreement will outline the specific responsibilities that UNCG and the organization operating the IRB entity will undertake to ensure compliance with the requirements of this policy as described in 46.103(e)

In the conduct of collaborative research projects involving multiple institutions, UNCG acknowledges that each institution is responsible for safeguarding the rights and welfare of human participants and for complying with applicable federal regulations. When a cooperative agreement exists, UNCG may enter a joint review arrangement, rely on the review of another qualified IRB, or make similar arrangements for avoiding duplication of effort.

- When UNCG reviews research to be conducted at another institution, the characteristics of each institution's local research context must be considered, either (i) through knowledge of its local research context by the UNCG IRB, or (ii) through subsequent review by appropriately designated institutional officials, such as the Chairperson and/or other IRB members.
- At the time of initial review, the IRB will assess the procedures for dissemination of protocol information (e.g., unanticipated problems involving risks to participants or others, protocol modifications, interim findings) to all participating sites.
- Multi-site studies submitted to IRB by UNCG Faculty:

Because cooperative or reliance agreements are on a case-by-case basis, all UNCG faculty research should be on file with the UNCG IRB if they are collaborating with another institution so that there is a record maintained at each site. IRB approval from that site, if applicable, should also be submitted to the UNCG IRB at the time it is received.

The UNCG IRB evaluates serving as the IRB of record on a **case-by-case basis** based on whether they can effectively serve as the IRB of record for a proposed multi-site project or if an external IRB should be used. The main evaluation criteria are:

- Whether the UNCG PI is the direct recipient of the federal grant
- The risk level to the human subjects
- At which site most of the data collection will take place
- The number of collaborating institutions and the research activity to be conducted by those institutions
- The experience level of the UNCG PI/study team
- The involvement of the UNCG PI/study team

UNCG IRB reserves the right to decline being the IRB of record on any project but will provide support to the UNCG study teams to locate an external IRB to act as the IRB of record

## **Research at Cone Health**

Cone Health System IRB has signed Authorization Agreements to rely on the IRBs at the University of North Carolina located at Greensboro, NC and Chapel Hill, NC (UNC School Systems) for review of research proposals in which investigators at UNC School Systems plan to collaborate with the Cone Health System (CHS).

Cone Health System asks that the UNC-A-01 IRB form be completed for studies using this Authorization Agreement. This form is located under the “Forms” link on the CHS IRB website: <http://www.mosescone.com/IRBhttp://www.mosescone.com/body.cfm?id=20&oTopID=741>. Cone Health System would like to receive notification of annual renewals, closure notices, and SAEs/Unanticipated Problems for all Cone Health System patients. These submissions will be reviewed and placed in the appropriate file.

## **4.4 Roles and Responsibilities**

### **4.4.1 Chairperson of the IRB**

The Director, on behalf of the Institutional Official, recommends individuals to the Vice Chancellor for Research and Engagement to serve as Chairperson of the IRB. The Vice Chancellor for Research and Engagement, in consultation with the Provost for Academic Affairs and approval of the Chancellor, appoints a Chair of the IRB to serve for renewable two-year terms. Any change in appointment, including reappointment or removal, requires written notification.

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

The IRB Chair is a voting member of the IRB and counts toward quorum. The IRB Chair is responsible for conducting IRB meetings and is a signatory for correspondence generated by the IRB. The Assistant Director of the ORCI will serve as co-Chair if the Chair is unavailable to Chair an IRB meeting.

The IRB Chair may designate other IRB members (e.g., the Past Chair, ORCI Assistant Director and, specific IRB members) to perform duties as deemed appropriate including reviewing and approving protocols with signature authority.

The IRB Chair or Co-Chair advises the Director of the ORCI about IRB member performance and competence.

The performance of the IRB Chair will be evaluated on an annual basis by the Director of the ORCI and the Vice Chancellor for Research and Engagement. If the Chair is not acting in accordance with the IRB's mission, following these policies and procedures, has an undue number of absences, or is not fulfilling the responsibilities of the Chair, a recommendation for removal may be made by the Vice Chancellor for Research and Engagement to the Chancellor.

#### **4.4.2 Subcommittees of the IRB**

The Chair, in consultation with the Director of the ORCI, may designate one or more other IRB members (i.e., a subcommittee) to perform duties as deemed appropriate including reviewing protocols with signature authority, and other IRB functions.

**Duties of a subcommittee** may include the following:

1. Serve as designees by the IRB Chair for the **expedited review** of new or continuing protocols and/or modifications of continuing protocols. The analyst is usually a staff member of the ORCI and is the first person to look at the protocol. The IRB Chair can appoint themselves or any IRB member deemed capable to review the type of research being conducted as the first reviewer.
2. **Review and approve revisions requiring only simple concurrence** submitted by investigators for a protocol given provisional approval, i.e., deferred for minor changes, by the convened IRB.
3. **Conduct an inquiry.** A subcommittee is appointed consisting of IRB members, and non-members if appropriate, to conduct an inquiry into allegations of IRB non-compliance. Such a subcommittee will be given charges by the IRB, which may include any of the following:
  - a. Review of the protocol(s) in question,
  - b. Review of any relevant documentation, including consent documents and investigational files, etc. as they relate to the investigator's execution of the relevant research involving human participants,
  - c. Interview of appropriate personnel,
  - d. Preparation of either a written or oral report of findings to be presented to the full IRB at its next meeting,
  - e. Recommended actions.
4. **Conduct on-site review.** Determination of the review interval and the need for additional supervision and/or participation is made by the IRB on a protocol-by-protocol basis. For example, for an investigator who is performing particularly risky research, an investigator

who has recently had a protocol suspended by the IRB due to regulatory concerns, or a project/investigator whose initial application or modification application has raised concerns in the eyes of the IRB, may be subject to on-site review by an IRB subcommittee. Such a review might occur, or approval might be subject to an audit of study performance, after a few months of enrollment or after enrollment of the first several participants.

#### **4.5 Resources for the IRB**

The Vice Chancellor for Research and Engagement provides resources to the IRB and the ORCI, including adequate meeting and office space and staff for conducting IRB business. Office equipment and supplies, including technical support, file cabinets, computers, internet access, and copy machines, will be made available to the IRB and ORCI staff. The resources provided for the IRB and the ORCI will be reviewed during the annual budget review process

#### **4.6 Conduct of Quality Assurance/Quality Improvement Activities for IRB Operation**

The ORCI staff will conduct investigations and audits of ongoing research when the IRB directs an audit to be conducted or a complaint or allegation of non-compliance is received. In addition, the staff will conduct “for cause” and “not for cause” audits of research. (See Section 11 for a detailed discussion of investigations and audits.)

### **5. IRB Membership**

#### **5.1 Composition of the IRB**

1. The IRB will have at least five members with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the institution. The IRB will not consist of entirely men or entirely women.
2. The IRB will be sufficiently qualified through the experience and expertise of its members, and the diversity of the members, including consideration of race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human participants.
3. In addition to possessing the professional competence necessary to review specific research activities, the IRB will be able to ascertain the acceptability of proposed research in terms of institutional policies and regulations, applicable law, and standards of professional conduct and practice. The IRB will therefore include persons knowledgeable in these areas.
4. If the IRB regularly reviews research that involves a vulnerable category of participants (e.g., children, prisoners, pregnant women, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons), consideration will be given to the inclusion of one or more individuals on the IRB, who are knowledgeable about and experienced in working with these participants. When protocols involve vulnerable populations, the review process will include one or more individuals who are knowledgeable about or experienced in working with these categories of subjects, either as members of the IRB or as consultants (see Section 5.3).
5. The IRB includes at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas.
6. The IRB includes at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution.
7. One member may satisfy more than one membership category.

## 5.2 Appointment of Members to the IRB

The IRB Chair and the Assistant Director of the ORCI identify needs for new or replacement members or alternate members. Department Chairs and other UNCG administrators may forward IRB nominations to the ORCI Director or Assistant Director, the Vice Chancellor for Research and Engagement, or the IRB Chairperson.

In replacing faculty members on the IRB, the Director will consult with the current IRB members to request a recommendation for replacement. The Vice-Chancellor will then contact the nominee to discuss his or her interest and/or qualifications. If there are no nominees, then appropriate Department Chairs or Program Directors will be contacted in writing by the Vice Chancellor for Research and Engagement or the Director concerning the vacancies and nominees will be solicited from the Department Chairs or Program Directors.

The final decision in selecting new members is made by the Vice Chancellor for Research and Engagement and the Director.

Appointments are made for a renewable three-year period of service. Any change in appointment, including reappointment or removal, requires written notification. Members may resign by written notification to the Chair.

On an annual basis, the IRB Chair and the Director review the membership and composition of the IRB to determine if it continues to meet regulatory and institutional requirements.

**Alternate members:** The role of the alternate member is to serve as a voting member of the IRB when the regular member is unavailable to attend a convened meeting. The appointment and function of alternate members is the same as that for primary IRB members, and the alternate's expertise and perspective are comparable to those of the primary member.

The IRB roster identifies the primary member for whom each alternate member may substitute. The alternate member will not be counted as a voting member unless the primary member is absent. When an alternate member substitutes for a primary member, the alternate member will receive and review the same materials prior to the IRB meeting that the primary member received or would have received. The IRB minutes will document when an alternate member replaces a primary member. Alternate IRB members should be individuals who have formerly served as regular IRB members or have the work experience to ensure their knowledge, ability, and familiarity with UNCG IRB policies and procedures and relevant federal documents governing IRB operations.

## 5.3 Use of Consultants (Outside Reviewers)

When necessary, the IRB Chair or the Director may solicit individuals from the University or the community with competence in special areas to assist in the review of issues or protocols which require appropriate scientific or scholarly expertise beyond or in addition to that available on the IRB. For full reviews, the need for an outside reviewer will be determined in advance of the IRB meeting in which the review will occur by the Director or the Chair by reviewing the protocols scheduled to be reviewed at the convened meeting. The ORCI will ensure that all relevant materials, including the protocol, are provided to the outside reviewer prior to the convened meeting. For expedited or exempt reviews, the need for an outside reviewer will be determined by the Director or

the Chair by reviewing the protocol itself. The ORCI will ensure that all relevant materials are provided to the outside reviewer as soon as he or she is identified.

Prior to committing to review, consultants will be informed of the IRB conflict of interest policy either by telephone, email, or letter from the Director. Consultants must verbally confirm to the Director that they do not have a conflict of interest prior to review. Individuals who have a conflicting interest or whose spouse or family members have a conflicting interest in the sponsor of the research will not be invited to provide consultation.

In the case of full reviews, the consultant's findings may be presented to the IRB for consideration in person. If in attendance, these individuals will provide consultation but will not participate in the vote. The consultant may be asked to participate in the IRB's deliberations at the IRB's discretion. In the case of expedited or full reviews, consultants will be asked to provide written documentation concerning their findings. Written statements of consultants will be kept in IRB records. Key information provided by consultants at meetings will be documented in the minutes.

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

#### **5.4 Duties of IRB Members**

IRB Members have many responsibilities inclusive of initial protocol and modification review, attending committee meetings, assisting in procedure development, and possibly serving on subcommittees.

In preparation for convened meetings, IRB members are provided the following information: the agenda and submission materials including protocols, proposed informed consent forms, and other appropriate documents. These are distributed to members prior to the convened meetings at which the research is scheduled to be discussed. Members receive the materials at least one week before each meeting to participate fully in the review of each proposed project. IRB members will treat the research proposals, protocols, and supporting data confidentially.

#### **5.5 Attendance Requirements**

Members should attend all scheduled IRB meetings. Given that IRB meetings are scheduled at a standard time and location, individuals should not be appointed to the IRB unless they have indicated their willingness and ability to attend meetings as scheduled. Members should attend the majority of scheduled meetings during an academic year. If a member is unable to attend a scheduled meeting, he or she should inform the IRB Chair or the Assistant Director. If the inability to attend will be prolonged, a request for an alternate to be assigned may be submitted to the Chair or the Assistant Director. This is vital to ensure that quorum can be met at all meetings.

If an IRB member is to be absent for an extended period, such as for a sabbatical, he or she must notify the IRB at least 30 days in advance so that an appropriate replacement can be obtained. The replacement can be temporary, for the period of absence, or permanent if the member is not

returning to the IRB. If the member has a designated alternate (See Section 7.5.2), the alternate may serve during the primary member's absence, provided the IRB has been notified in advance.

## **5.6 Training / Ongoing Education of Chair and IRB Members in Regulations, Procedures**

A vital component of a comprehensive human research protection program is an education program for the IRB Chair and the IRB members. UNCG is committed to providing training and an ongoing educational process for IRB members and the staff of the ORCI related to ethical concerns and regulatory and institutional requirements for the protection of human participants.

### **Orientation**

New IRB members, including alternate members, will meet with the IRB Chair and the Director or Assistant Director of the IRB for an informal orientation session. At the session, the new member will be given a copy of the Institutional Review Board Member Handbook, IRB review procedures will be discussed, they will be provided the most current IRB SOPs, and they will be informed the CITI modules must be completed.

New members are required to complete the Initial Education requirements for IRB members before they may serve as a reviewer.

### **Initial Education**

In addition to the orientation meeting described above, IRB members will complete the following online tutorials or attend the in-person human subject's research training offered by UNCG ORCI:

- CITI IRB Member Modules

ORCI staff will also complete the following or attend the in-person human subject's research training offered by UNCG ORCI: CITI IRB Member Modules

### **Continuing Education**

To ensure that oversight of human research is ethically grounded and that decisions made by the IRB are consistent with current regulations and policies, training will be ongoing for IRB members throughout their service on the IRB. Ongoing educational activities will include, but are not limited to:

- In-service training at IRB meetings,
- Reviewing copies of appropriate publications,
- Identification and dissemination by the Director or Assistant Director of new information that might affect the human research protection program, including laws, regulations, policies, procedures, and emerging ethical and scientific issues distributed to IRB members via email, mail, or during IRB meetings,
- Completion of CITI Training.

The Vice Chancellor for Research and Engagement will provide support for the Chair and as many members of the ORCI/IRB staff as possible to attend the annual PRIM&R conference on human research protections.

## **5.7 Liability Coverage for IRB Members**

All University employees and authorized volunteers at UNCG are covered by the Defense of State Employees Act and the UNC System excess liability insurance policy in case of a lawsuit claiming that the employee or volunteer injured another's person or property. To qualify for that coverage, the employee or volunteer must have been acting within the course and scope of his or her job or volunteer duties and must not have violated laws, regulations, or University policies. Intentional acts of wrongdoing are also excluded. The coverage provides for free legal defense by the Attorney General's office and, if a judgment is entered against the employee or volunteer, the judgment will be paid up to the limits of coverage (currently \$5,000,000). All UNCG IRB members will be covered under the conditions described here. More information can be found at:

<http://www.uncg.edu/ucn/faq/liability.html>.

## **5.8 Performance of IRB Members**

The performance of IRB members will be discussed as necessary by the Director or Assistant Director, the IRB Chair, and the Vice Chancellor for Research and Engagement. Members who are not acting in accordance with the IRB's mission, following these policies and procedures, have an undue number of absences, or are not fulfilling the responsibilities of an IRB member may be recommended for removal by the Vice Chancellor for Research and Engagement to the Chancellor.

## **IRB Records**

The IRB must prepare and maintain adequate documentation of the IRB's activities including copies of all items reviewed including, but not limited to, research protocols, recruitment materials, scientific evaluations (if any) that accompany protocols, approved consent documents, DHHS approved sample consent documents when they exist, any proposed amendments and the IRB action on each amendment, reports of injuries to participants and serious and unexpected adverse events, documentation of protocol violations, and documentation of non-compliance with applicable regulations. These documents may be maintained either in printed form or electronically.

- IRB records for initial and continuing review by the expedited procedure must include the specific permissible category, and any determinations required by the regulations and protocol-specific findings supporting those determinations.
- IRB records must document any determinations required by the regulations and protocol-specific findings supporting those determinations.
- IRB records must document the rationale for determining research that falls into expedited categories that are greater than minimal risk.
- IRB records must document the rationale for conducting continuing review of research that otherwise would not require it.

For nonexempt research involving human subjects covered by the Common Rule (or exempt research for which limited IRB review takes place) that takes place at an institution where IRB oversight is conducted by an IRB that is not operated by UNCG, the organization operating the IRB and UNCG shall document UNCG's reliance on the external IRB entity for oversight of the research and the responsibilities that each entity will undertake to ensure compliance with the requirements of this policy (e.g., in a written agreement between the institution and the IRB, by implementation of an institution-wide policy directive providing the allocation of responsibilities

between UNCG and an IRB that is not affiliated with UNCG, or as set forth in a research protocol). The rationale for an expedited reviewer's determination under 46.110(b)(1)(i) that research appearing on the expedited review list described in 46.110(a) is more than minimal risk.

Documentation specifying the responsibilities that UNCG and the organization operating the IRB entity each will undertake to ensure compliance with the requirements of this policy as described in 46.103(e)

IRB records must also include copies of all correspondence between the IRB and investigators, and statements of significant new findings provided to participants. Such information must be maintained with the related research proposal and, when reviewed at an IRB meeting, must be documented in the minutes.

All IRB records, including protocols, are covered under the North Carolina Public Records Act and must be made available to requesting North Carolina residents upon request. Exceptions to this requirement include data and information protected under HIPAA and proprietary information.

## **6.1 Minutes of an IRB Meeting**

Proceedings must be written and available for review by the next regularly scheduled IRB meeting date. Once approved by the members at a subsequent IRB meeting, the minutes must not be altered by anyone including a higher authority. Minutes of IRB meetings must show:

1. The presence of a quorum when official business is conducted; To review proposed research at a convened meeting, a majority of the members of the IRB must be present, including at least one member whose primary concerns are in nonscientific areas (45 CFR 46.108(b); 21 CFR 56.108(c)). A quorum must be maintained throughout the meeting. If quorum is lost during a meeting, then the IRB may not vote on proposed research (45 CFR 46.108(b); 21 CFR 56.108(c)).
2. Attendance at the meetings including those members or alternate members who are participating through videoconference or teleconference and documentation that those attending through videoconferencing or teleconferencing received all pertinent material prior to the meeting and were able to participate in all discussions actively and equally.
3. Alternate members attending the meeting and the members for whom they are substituting.
4. Actions taken by the IRB including those involving full review. The IRB must use the minutes to notify IRB members of actions taken through expedited review.
5. Separate deliberations, actions, and votes for each protocol undergoing continuing review by the convened IRB.
6. To approve research, the IRB must determine that all of the criteria for IRB approval of research are satisfied (45 CFR 46.111; 21 CFR 56.111).
7. Documentation that the research reviewed meets the required criteria [45 CFR 46.116(d) and 21 CFR 56.111(a)(4) (when applicable)] when approving a consent procedure that does not include or that alters some or all of the required elements of informed consent, or when waiving the requirement to obtain an informed consent.
8. Documentation that the research meets the required criteria [45 CFR 46.117(c)] when the requirements for documentation of consent are waived.
9. When approving research that involves populations covered by section 10, the minutes will document the IRB's justifications and findings regarding the determinations stated in the

- Subparts or the IRB's agreement with the findings and justifications as presented by the investigator on IRB forms.
10. The vote on actions, including the number of members voting for, against, and abstaining.
  11. A note indicating that when an IRB member has a real or potential conflict of interest, as defined by university policy (see Section 7.5.9), relative to the proposal under consideration the IRB member was not present during the deliberations or voting on the proposal (and that the quorum was maintained).
  12. The basis for requiring changes in or disapproving research and documentation of resolution of these issues when resolution occurs.
  13. A written summary of the discussion of controversial issues and their resolution.
  14. Review of additional safeguards to protect vulnerable populations if entered as study participants when this is not otherwise documented in IRB records.
  15. The determination of the level of risk, if not recorded elsewhere in IRB records.
  16. The frequency of continuing review of each proposal, as determined by the IRB, if not recorded elsewhere in IRB records.
  17. Documentation, as required by 45 CFR 164(i)(2), indicating the approval of a waiver or alteration of the HIPAA Authorization.
  18. Key information provided by consultants will be documented in the minutes or in a report provided by the consultant.
  19. Note the justification for any deletion or substantive modification of information concerning risks or alternative procedures contained in the DHHS approved sample consent document.
  20. Note the rationale for significant risk/non-significant risks device determinations.
  21. Both OHRP and FDA regulations authorize an IRB to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects (45 CFR 46.113; 21 CFR 56.113). Any IRB action to suspend or terminate IRB approval that occurs at a convened meeting must be documented in the minutes (45 CFR 46.115(a)(2); 21 CFR 56.115(a)(2)). Any suspension or termination of approval must include a statement of the reasons for the IRB's action (45 CFR 46.113; 21 CFR 56.113). Any decision to suspend or terminate the study that occurs outside of a convened IRB meeting (e.g., as determined by the IRB Chair or Institutional Official for subject safety reasons) should be reported to the convened IRB and the discussion summarized in the minutes. Any subsequent action taken by the convened IRB (e.g., to lift the suspension or to terminate the study) must be documented in the minutes (45 CFR 46.115(a)(2); 21 CFR 56.115(a)(2)).

## **6.2 Membership Rosters**

A membership list of IRB members must be maintained; it must identify members sufficiently to describe each member's chief anticipated contributions to IRB deliberations. The list must contain information such as a member's name, earned degrees, affiliated or non-affiliated status, member status as scientist (physician-scientist, other scientist, non-scientist, or social behavioral scientist), voting status, alternate status, or status as chairperson.

The ORCI must keep IRB membership lists current. The Director must promptly report changes in IRB membership to the Office for Human Research Protections and the Department of Health and Human Services.

### **6.3 Records Retention Requirements**

The above detailed records must be stored securely in the ORCI and must be retained for at least 3 years. Records pertaining to research which is conducted must be stored securely in the ORCI and must be retained for three years after the application is closed. After that time, the records will be destroyed or archived. All records must be accessible for inspection and copying by authorized representatives of the OHRP, sponsors, and other authorized entities at reasonable times and in a reasonable manner.

Electronic records will be stored electronically per UNCG standards and in the appropriate electronic system which is password protected. IRB records are available only to IRB members (including the Chair), ORCI staff and authorized entities as specified above.

### **6.4 Written Procedures and Guidelines**

The UNCG *Procedures for Human Research Protection* detail the regulations governing research with human participants and the requirements for submitting research proposals for review by the UNCG IRB.

These procedures also detail:

1. Written procedures which the IRB must follow for conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and the institution, determining which projects require review more often than annually and which projects need verification from sources other than the investigators that no material changes have occurred since previous IRB review, and ensuring prompt reporting to the IRB of proposed changes in a research activity and for ensuring that such changes in approved research during the period for which IRB approval has already been given may not be initiated without IRB review and approval except when necessary to eliminate apparent immediate hazards to the participant.
2. Written procedures for ensuring prompt reporting to the IRB, appropriate institutional officials, and the federal Department or Agency head of any unanticipated problems involving risks to participants or others, or any serious or continuing noncompliance with 45 CFR 46 or the requirements or determinations of the IRB suspension or termination of IRB approval.

The procedures present the most current information for reference by potential investigators and their staff; however, this is not a static document. The procedures are subject to annual review and revision by the Director, Assistant Director, the Institutional Review Board, and University counsel. The Vice Chancellor for Research and Engagement, in consultation with the Director, will approve all revisions of the procedures. The Director, Assistant Director, or Vice Chancellor for Research and Engagement will keep the University research community apprised of new information that may affect the human research protection program including laws, regulations, policies, procedures, and emerging ethical and scientific issues on its website and through campus electronic mailing lists. The procedures are available upon request.

## 7. IRB Review Process

### 7.1 Online Submission

In February of 2013, the Office of Research Compliance and Integrity introduced an online submission system to the UNCG campus. This system allows Faculty and Student Researchers to submit their IRB proposal electronically as well as direct communication with the IRB reviewer. The system has a built-in, smart logic to help with the application process and guides the applicant through the process by addressing specific items in relation to the federal guidelines.

These procedures and guidelines apply to all research involving human participants, regardless of sponsorship and performance site, conducted under the auspices of UNCG. During the review process, PIs are responsible for responding to the IRB's inquiries within 90 days or the protocol can be administratively withdrawn or closed.

### 7.2 Human Participants Research Determination

The responsibility for the initial contact related to any activity that may constitute human participant research rests with the investigator. But official determinations related to research involving human participants can only be made by the IRB. The investigator is responsible for applying to the IRB for review if an official determination is wanted.

Investigators are allowed to make their own Not Human Subjects Determination for unfunded projects by completing a Qualtrics application and keeping the application for their records. **This is not an official determination from the IRB.** Since the University will hold investigators responsible if an IRB application was not submitted when it was required, **investigators are urged to request a confirmation from the IRB that an activity does not constitute human participant research if they are not certain their activity is Not Human Subjects Research.** If the investigator submits a formal application, the request must include sufficient documentation of the activity to support the determination. Formal submissions will be responded to by email and a copy of the submitted materials and determination letter/email will be kept in the online system.

Examples of Research That Does Not Involve Human Participants:

- Research involves only analysis of data from a database that contains no individually identifying or private information (see SOP 15.8 for definition of private information).
- Research involves analysis of private information or specimens that were not collected specifically for the currently proposed research project through interaction or intervention with living individuals **and** the data is coded in such a way that the researcher cannot readily ascertain the identity of the individuals to whom the information pertains (SOP 15.8).

### 7.3 Case Studies or Case Reports

A case report is a medical or educational activity involving the presentation or publication of information and analysis for the purpose of highlighting an interesting experience, observation, treatment, relationship, or outcome.

A case study or case reports for IRB purposes is a retrospective analysis of one clinical case. If more than one case is involved in the activity, the activity could constitute “research.” A case report is a medical/educational activity that does not meet the DHHS definition of “research”, which is: "a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge." Therefore, the activity does not have to be reviewed by the UNCG IRB, even if publication is likely.

Research, as defined by DHHS at 45CFR46.102(d), means a "systematic investigation", including research development, testing and evaluation, designed to develop or contribute to "generalizable knowledge," such that conclusions will be drawn that can be applied to populations outside of the specific study population. For IRB purposes, a single case report, case study, and/or case series is a retrospective analysis of one, two, or three clinical cases and generally does not meet the definition of “research”.

In general, a report on one or a series of patients seen in one’s own practice and a comparison of these patients to existing reports in the literature is not research and does not require UNCG IRB approval. Going beyond one’s own practice to seek out and report cases seen by other clinicians creates the appearance of a systematic investigation with the intent to contribute to generalizable knowledge and therefore is considered research and would require IRB approval.

If a journal requires that UNCG IRB issue a formal determination, this will be issued as Not Human Subjects Research. Under HIPAA, a case report is an activity to develop information to be shared for medical/educational purposes. Although the use of protected health information to prepare the paper does not require UNCG IRB review, the author of a case report must comply with HIPAA.

#### **7.4 Exempt Research**

All research, regardless of funding, using human participants must be approved by the institution. Certain categories of research (i.e., “exempt research”) do not require convened IRB review and approval. Per OHRP guidance, exempt determinations cannot be made by the principal investigator of the study. Exempt research is subject to institutional review and must be reviewed by the ORCI staff or IRB Chair.

Upon receipt by the IRB office, the study submission will be reviewed to determine if the study meets exempt criteria. If it is determined that the study application meets exempt criteria, this will be confirmed and conveyed through an email from the system.

If the study meets criteria for an exempt category requiring limited IRB review, an IRB review of both the study application and applicable study documents will be conducted by IRB staff and/or the IRB Chair.

“Limited IRB Review” is a type of exempt review process required in the Common Rule. Its purpose is to ensure privacy/confidentiality protections are in place with exempt research that involves the collection or use of sensitive, identifiable data (exemptions 2, 3 and 8) **and**, for exemption 7, that “broad consent” was obtained and (if appropriate) documented according to an approved protocol. For exempt studies involving access to PHI (e.g., from medical records), the

required Privacy Board review may be integrated with Limited IRB Review by the same assigned reviewer.

There are no expiration dates on exempt research, but an administrative check-in is required every 3 years so that the IRB can confirm exempt studies that are actively recruiting participants. Any modifications to an exempt protocol must be submitted for review to ensure that the study continues to meet exempt status. The PI is responsible for closing the study within the online system when the research has been completed.

#### **7.4.1 Categories of Research Permissible for Exemption**

Unless otherwise required by law or by department or agency heads, research activities in which the only involvement of human subjects will be in one or more of the categories in paragraph (d) of this section, are exempt from the requirements of this policy, except that such activities must comply with the requirements of this section and as specified in each category.

(a) Use of the exemption categories for research subject to the requirements of subparts B, C, and D: Application of the exemption categories to research subject to the requirements of 45 CFR part 46, subparts B, C, and D, is as follows:

(1) Subpart B. Each of the exemptions in this section may be applied to research subject to subpart B if the conditions of the exemption are met.

(2) Subpart C. The exemptions in this section do not apply to research subject to subpart C, except for research aimed at involving a broader subject population that only incidentally includes prisoners.

(3) Subpart D. The exemptions in paragraphs (d)(1), (4), (5), (6), (7), and (8) of this section may be applied to research subject to subpart D if the conditions of the exemption are met. Paragraphs (d)(2)(i) and (ii) of this section may only be applied to research subject to subpart D involving educational tests or the observation of public behavior when the investigator(s) do not participate in the activities being observed. Paragraph (d)(2)(iii) of this section may not be applied to research subject to subpart D.

(b) [Reserved]

(c) Except as described in paragraph (a) of this section, the following categories of human subject's research are exempt from this policy:

(1) Research, conducted in established or commonly accepted educational settings, that specifically involves normal educational practices that are not likely to adversely impact students' opportunity to learn required educational content or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public

behavior (including visual or auditory recording) if at least one of the following criteria is met:

- (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;
- (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or
- (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

(3) Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met:

- (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects,
- (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation, or
- (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

For this provision, benign behavioral interventions are brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing. Provided all such criteria are met, examples of such benign behavioral interventions would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else.

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

the nature or purposes of the research.

(4) Secondary research for which consent is not required: Secondary research uses identifiable private information or identifiable biospecimens, if at least one of the following criteria is met:

(i) The identifiable private information or identifiable biospecimens are publicly available,

(ii) Information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects,

(iii) The research involves only information collection and analysis involving the investigator's use of identifiable health information when that use is regulated under 45 CFR parts 160 and 164, subparts A and E, for the purposes of "health care operations" or "research" as those terms are defined at 45 CFR 164.501 or for "public health activities and purposes" as described under 45 CFR 164.512(b), or

(iv) The research is conducted by, or on behalf of, a Federal department or agency using government-generated or government-collected information obtained for non-research activities, if the research generates identifiable private information that is or will be maintained on information technology that is subject to and in compliance with section 208(b) of the E-Government Act of 2002, 44 U.S.C. 3501 note, if all of the identifiable private information collected, used, or generated as part of the activity will be maintained in systems of records subject to the Privacy Act of 1974, 5 U.S.C. 552a, and, if applicable, the information used in the research was collected subject to the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 et seq.

(5) Research and demonstration projects that are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated authority to conduct the research and demonstration projects), and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants. Exempt projects also include waivers of otherwise mandatory requirements using authorities such as sections 1115 and 1115A of the Social Security Act, as amended.

(i) Each Federal department or agency conducting or supporting the research and demonstration projects must establish, on a publicly accessible Federal website or in such other manner as the department or agency head may determine, a list of the research and

demonstration projects that the Federal department or agency conducts or supports under this provision. The research or demonstration project must be published on this list prior to commencing research involving human subjects.

(ii) [Reserved]

(6) Taste and food quality evaluation and consumer acceptance studies:

(i) If wholesome foods without additives are consumed, or

(ii) If a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

(7) Storage or maintenance for secondary research for which broad consent is required: Storage or maintenance of identifiable private information or identifiable biospecimens for potential secondary research use if an IRB conducts a limited IRB review and makes the determinations required by §46.111(a)(8).

(8) Secondary research for which broad consent is required: Research involving the use of identifiable private information or identifiable biospecimens for secondary research use, if the following criteria are met:

(i) Broad consent for the storage, maintenance, and secondary research use of the identifiable private information or identifiable biospecimens was obtained in accordance with §46.116(a)(1) through (4), (a)(6), and (d),

(ii) Documentation of informed consent or waiver of documentation of consent was obtained in accordance with §46.117,

(iii) An IRB conducts a limited IRB review and makes the determination required by §46.111(a)(7) and makes the determination that the research to be conducted is within the scope of the broad consent referenced in paragraph (d)(8)(i) of this section, and

(iv) The investigator does not include returning individual research results to subjects as part of the study plan. This provision does not prevent an investigator from abiding by any legal requirements to return individual research results.

#### **7.4.2 Categories of Research NOT Permissible for Exemption**

##### **Vulnerable Populations:**

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

a limited IRB review, is NOT applicable to research in children. Exemption #3 does NOT apply to research involving children. [§.104(b)(3)]

- Exemptions do NOT apply for Prisoners unless the research is aimed at involving a broader population that only incidentally includes prisoners, persons who are cognitively impaired, or persons who are economically or educationally disadvantaged.
- Pregnant women when engaging in physical activity are not eligible for exemption.

#### Impermissible Research

- Studies that involve techniques which expose the participants to discomfort or harassment beyond levels encountered in daily life are not eligible for exemption.
- Other than exempt category 6, these categories do not apply to research that is also FDA-regulated.

#### 7.4.3 Additional Protections

Although exempt research is not covered by the federal regulations, this research is not exempt from the ethical guidelines of the Belmont Report. The individual making the determination of exemption may require additional protections for participants in keeping with the guidelines of the Belmont Report.

#### 7.5 Expedited Review of Research

The IRB may use the expedited review procedure to review either or both of the following:

1. some or all the research appearing on the list of expedited review categories and unless the reviewer(s) determines that the study involves more than minimal risk. If the IRB reviewer determines that a study that falls into expedited categories is greater than minimal risk and requires full committee review, the reason for requiring full committee review must be documented.
2. minor changes in previously approved research having received expedited review during the period (of one year or less) for which approval is authorized or
3. Research for which limited IRB review is a condition of exemption under 46.104(d)(2)(iii), (d)(3)(i)(C), and (d)(7)(8).

A minor change is one which, in the judgment of the IRB reviewer, makes no substantial alteration in (i) the level of risks to participants, (ii) the research design or methodology, (iii) the number of participants enrolled in the research (no greater than 10% of the total requested), (iv) the qualifications of the research team, (v) all added procedures fall into categories (1)-(7) of research that could be reviewed using the expedited procedure, (vi) the facilities available to support safe conduct of the research, or (vii) any other part of the research that would otherwise warrant review of the proposed changes by the convened IRB.

Once the online application is received by ORCI, the ORCI IRB analyst will review the application and all accompanying documentation.

If stipulations are noted and modifications are required, the IRB analyst will inform the investigator via the online system and the system will send an email. Once the PI has responded to the

stipulations, they will re-submit the application to ORCI via the online system. Under an expedited review procedure, the review may be carried out by the IRB Chair or by one or more reviewers designated by the Chair from among members of the IRB. IRB members, who serve as designees by the IRB Chair for expedited review, will be experienced in terms of seniority on the IRB and will be matched as closely as possible to the field of expertise for the study. Alternate members will not be designated as expedited reviewers. The IRB analyst will ensure that all modifications have been made prior to forwarding the application to the IRB Chair or designated IRB member for final review.

If the reviewer(s) find that the research does not meet the criteria for expedited review or if they recommend review by the full IRB, the PI will be notified, and the protocol will be placed on the agenda at an upcoming IRB meeting.

If expedited review is carried out by more than one IRB member and the expedited reviewers disagree, the Director and/or IRB Chair may make a final determination. The protocol will be submitted to the IRB for full review at the discretion of the Director or IRB Chair.

In reviewing the research, the reviewers will follow the Review Procedures described in Section 7.5 and may exercise all the authorities of the IRB except that the reviewers may not disapprove the research. A research activity may be disapproved only after full review.

#### **7.5.1 Categories of Research Eligible for Expedited Review**

[63 FR 60364-60367, November 9, 1998]

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

- The expedited review procedure may not be used where identification of the participants and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the participants financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.
- The expedited review procedure may not be used for classified research involving human participants.
- 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.

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

- (1) Clinical studies of drugs and medical devices only when condition (a) or (b) is met.
  - a. Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases

the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.)

- b. Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.
- (2) Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:
- a. from healthy, nonpregnant adults who weigh at least 110 pounds. For these participants, the amounts drawn may not exceed 550 ml in an 8-week period and collection may not occur more frequently than 2 times per week; or
  - b. from other adults and children<sup>1</sup>, considering the age, weight, and health of the participants, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these participants, 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. [<sup>1</sup>Children are defined in the DHHS 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)]
- (3) Prospective collection of biological specimens for research purposes by noninvasive means.

Examples: (a) hair and nail clippings in a non-disfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) un-cannulated saliva collected either in an unstimulated fashion or stimulated by chewing gum base 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 participant or an invasion of the participant's privacy; (b) weighing or testing sensory acuity; (c) magnetic resonance imaging; (d) electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography; (e)

moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

- (5) Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis). [NOTE: Some research in this category may be exempt from the DHHS regulations for the protection of human participants. See Exempt Categories and 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<sup>4</sup>.
- (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 participants; (ii) all participants have completed all research-related interventions; and (iii) the research remains active only for long-term follow-up of participants<sup>5</sup>, *or*
  - (b) where no participants 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<sup>6</sup>.

**Note:** if a research protocol has been initially approved through a full-board review procedure, the continuing review may **not** be done by the expedited review procedure unless it falls within Category 8 or 9, above.

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<sup>4</sup> NOTE: Some research in this category may be exempt from the DHHS regulations for the protection of human participants. See Exempt Categories and 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.

<sup>5</sup> Category (8) identifies three situations in which research that is greater than minimal risk and has been initially reviewed by a convened IRB may undergo subsequent continuing review by the expedited review procedure. For a multi-center protocol, an expedited review procedure may be used by the IRB at a particular site whenever the conditions of category (8)(a), (b), or (c) are satisfied for that site. However, with respect to category 8(b), while the criterion that "no participants have been enrolled" is interpreted to mean that no participants have ever been enrolled at a particular site, the criterion that "no additional risks have been identified" is interpreted to mean that neither the investigator nor the IRB at a particular site has identified any additional risks from any site or other relevant source.

<sup>6</sup> Under Category (9), an expedited review procedure may be used for continuing review of research not conducted under an investigational new drug application or investigational device exemption where categories (2) through (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. The determination that "no additional risks have been identified" does not need to be made by the convened IRB.

## **7.6 Full Board Meetings**

Except when an expedited review procedure is used, the IRB must review proposed research at convened meetings (also known as **Full-Board meetings**) at which a **quorum** (see below) is present.

### **7.6.1 Schedule of IRB Meetings**

The IRB meets on second and fourth Wednesdays on a regular basis throughout the academic year. The schedule for the IRB may vary due to holidays or lack of quorum.

### **7.6.2 Quorum**

A quorum consists of a simple majority of the voting membership, including at least one member whose primary concern is in a non-scientific area. The IRB Chair, with the assistance of the IRB staff, will confirm that an appropriate quorum is present prior to initiating any discussion regarding the full review. The IRB Chair will be responsible for ensuring that the meetings remain appropriately convened.

ORCI staff will monitor quorum and ensure that quorum is met prior to initiating any discussion regarding the full review. If a quorum is not maintained, the protocol must be tabled, or the meeting must be terminated. All members present at a convened meeting have full voting rights, except in the case of a conflict of interest (see below). For the research to be approved, it must receive the approval of a majority of those voting members present at the meeting.

Opinions of absent members that are transmitted by mail, telephone, facsimile, or e-mail may be considered by the attending IRB members but may not be counted as votes or to satisfy the quorum for convened meetings.

### **7.6.3 Pre-Meeting Distribution of Documents**

The place and time of meetings will be set forth on the agenda cover sheet distributed to all IRB members. All materials for review shall be submitted as soon as possible prior to the next scheduled meeting.

The agenda, along with all protocols and supporting documentation to be reviewed at the meeting, are provided to all IRB members approximately one week prior to each meeting.

### **7.6.4 Guests**

The Principal Investigator (and students affiliated with faculty research) may be invited to the IRB meeting to answer questions about their proposed or ongoing research. The IRB must ensure compliance with the North Carolina Open Meetings Law. All IRB meetings may be attended by guests from the public who may also review IRB minutes. The IRB can go into closed session which must be done with a motion and vote during open session. This motion must state the reasons and authority for closing that portion of the meeting. Discussion during the closed session must be limited to the subject matter for which a closed meeting was authorized. Final action on closed session matters may be made in closed session and does not need to be repeated in open session. Closed sessions must also include minutes which would not be available for review by guests. Guests may not speak unless requested by the IRB.

If the IRB permits non-members and guests to attend a convened meeting (e.g., IRB support staff, the investigator whose study is being reviewed, study coordinator), then the minutes must record the name(s) of all such attendees (45 CFR 46.115(a)(2); 21 CFR 56.115(a)(2))

### **7.6.5 Informing the IRB**

All members of the IRB will be informed at the next scheduled meeting of all expedited review approvals by means of the agenda under a section entitled “Approved Expedited protocols”. Copies of the expedited review approvals will be made available for any optional review at the request of any IRB member.

### **7.6.6 Primary Reviewers for Full Review Applications**

The ORCI staff assigns a Primary Reviewer from the members of the IRB for all protocols requiring initial full committee review. In most cases, the primary reviewer will be the IRB Chair or the IRB member who represents the department or school from which the protocol originated. Reviewers are assigned protocols based on related expertise. When making reviewer assignments, IRB staff takes into consideration the vulnerable populations involved in the research and assigns the protocol to at least one individual who has experience with this population or research topic. If the IRB Staff cannot identify a primary reviewer with appropriate expertise, the IRB Chair or the Director may solicit consultants from the University or the community with competence in special areas to assist in the review of issues which require appropriate scientific or scholarly expertise beyond or in addition to that available on the IRB (see “Use of Consultants,” Section 5.3).

Before the meeting, the protocol application (including background information, project protocol, IRB protocol review checklist, and informed consent and the DHHS-approved sample consent document when one existed) is carefully reviewed by the Primary Reviewer.

At the meeting, the **Primary Reviewer** presents an overview of the goals, design, study procedures, safety procedures, and qualifications of the investigators and leads the IRB through the completion of the criteria for approval appropriate for the type of review (initial, continuing, or modification). Problems identified by the Primary Reviewer or by other IRB members are discussed and suggestions for any necessary changes are agreed upon by the IRB. These issues are considered in the vote to decide IRB action.

### **7.6.7 IRB Required Information for Review by Full Board**

The Protocol Application must, at a minimum, include enough information for reviewers to make determinations based upon the **Criteria for IRB approval of Research** [45 CFR 46.111]. Each application must include or address:

1. Title of the study
2. Purpose of the study
3. Sponsor of the study
4. Participants inclusion/exclusion criteria
5. Recruitment Procedures

6. The importance of the knowledge that might reasonably be expected, i.e., the scientific or scholarly validity.
7. Description of procedures to be performed
8. The possible/potential risks to the participants
9. Provisions for minimizing risks/managing adverse reactions
10. The anticipated benefits of the research
11. Circumstances surrounding the consent procedure
  - a. Setting
  - b. Participant autonomy concerns
  - c. Language difficulties
  - d. Vulnerable populations
  - e. Procedures for documenting informed consent
  - f. Obtaining assent from minors
  - g. Using witnesses and/or translators
12. Document storage
13. Compensation to participants for their participation
14. Compensation for injured research participants (for more than minimal risk studies)
15. Provisions for protection of participant's privacy
16. Protocol-specific conflict of interest information

**Assurances:**

17. The PI must certify that
  - 1) the study has been designed to protect the human participants,
  - 2) the PI is responsible for the scientific conduct of the research and for providing all reports and information to the IRB as required,
  - 3) all members of the research team are appropriately credentialed to perform the work undertaken in the protocol, and
  - 4) the PI and the other co-investigators are not in violation of the university's Conflict of Interest Policy while carrying out the research.

**7.6.8 Materials Received by the IRB**

IRB members reviewing protocols can view the full application, IRB protocol review checklist and attachments (consent and assent forms, recruitment materials, certifications, etc.) as well as relevant correspondence between the PI and the IRB reviewer and/or IRB Chair.

The revised Common Rule removes the requirement that the IRB review the Federal grant application or proposal for consistency with the protocol submitted to the IRB. Unless required by the Federal department or agency conducting or supporting the research, or by foreign, state, or local laws or regulations (including tribal law), the UNCG IRB will no longer require submission of, or conduct review of, Federal grant applications or proposals when research is subject to the revised Common Rule.

The UNCG IRB requires that agency letters be included with IRB applications under either of the following two circumstances:

1. Under circumstances involving UNCG being "either a) the primary awardee under a federal grant, contract, or cooperative agreement supporting research to which the FWA applies, or b) the coordinating center for federally-conducted or –supported research to which the FWA

applies, the Institution is responsible for ensuring that all collaborating institutions engaged in such research operate under an appropriate OHRP-approved or other federally-approved assurance for the protection of human subjects.” Under such circumstances, the UNCG investigator must attach to the IRB application evidence which may take the form of an agency letter.

2. Under circumstances involving an agency, school, organization, or individual providing the researcher access to potential research participants or authorizing data collection at the location of the agency, school, or organization. Consistent with this requirement:
  - a. When access to potential research participants involves use of organizational directories, mailing lists, etc., the agency letter is not required if the contact information is publicly available or can be purchased for the purpose of contacting potential research participants. This does not apply to universities.
  - b. In the case of listservs, agency letters are not required when an individual managing the listserv sends out the recruitment information (as such an action implies agreement of the managing individual/organization). If an individual who does not manage the listserv sends out the information (e.g., a listserv member), an agency letter or documentation explicitly stating that the listserv is available for recruitment of research participants must be attached to the application.
  - c. Recruitment of participants from a UNCG class requires an agency letter from an instructor or department chair. This requirement does not apply to recruitment of Psychology students through the SONA system.

NOTE: Agency letters are not required when an agency, school, organization, or individual will be made aware of the research project and asked to refer potential participants to the investigator to be provided additional information regarding participation.

#### **7.6.9 IRB Member Meeting Conflicts of Interest**

IRB members and consultants will not participate in any IRB action taken, including the initial and continuing review of any project, in which the member or consultant has a conflicting interest, except to provide information requested by the IRB. IRB members are expected to self-identify conflicting interests. A primary or secondary reviewer with a conflict of interest must notify the IRB staff who will re-assign the protocol for review. An IRB member is considered to have a conflict of interest when the IRB member or an immediate family member of the IRB member:

1. Is involved in the design, conduct, or reporting of the research
2. Is the project director or other member of the research team
3. Has a financial interest in the research whose value cannot be readily determined or whose value may be affected by the outcome of the research
4. Has a financial interest in the research with value that exceeds the specified monetary threshold in the University Conflict of Interest Policy
5. Has received or will receive any compensation whose value may be affected by the outcome of the study
6. Has a proprietary interest in the research (property or other financial interest in the research including, but not limited to, a patent, trademark, copyright, or licensing agreement)
7. Has received payments from the sponsor that exceed the specified monetary threshold in the University Conflict of Interest Policy in one year

8. Is an executive or director of the agency/company sponsoring the research
9. Any other situation where an IRB member believes that another interest conflicts with his or her ability to deliberate objectively on a protocol

Except when requested by the IRB to be present to provide information, IRB members will recuse themselves from the meeting room when the IRB reviews research in which they have a conflicting interest. The Chair will allow for board discussion once the conflicted member has recused him/herself. The absent member is not counted toward quorum and his/her absence during the discussion and vote on the protocol will be noted in the IRB meeting minutes. In accordance with UNCG policy, all IRB members who are UNCG faculty and staff will have submitted annual disclosure forms to the Conflict-of-Interest Committee. If the Conflict-of-Interest status of an IRB member changes during a study, the IRB member is required to declare this to the IRB Chair and/or ORCI Assistant Director.

#### **7.6.10 Possible IRB Actions Taken by Vote (Full Review Protocols)**

- **Approval** - The study is approved as submitted.
- **Minor stipulations**- The Committee will approve the submission pending adequate response to stipulated changes and/or clarifications as detailed in these minutes and in a response to the principal investigator for the requested changes. The Chair and another IRB member is authorized to grant final approval upon verifying a satisfactory response to the stipulated changes.
- **Deferred**- The Committee requested further information or substantive changes as detailed in these minutes and in a memo to the principal investigator. Responses will be returned for consideration by the convened Committee.

If the application is deferred for substantive issues, the following will occur:

1. The IRB Chair informs the investigator in writing of the IRB's decision, questions, and concerns.
2. The investigator's response is sent to the IRB Chair.
3. To receive approval for a deferred protocol, the protocol must be submitted for full IRB review at a subsequent convened meeting of the IRB. The ORCI provides IRB members with the investigator's response, the revised protocol, and the previously submitted protocol. The item is placed on the agenda for a subsequent IRB meeting.
4. The protocol application is given full IRB review again.
5. The outcome of the IRB's deliberations is once again communicated to the investigator in writing.
6. The IRB's determination concerning the subsequent amended submission will be documented in the minutes of that meeting.

**Note:** Approval of the protocol application will not be granted, and certification will not be issued until all deficiencies, if any, are corrected to the satisfaction of the IRB or IRB designee(s).

- **Disapproved** - The Committee disapproved the submission for reasons detailed in these minutes and in a memo to the principal investigator. The investigator will be given the option of appealing the decision. Any appeals or resubmissions will be returned for consideration by the convened Committee.

### **Approval in Principle [45 CFR 46.118]**

There is one circumstance under which the IRB may grant approval without having reviewed all the study procedures and consent documents: If study procedures are to be developed during the course of the research, but human participants' approval is required by the sponsoring agency. The IRB may then grant approval without having reviewed the yet undeveloped recruitment, consent, and intervention materials. However, if the proposal is funded, the Principal Investigator must submit such materials for approval before recruiting human participants into the study, or into any pilot studies or pre-tests. Approval in principle is granted to satisfy sponsoring agency requirements or to allow investigators to have access to funding to begin aspects of the project that do not involve human participants.

### **7.6.11 Reporting IRB Actions**

All IRB actions are communicated to the Principal Investigator (PI) in writing within ten (10) working days after final determination by the ORCI and/or the Chair of the IRB via an email. Special situations or conditions of approval will be indicated within the notification. For a disapproval, termination, or suspension, the notification will include the basis for making that decision.

The IRB reports its findings and actions to the institution in the form of its minutes which are kept in the Cayuse system.

### **7.6.12 Determination of Risk**

At the time of initial and continuing review, the IRB will make a determination regarding the risks associated with research protocols. Risks associated with the research will be classified as either "minimal" or "greater than minimal."

"Minimal risk" is defined as the probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons (45 CFR 46.303(d)).

If research falls into one of more categories allowing review using the expedited review procedures, but involves more than minimal risk, the IRB must document the rationale for this more than minimal risk determination. Once the risks associated with the research have been identified, the process of categorizing the risks as *minimal* or *greater than minimal* may begin. Two characteristics influence the nature of the risk: 1) the probability of harm; 2) the magnitude of harm. The magnitude of harm can be related to the severity, duration, and reversibility of a potential harm. The IRB reviewer should consider both the likelihood and magnitude of harm and whether they are greater than the ordinary daily life of a healthy person. An aspect of risk assessment that is often overlooked is what protections are in place to minimize the harm. An IRB may diminish the risks to subjects by minimizing the probability and/or magnitude of harm to subjects. A greater than minimal risk may be reduced to minimal risk if protections are adequate to protect subjects.

An IRB reviewer identifies any risks involved with the study and classifies those risks as minimal or as greater than minimal risk, weighing the benefits of the study against those risks. The IRB reviewer then assesses whether the risks to participants are reasonable in relation to the anticipated benefits to

participants, if any, and the importance of the knowledge that may reasonably be expected to result. The meeting minutes will reflect the Committee's determination regarding risk levels for full review protocols.

### **7.6.13 Period of Approval**

At the time of initial review and at continuing review, the IRB will make a determination regarding the frequency of review of research protocols. All full board protocols will be reviewed by the IRB at intervals appropriate to the degree of risk but no less than once per year. Under some circumstances, a shorter review interval (e.g., biannually, quarterly, or after accrual of a specific number of participants) may be required. The meeting minutes will reflect the IRB's determination regarding review frequency for full review protocols.

### **7.6.14 Review More Often Than Annually**

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

1. Significant risk to research participants (e.g., death, permanent or long-lasting disability or morbidity, severe toxicity) without the possibility of direct benefit to the participants;
2. The involvement of especially vulnerable populations likely to be subject to coercion (e.g., institutionalized psychiatric patients, incarcerated minors); or
3. A history of serious or continuing non-compliance on the part of the Principal Investigator.

The following factors will also be considered when determining which studies require review more frequently than on an annual basis:

1. The probability and magnitude of anticipated risks to participants,
2. The overall qualifications of the responsible Investigator and other members of the research team,
3. The specific experience of the Responsible Investigator and other members of the research team in conducting similar research,
4. The nature and frequency of adverse events observed in similar research at this and other institutions,
5. Characteristics of the research making unanticipated adverse events more likely, or
6. Any other factors that the IRB deems relevant.

In specifying an approval period of less than one year, the IRB may define the period with either a time interval or a maximum number of participants either studied or enrolled. If a maximum number of participants studied or enrolled is used to define the approval period, it is understood that the approval period in no case may exceed 1 year and that the number of participants studied or enrolled determines the approval period only when the number of participants is studied or enrolled in less than 1 year.

### **7.6.15 Independent Verification Regarding Material Changes**

Protecting the rights and welfare of participants sometimes requires that the IRB verify independently, utilizing sources other than the investigator, information about various aspects of the study including, but not limited to, adverse event reporting, information in the scientific literature, and that no material changes occurred during the IRB-designated approval period.

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

1. Protocols for which concerns about possible material changes occurring without IRB approval have been raised based on information provided in continuing review reports or from other sources,
2. Protocols conducted by Principal Investigators who have previously failed to comply with Federal regulations and/or the requirements or determinations of the IRB,
3. Protocols randomly selected for internal audit, or
4. Whenever else the IRB deems verification from outside sources is relevant.

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

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

In making determinations about independent verification, the IRB may prospectively require that such verification take place at predetermined intervals during the approval period, may retrospectively require such verification at the time of continuing review, or may require such verification at any time during the approval period in the light of new information.

#### **7.6.16 Consent Monitoring**

In reviewing the adequacy of informed consent procedures for proposed research, the IRB may on occasion determine that special monitoring of the consent process by an impartial observer (consent monitor) is required to reduce the possibility of coercion and undue influence.

Such monitoring may be particularly warranted for cases in which the research presents significant risks to participants or if participants are likely to have difficulty understanding the information to be provided. Monitoring may also be appropriate as a corrective action when the IRB has identified problems associated with a particular investigator or research project. When monitoring is determined to be necessary, there will be coordination with the investigator to determine how to have someone from the ORCI participate in this phase of data collection.

#### **7.6.17 Investigator Conflicts of Interest**

It is the expectation of the University of North Carolina at Greensboro that all research be conducted following federal regulations, governing law, and that it meets the highest ethical standards. These expectations apply to everyone involved in the conduct of research involving human subjects, including investigators and their staff, research sponsors, ORCI staff, and IRB members.

##### **7.6.17.1 Conflict of Interest Management**

All Investigators and key research personnel must follow the UNCG Conflict of Interest Policy. Key research personnel are those individuals who: 1) obtain consent from human participants; 2) recruit human participants, or 3) evaluate the responses of human participants. As part of its general financial disclosure procedures, the University will ask if any research being planned involves

human participants. If this is determined to be the case, any conflict management plan which is developed will be forwarded to the IRB for review prior to approval. For research involving human subjects, the conflict management plan will be reviewed by both the conflict of interest staff and the IRB Chair.

As part of their review the IRB Chair (or designee) may

1. Accept the management plan and recommend approval,
2. Recommend changes in the management plan, or
3. Refer the review to the full IRB

If referred for review to the full IRB by the IRB Chair (or designee), the convened IRB will determine if the conflict adversely affects the protection of human participants and if the management plan is adequate. The convened IRB has the final authority to decide whether the interest and its management, if any, allow the research to be approved. Based on the significance of the conflict and the potential for adverse effects on the protection of participants, conflict management plans may include:

- Disclosure to participants through the consent process,
- Modifications in the research plan,
- Monitoring by independent reviewers,
- Divestiture of financial interests,
- Appointment of a non-conflicted Principal Investigator, or
- Prohibition of conduct of the research at the University

The IRB application asks whether the PI believes there is a conflict of interest for the faculty investigators. As part of its review process, the IRB will make a determination as to whether the conflict adversely affects the protection of human participants. If a conflict of interest exists, final IRB approval cannot be given until an approved conflict management plan that adequately protects the human participants in the protocol is in place. A copy of the final, approved conflict management plan will be filed with the ORCI.

#### **7.6.17.2 Protocol-Specific Conflict Management for the Full Board Review**

The IRB application asks a protocol-specific question regarding conflict of interest for investigators and key personnel. As part of its review process, the IRB will make a determination as to whether the conflict adversely affects the protection of human participants. If the answer is yes and an approved conflict management plan exists, the IRB will review the plan to determine if it adequately protects the human participants in that protocol.

If no approved conflict management plan exists, the IRB will forward the conflict information to the ORCI and an appropriate conflict management plan will be developed according to the procedures described above.

Review of conflict management plans are documented in the IRB minutes for full board reviews or in the protocol file for expedited review. If a conflict of interest exists, final IRB approval cannot be given until an approved conflict management plan that adequately protects the human participants in the protocol is in place.

If the conflict-of-interest status of an investigator changes during a study, the individual is required to notify the ORCI within ten working days of the change. The IRB will review the change as a modification to the protocol.

#### **7.6.18 Other Committee Approvals**

In the application, the investigator will be asked specific questions to determine if the research requires approval from other pertinent research compliance committees (Radiation Safety Committee, Institutional Biosafety Committee, etc.). If the investigator answers yes to any of the questions, then he or she might be requested to provide documentation of approval from the other committees. Final approval from the IRB may be contingent on receipt of the required documentation.

#### **7.6.19 DXA Scanning**

When research is conducted with use of the DXA scanner in the Nutrition Laboratory Principal Investigators must follow the Procedure for protecting human participants undergoing DXA scans in the Human Nutrition Laboratory, Stone Building, UNCG document. The IRB initial reviewer will ensure that the individual named to conduct the scans for the study is named as a person trained to use the DXA prior to recommending approval for the study.

State law (§90-21.2) defines “treatment” sufficiently broadly to encompass the DXA scan even for research purposes, and the DXA scan would not qualify as the type of treatment that can be conducted on a minor without parental consent as described in § 90-21.1. When conducting studies that will include DXA scans of minors, the parental permission/consent for the DXA scan must be obtained.

State law (§90-21.5), however, provides that a minor can provide consent for, among other things, “diagnosis ... pregnancy,” which means parental permission/consent is not required for the pregnancy test portion of the study. The general rule under HIPAA regarding control of a patient’s protected health information is that if state law does not require for treatment, then the minor controls the protected health information – which means the results of the pregnancy test portion of the study should go to the minor participant, not the parent/guardian, unless the minor participant provides consent for providing the results to the parent/guardian. The parental permission/consent document cannot be misleading and should include a phrase like the following: “pre-screening procedure for safety” will be conducted prior to the DXA scan taking place.

#### **7.6.20 Magnetic Resonance Imaging (MRI)**

During the use of MRI in research, the PI may become aware of a condition which is of such clear clinical significance (e.g., brain tumor), that he/she feels ethically compelled to tell the subject. In this case, the PI should report the matter to the IRB immediately for assistance in determining how to proceed with potential reporting. This information should be relayed to the PI at time of proposal review by ORCI.

### **7.6.21 Use of test articles in research: INDs or IDEs Investigational New Drug and Investigational Device Exemption studies**

An Investigational New Drug (IND) Application or Investigational Device Exemption (IDE) are exemptions from the law that otherwise requires that a drug, biologic, or device must be approved before it can be transported across state lines. Generally, one of these exemptions is required whenever a research study uses a drug, biologic or significant risk device that has not received FDA marketing approval. An IND may also be required for a drug that does have FDA marketing approval if the research study proposes a use of the drug that was not included in the existing FDA approval. (See the FDA Information Sheets on “Off-Label” and Investigational Use of Marketed Drugs, Biologics, and Medical Devices “for additional requirements”.) IND and IDE research studies are subject to the same new and continuing review requirements as human subjects research in general, but they also require FDA approval for the proposed research use.

Most IND and IDE studies at UNCG are research protocols developed and sponsored by the commercial entity that is developing a drug or device pursuant to FDA regulations and is itself responsible for obtaining the IND or IDE approvals and for fulfilling all other FDA requirements for such a study. There are some IND or IDE studies for which the study protocol has been developed independently by a university investigator and for which that investigator is responsible for obtaining the IND or IDE and for fulfilling all FDA required filings and other documentation. Investigators should contact the Office of Clinical Trials for guidance and support regarding IND and IDE studies. Investigators will provide the IND or IDE number as a part of the IRB application; the IRB primary reviewer should verify that the IND or IDE number is valid by assuring consistency across documents (e.g., FDA letters, sponsor protocol).

The IRB is not required to monitor the investigator’s performance of required FDA paperwork. However, in reviewing the study, the IRB should be mindful that in this context, the IRB review should include a determination of whether an IND or IDE is required and may also require more intense IRB scrutiny of the protocol and related risks as well as more guidance to the investigator regarding the scientific design, subject safety parameters, informed consent process and other human subjects protection factors.

- For emergency use of an investigational product, see Emergency Use of an Investigational or Unlicensed Test Article.
- For non-emergency situations, prospective IRB approval is required. Single patient use allows a physician to obtain access to an investigational drug upon receiving approval from the IRB. This approval is granted for the treatment of a single patient. The treatment use may occur only after IRB approval is obtained.

#### **7.6.22.1 Compliance with IND regulations**

When research involves the use of a drug other than the use of a marketed drug during normal medical practice, UNCG will confirm that:

- The drug has an IND; or
- The protocol meets one of the FDA exemptions from the requirement to have an IND.

Exemption 1

- The drug product is lawfully marketed in the United States.
- The investigation is not intended to be reported to FDA as a well-controlled study in support of a new indication for use nor intended to be used to support any other significant change in the labeling for the drug.
- If the drug that is undergoing investigation is lawfully marketed as a prescription drug product, the investigation is not intended to support a significant change in the advertising for the product.
- The investigation does not involve a route of administration or dosage level or use in a patient population or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with the use of the drug product.
- The investigation will be conducted in compliance with 21 CFR 50 and 56.
- The investigation will be conducted in compliance with the requirements of 21 CFR 312.7.

#### Exemption 2

- A clinical investigation is for an in vitro diagnostic biological product that involves one or more of the following:
  - Blood grouping serum.
  - Reagent red blood cells.
  - Anti-human globulin.
- The diagnostic test is intended to be used in a diagnostic procedure that confirms the diagnosis made by another, medically established, diagnostic product or procedure.
- The diagnostic test will be shipped in compliance with 21 CFR 312.160.

#### Exemption 3

- A drug intended solely for tests in vitro or in laboratory research animals if shipped in accordance with 21 CFR 312.160.

#### Exemption 4

- A clinical investigation involving use of a placebo if the investigation does not otherwise require submission of an IND.

#### **7.6.22.2 Compliance with IDE regulations**

The device fulfilled the requirements for an abbreviated IDE:

- The device is not a banned device,
- The sponsor labels the device in accordance with 21 CFR 812.5,
- The sponsor will obtain IRB approval for the investigation after presenting the reviewing IRB with a brief explanation of why the device is not a significant risk device and maintains such approval,
- The sponsor will ensure that each investigator participating in an investigation of the device obtains from each subject under the investigator's care, consent under 21 CFR 50 and documents it, unless documentation is waived,
- The sponsor will comply with the requirements of 21 CFR 812.46 with respect to monitoring investigations,
- The sponsor will maintain the records required under 21 CFR 812.140(b) (4) and (5) and report as required under 21 CFR 812.150(b) (1) through (3) and (5) through (10),

- The sponsor will ensure that participating investigators maintain the records required by 21 CFR 812.140(a)(3)(i) and report as required under 812.150(a) (1), (2), (5), and (7), and
- The sponsor will comply with the prohibitions in 21 CFR 812.7 against promotion and other practices, or

The device fulfills one of the IDE exemption categories:

- A device, other than a transitional device, in commercial distribution immediately before May 28, 1976, when used or investigated in accordance with the indications in labeling in effect at that time.
- A device, other than a transitional device, introduced into commercial distribution on or after May 28, 1976, that the FDA had determined to be substantially equivalent to a device in commercial distribution immediately before May 28, 1976, and that is used or investigated in accordance with the indications in the labeling FDA reviewed under subpart E of part 807 in determining substantial equivalence.
- A diagnostic device, if the sponsor complies with applicable requirements in 21 CFR 809.10(c) and if the testing:
  - Is noninvasive.
  - Does not require an invasive sampling procedure that presents significant risk.
  - Does not by design or intention introduce energy into a participant.
  - Is not used as a diagnostic procedure without confirmation of the diagnosis by another, medically established diagnostic product or procedure.
  - A device undergoing consumer preference testing, testing of a modification, or testing of a combination of two or more devices in commercial distribution, if the testing is not for the purpose of determining safety or effectiveness and does not put participants at risk.
  - A custom device as defined in 21 CFR 812.3(b), unless the device was being used to determine safety or effectiveness for commercial distribution.

### 7.6.22.3 IRB Determination of a Significant vs. Non-significant risk device:<sup>7</sup>

What is a medical device?

A **medical device** is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is 1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them; 2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or 3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes (21 U.S.C. 321(h)).

### What is a significant risk (SR) device?

Definition

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<sup>7</sup> Taken from: <http://www.fda.gov/downloads/Training/CDRHLearn/UCM176494.pdf>

- Intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject
- Purported or represented for supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a subject
- Used for substantial importance in diagnosing, curing, mitigating, or treating disease and presents a potential for serious risk to the health, safety, or welfare of a subject
- Otherwise presents a potential for serious risk to health, safety, or welfare of a subject
- Examples: Dental lasers, embolization, devices for urological use, and collagen and bone replacements

**What is a non-significant risk (NSR) device?**

- One that does not meet the definition of a significant risk device
- Examples: External monitors for insulin reactions, general biliary catheters, MRI within specified parameters

**Who decides whether a device is SR or NSR?**

Sponsors

- Make the initial risk determination
- Presents the IRB with this information

IRB

- Required to determine whether the NSR device study involves a SR or NSR device

FDA

- Available to help
- Final arbiter

**Requirements in 21 CFR 812 for NSR device studies**

- Abbreviated requirements at 21CFR 812.2(b)
  - Labeling, IRB approval, informed consent, monitoring, record keeping, reports, and prohibition against promotion.
- NSR studies are considered to have an approved IDE therefore no IDE to FDA.
- Sponsors and IRBs do not have to advise FDA of NSR device studies.
- IRBs must make a SR or NSR determination for every NSR study (21 CFR 812.66).

**The IRB will review the following information when making a NSR device determination:**

- IRBs must make a SR or NSR determination for every NSR study (21 CFR 812.66).
- Sponsor will provide the IRB with a brief explanation of why the device is not significant risk or provide a letter from FDA that FDA determined the device to be nonsignificant risk.

Any other information requested by the IRB such as:

- Description of device,
- Reports of prior investigations,
- Proposed investigational plan, or
- Subject selection criteria.

The IRB will make a SR or NSR determination by reviewing relevant information at a convened meeting.

**When making the SR or NSR determination, the IRB will consider:**

What is the basis for the risk?

- Proposed use of the device.

What is the nature of harm that may result from the use of the device?

Any additional procedures required for device use?

- Potential harm from procedures.

**If the IRB determination of NSR agrees with the sponsor's NSR:**

- IRB can review the study using criteria at 21 CFR 56.111 and 21 CFR 56.812.2(b).
- Non-significant risks studies are considered an approved IDE, so no IDE to FDA.
- Sponsors and IRBS do not have to advise the FDA of NSR device studies.

**Documenting SR or NSR determination**

- Write the determination in the minutes,
- The minutes will document the reason for the determination,
- For non-significant risk studies, all materials reviewed will be maintained.

**If the IRB determination does not agree with the sponsor determination of NSR**

If the IRB determines that a NSR device study involves a significant risk device, the IRB will:

- Inform the clinical investigator and where appropriate, the sponsor.
- The study cannot start until the sponsor obtains an IDE.

## **7.7 Continuing Review or Administrative Check-In of Active Protocols**

### **7.7.1 Exempt Studies**

The UNCG IRB requires that exempt studies have an initial administrative check-in date of 3 years or the date of graduation for student protocols (whichever occurs first). After the initial check-in, the period for subsequent check-in is at 3 year intervals until closure or 1 year intervals for student protocols. Administrative check-in is completed in the Cayuse system.

### **7.7.2 Renewals (Continuing Review)**

The revised Common Rule modifies when continuing review is required. UNCG requires continuing review for expedited and full board studies where data collection and/or interaction or follow-up with participants is ongoing. Continuing review in the Cayuse system is called Renewal. Renewals for expedited studies need only to be reviewed by the IRB Chair, an experienced IRB analyst (who is an IRB Member), or an experienced IRB Member. Unless UNCG IRB determines otherwise, continuing review of research is not required for research subject to the revised Common Rule in the following circumstances:

1. Research that has progressed to the point that it involves only one or both of the following, which are part of the IRB-approved study:

- a. Data analysis, including analysis of identifiable private information or identifiable biospecimens, or
- b. Accessing follow-up clinical data from procedures that subjects would undergo as part of clinical care.

UNCG IRB may determine that continuing review is required for any research protocol that falls within the above criteria. The following is not required but provided as an example of factors an IRB may consider. For example, the IRB may determine that continuing review is required when:

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

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

If continuing review is not required, the IRB staff are not required to check CITI training for study personnel. An Administrative Check-In is required for all expedited studies in data analysis only. This check-in should be scheduled at the time of the first renewal in which the study is stated to be in data analysis only. Administrative check-in will occur in 3-year intervals after the study is first put into data analysis only status or for student protocols 1 year intervals or the date of graduation minus 1 day. Administrative check-in will continue until the study is closed.

If a continuing review is not submitted and approved by the expiration date, all work on the study must stop. An incident report will need to be submitted to explain why the project was allowed to lapse into expired status. Once the incident report is reviewed, a renewal can be reviewed by the IRB.

### **7.7.3 Continuing Review of Full Board Studies**

To assist investigators with continuing approval of studies, the ORCI staff will send out renewal notices to investigators two months and one month in advance of the expiration date via the online submission system; however, it is the investigator's responsibility to ensure that the continuing review of ongoing research is approved prior to the expiration date and in time for the next scheduled IRB meeting. By federal regulation, no extension to that date can be granted. For continuing review, investigators must submit a renewal through the online system to the IRB. If there are anticipated changes to the protocol or consent forms, such changes can be submitted as a modification. Some changes may be reviewed as expedited and approved by the IRB reviewer in the ORCI and will not require full board review.

Generally, if research did not qualify for expedited review at the time of initial review, it does not qualify for expedited review at the time of continuing review, except in limited circumstances

described by expedited review categories (8) and (9) at 63 FR 60364-60367 (see Expedited Review Categories). It is also possible that research activities that previously qualified for expedited review in accordance with 45 CFR 46.110 have changed or will change such that expedited IRB review would no longer be permitted for continuing review. Continuing review of research not eligible for expedited review will occur at a scheduled IRB meeting. All IRB members are provided with the information contained in the IRB protocol file including modification applications, the completed renewal form, and updated IRB application. At the IRB meeting, the Primary Reviewer will lead the IRB through the regulatory criteria for approval.

ORCI staff attends the convened meetings and brings the complete protocol files or displays the protocols via projection for each protocol on the agenda. The IRB staff will retrieve any additional related materials the IRB members may request.

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

#### **7.7.4 Study Closure**

Studies may be closed when the involvement of human subject's ceases.

Do not file a study closure report if any of the following six conditions apply. Such studies must remain active and continue to receive ongoing IRB review and approval:

- Enrollment at the UNCG approved site is ongoing.
- Research-related interventions and/or follow-up at the UNCG-approved site is ongoing.
- Participant follow-up at the UNCG -approved site is ongoing.
- Biological specimens containing personally identifiable information are being maintained in a repository that has been approved as part of this study or upon which analysis or research is ongoing. If, however, specimens were transferred to a separate repository that has ongoing IRB approval, the study may be closed.
- Data analysis or manuscript preparation that involves the use or access to personally **identifiable information** is ongoing.
- If there is an external study sponsor and the sponsor has not provided permission to close the study with the IRB

A research project no longer involves human subjects once the investigators have finished obtaining data through interaction or intervention with subjects or obtaining identifiable private information about the subjects, which includes the using, studying, or analyzing of identifiable private information. Once all such activities described in the IRB-approved protocol are finished, the research project no longer needs to undergo continuing review. For example, when the only remaining activity of a research project involves the analysis of aggregate data sets without individual subject identifiers, no further continuing review is necessary. The above criteria also fit in the case of a study which is merely awaiting publication, and all data has been analyzed and deidentified. Similarly, simply maintaining individually identifiable private information without using, studying, or analyzing such information is not human subjects' research and thus does not require continuing review.

#### **7.7.4.1 Study Closure Review**

The IRB will review study closure submission and acknowledge the closure of the study or request additional information or clarification of facts from the investigator.

#### **7.7.4.2 Continuing Review and Closure**

Investigators have up to 90 days after a study expires or required administrative check-in to submit a renewal application and/or obtain approval. After 90 days, the IRB will permanently close the study. If the investigator wishes to continue work, they will need to submit a new study for review.

#### **7.7.5.1 PI Moves to another Institution**

If a PI leaves the university to work at another institution, studies that are active at UNCG must be opened at the new site or moved to a different investigator that is at UNCG. If the study is moved to a new site, it should be closed at UNCG. The PI can close any active study at any point in the study by completing a closure form in Cayuse. Completion of this form allows the IRB to appropriately close the file while ensuring that all regulatory requirements have been met.

#### **7.7.6.2 Student Research and Graduation/Departure**

In the case of student investigators, ORCI recommends that a study be closed prior to or at the point of graduation if all the previous criteria (SOP 7.6) from the OHRP have been met. If this is not done, the Faculty Advisor must assume responsibility for the study and all renewals. A modification must be submitted to make the Faculty Advisor the PI of record, otherwise notification for renewals and administrative check-ins will continue to be sent to the student even if they are no longer affiliated with UNCG. The Faculty Advisor will be required to store all deidentified data and consent forms until at least five years after the **closure date**, as stated in the IRB application.

Faculty Advisors who renew protocols for students who have graduated or wish to be associated with the study are fully responsible for the study and must be indicated as the primary investigator for the protocol. The former student must be removed from the study and may open their study at another institution in which they are affiliated if the study is still considered to be in an active state. The Faculty Advisor must maintain the original research data including signed informed consent forms and confidentiality agreements or obtain such documents upon request from the IRB or ORCI for Data Safety Monitoring auditing purposes. If the Faculty Advisor does not choose one of the two options above, he or she is required to close the project. To assist investigators, the ORCI staff will send out renewal notices to investigators two months and one month in advance of the expiration date; however, it is the student and/or the Faculty Advisor's responsibility to ensure that the continuing review of ongoing research is approved prior to the expiration date.

It is important to note that the location of the data will need to adhere to the University's Data and Retention Policy and the ability to transfer data collected at UNCG as part of a research study may

require an “Original Data Transfer Request” form and may require a signature from UNCG if data from a study will be transferred to another institution.

***Any lapse in approval will require that the research stop and, if the research is DHHS-sponsored, notification of the funding agency.***

## **7.8 Modification of an Approved Protocol**

Investigators may wish to modify or amend their approved applications. **Investigators must seek IRB approval before making any changes in approved research** - even though the changes are planned for the period for which IRB approval has already been given - unless the change is necessary to eliminate an immediate hazard to the participants (in which case the IRB must then be notified at once). Failure to obtain IRB approval before implementing changes (when there is no immediate hazard) may result in punitive actions or possible noncompliance from the IRB including, but not limited to, loss of IRB approval and closure of the study.

Modifications may be approved if they are within the scope of what the IRB originally authorized. For example, if a researcher wishes to add a population to an existing study, but not alter the study procedures or purpose, a modification request is usually appropriate. Likewise, modifying a procedure without changing the study's purpose or study population may also be appropriate. If, however, the researcher wishes to add a population and revise study procedures, he or she may need to submit a new application for IRB approval, due to the change in the scope of the study. The PI will be informed by the IRB reviewer if this action is necessary.

Investigators must submit any modifications through the online system to inform the IRB about the changes in the status of the study, including, but not necessarily limited to:

- Revised consent/parental permission/assent documents (if applicable) or other documentation that would be provided to participants when such information might relate to their willingness to continue to participate in the study
- Additional research staff or investigators
- Revised or additional recruitment materials
- Support letters from research sites not obtained at the time of the initial approval by the IRB
- Any other relevant documents provided by the investigator

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

### **7.8.1 Review of Protocol Modifications – Minor Modifications**

The IRB may use expedited review procedures to review minor changes in ongoing previously approved research during the period for which approval is authorized. Minor changes do not significantly alter the study design or increase the risk to participants. A minor change can include items such as:

- Changes in research personnel that do not alter the competence of the research team to conduct the research
- Changes that leave the research population at the same or lower risk than risk(s) already approved
- An increase in the number of study visits for the purpose of increased safety monitoring
- Minimal changes in remuneration
- Title Change
- Changes to improve the clarity of statements, enhance comprehension or to correct typographical errors, updating to current template, without altering the content or intent of the statement
- Clarification of discrepancies within the IRB review materials (protocol cover sheet, protocol, consent) such as numbers of subjects, number and identity of research sites, timing, nature, and duration of research procedures.

The modification must also meet both of the following criteria:

- All added procedures involve no more than minimal risk
- All added procedures fall into categories (1)-(7) of research that could be reviewed using the expedited procedure

If the criteria listed above are met, the change may be reviewed and approved by the IRB analyst and a member of the IRB committee.

### **7.8.2 Review of Protocol Modifications—Major Modifications**

When proposed changes to a research study are Major, then the IRB must review and approve the proposed change at a convened meeting before the change can be implemented, regardless of the initial categorization of the study (full board, expedited or exempt). Major modifications involve any increase in risk to participants that is more than minimal, OR any additional activity or procedure that would not be eligible for expedited review if submitted as part of new research, OR the research itself involves more than minimal risk and the changes significantly alter the study design, such as adding or removing major procedures.

Examples of major changes are those that are considered to increase the risk to the subject. Other examples include:

- Knowledge of a new risk which might affect the risk/ benefit ratio (For example, if a risk that is serious, life-threatening, or could potentially result in permanent disability). The addition of these sorts of risk might affect the IRB's view of the risk/benefit ratio and should therefore be reviewed by the full board.
- Changing the originally targeted population to include a more at-risk population (example: previous exclusion for those with renal failure are now allowed to enroll, or adding children or pregnant women to the study.)
- Multiple changes in the study design
- Adding additional procedures where the risk of the additional procedure is greater than minimal risk.

The only exception is a change necessary to eliminate apparent immediate hazards to the research participants. In such a case, the IRB should be promptly informed of the change following its

implementation and should review the change to determine that it is consistent with ensuring the participants' continued welfare. All IRB members are provided and review all documents given to the IRB by the investigator. At the meeting, the Primary IRB Reviewer presents an overview of the modifications and leads the IRB through the regulatory criteria for approval.

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

## **7.9 Data Safety Monitoring**

Data Safety Monitoring involves the oversight and monitoring of data collection, compliance with federal guidelines, UNCG policies, and that the procedures described within the application are being followed.

The investigator will disclose their plan to ensure the safety of research participants in the IRB protocol. This disclosure should also include a plan to terminate the research if warranted. The investigator must qualify/quantify how they will determine when they terminate the study due to increased risk(s) to participants. These risks could include but are not limited to: students with a high probability of failing a class in which the curriculum is experimental, physical harm to participants, or overwhelming emotional/psychological trauma. The IRB will review the plans for data safety for protocols during initial review and at continuing review.

### **7.9.1 Post Approval Monitoring Audits by the ORCI**

The ORCI may conduct Annual Post Approval Monitoring (PAM) Audits. Post Approval Monitoring is conducted to ensure that research is carried out according to the highest standards of scientific integrity and ethical behavior. The ORCI may randomly select up to 5% of active nonexempt IRB protocols to be monitored. Protocols will be selected by using a random calculation function in Excel.

Principal Investigators whose projects are selected for monitoring will be contacted by the ORCI to schedule an appointment for the Assistant Director to review the data from the selected protocol. IRB members may accompany the Assistant Director on Post Approval Monitoring visits. Following the audit, a report will be drafted and forwarded to the Principal Investigator stating findings and corrective actions, if any.

Federal regulations regarding the conduct of Human Participants Research, as well as UNCG Policies and Procedures, change regularly. Accordingly, it is possible that a Post Approval Monitoring Audit may bring to light forms or procedures that were approved by the IRB in the past, but that would not be approved were the application to be submitted at the time of the Audit. The purpose is also to ensure that the study is being conducted in compliance with the most recently approved protocol. In such cases, the following guidelines will be used to determine whether the PI will need make changes to forms or procedures:

- If Certificates of Training in the Protection of Human Research Participants have expired according to the current required renewal timeline, the PI will be required to update certificates according to current requirements.

- If Federal regulations have changed such that earlier approved procedures are now considered in violation of such regulations, the Director and IRB Chair will work with the PI to make changes to the project such that violations are no longer present.
- If UNCG policies and procedures have changed (e.g., UNCG is now requiring additional elements of consent that were not required at the time of the approval) the investigator will generally not be required to make changes to the project. However, at such time that a new IRB application or renewal application for the project is submitted, the new application will be required to conform to all current UNCG policies and procedures.

The following will also be reviewed at the annual PAM:

- Ensure that CITI training and statements of confidentiality are on file for all research team members.
- Ensure that the most recently approved version of the consent form is being used.
- Ensure that recruitment efforts and sample are consistent with the approved protocol.
- Ensure that any unanticipated or adverse events that have occurred during the conduct of the study, and actions taken in response to those events, are documented. Actions taken are consistent with the approved protocol.
- Ensure that data collection procedures have adhered to approved protocol.
- Ensure that data, databases and data points and analyses are stored and handled securely according to the approved protocol.

#### **7.10 Unanticipated Problems Involving Risks to Participants or Others and Adverse Events<sup>8</sup>**

Federal regulations require organizations to have written policies and procedures to ensure the prompt reporting of unanticipated problems involving risks to participants or others to the IRB, appropriate institutional officials, and regulatory agencies.

Not all unanticipated problems involve direct harm to participants. Events can occur which are unexpected and result in new circumstances that increased the risk of harm to participants without directly harming them. In addition, the event may have presented unanticipated risks to others (e.g., the sexual partners of the participants, individuals with whom the participant may come in contact such as family members, research personnel, etc.) in addition to participants. In each case, while the event may not have caused any detectable harm or adverse effect to participants or others, it nevertheless represents an unanticipated problem and should be promptly reported.

Events which result in direct harm to participants are referred to as “Adverse Events”. Although adverse events occur most commonly in the context of biomedical research, adverse events may also occur in the context of social and behavioral research. Only unexpected adverse events (adverse events that were not outlined in the risk section of the consent form) and that are related to the research, need to be reported.

#### **Reporting Timetable**

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<sup>8</sup> (NOTE: For simplicity, unanticipated problems involving risks to participants or others will be referred to as “unanticipated problems” in this policy)

1. Internal adverse events that are unexpected, fatal, or life-threatening, and related to the research intervention must be reported to the IRB within 24 hours of the event.
2. Internal adverse events which are unanticipated problems (but not fatal or life threatening), shall be reported to the IRB within ten (10) working days of the investigator becoming aware of the event.
3. External adverse events (i.e., external sponsor generated safety reports) which are unanticipated problems shall be reported to the IRB within ten (10) working days of their receipt.
4. Unanticipated problems that are not related to adverse events must be reported to the IRB within ten (10) working days of the event.

### **7.10.1 Definitions**

#### **Unanticipated Problem Involving Risks to Participants or Others (Unanticipated Problem):**

Any event or information that (1) was unforeseen and (2) indicates that the research procedures caused harm to participants or others or indicates that participants or others are at increased risk of harm.

**Adverse event:** Any physical, psychological, or social harm to participants during the research and because of participation in the research.

**Unexpected:** An event is “unexpected” when its specificity and severity are not accurately reflected in the informed consent document.

**Related to the research:** An event is “related to the research procedures” if it was more likely than not to have been caused by the research procedures or if it is more likely than not that the event affected the rights and welfare of current participants.

### **7.10.2 Reporting**

Principal investigators must report to the IRB as soon as possible, but in all cases within ten (10) working days any:

1. Adverse events which in the opinion of the principal investigator are both unexpected and related.
2. An unanticipated or unexpected event that involves risks to participants or other exposed individuals (e.g., research participants, investigators, research assistants, students, the public, etc.) and is more likely than not, related to the research.
3. Information that indicates a change to the risks or potential benefits of the research. For example:
  - a. An interim analysis or safety monitoring report indicates that frequency or magnitude of harms or benefits may be different than initially presented to the IRB.
  - b. A paper is published from another study that shows that the risks or potential benefits of your research may be different than initially presented to the IRB.
4. A breach of confidentiality.

5. Incarceration of a participant in a protocol not approved to enroll prisoners should the investigator intend to continue interactions with the participant while he or she is incarcerated.
6. Change to the protocol taken without prior IRB review to eliminate an apparent immediate hazard to a research participant.
7. Complaint of a participant when the complaint indicates unexpected risks or cannot be resolved by the research team.
8. Protocol violation (meaning an accidental or unintentional change to the IRB approved protocol) that harmed participants or others or that indicates participants or others may be at increased risk of harm.
9. Event that requires prompt reporting to the sponsor.
10. Sponsor imposed suspension for risk.
11. Proposed changes in a research activity and the premature completion of a study.

If the investigator is unsure whether the event should be reported, he or she should contact the ORCI for consultation.

Principal investigators should report the above events using the IRB Unanticipated Problem/Adverse Problem Form or report the event through the online system. Reports may be accepted by other means such as e-mail or by phone.

### **7.10.3 IRB Review of Reported Event**

Upon receipt of an IRB Incident Report in Cayuse (or documentation if Cayuse is not available) from a Principal Investigator, the ORCI staff checks the form for completeness. If any applicable sections of the Incident Report are incomplete or have been answered unsatisfactorily, the IRB staff contacts the investigator or the designated contact person to obtain additional information. Corrections are documented in the IRB file, indicating the date, the person spoken with, and the IRB staff making the correction.

The ORCI staff forwards the Incident Report and all supporting documents provided by the investigator to the IRB Chair for review. Changes in approved research initiated without IRB approval to eliminate apparent immediate hazards to the participant must be reviewed by the IRB to determine whether the change is consistent with ensuring the participants' continued welfare.

Based on the information received from the investigator, the IRB Chair may suspend research to ensure protection of the rights and welfare of participants. Suspension directives made by the IRB Chair must be reported to a meeting of the convened IRB. If the IRB Chair determines that either (1) the problem was foreseen OR (2) no participants or others were harmed AND participants or others are not at increased risk of harm, the IRB Chair indicates on the application that the problem is not an unanticipated problem. The note is placed in the Cayuse record, the determination is communicated to the investigator, and no further action is taken.

If the IRB Chair and Assistant Director determines that the problem is an unanticipated problem, but that the risk is no more than minimal, the chair or designee will review:

1. The currently approved protocol,
2. The currently approved consent document, and

3. Previous reports of unanticipated problems involving risks to participants or others for the project.

After reviewing all the materials, the IRB Chair or Assistant Director will take appropriate action depending on the nature of the risk involved including modification of the protocol or the consent form, if applicable. The results of the Chair's review will be recorded in the protocol record, communicated to the investigator, reported to the IRB, and referred to the ORCI to be handled according to the reporting procedures in Section 12.

All reported unanticipated problems in cases for which the risk is more than minimal will be reviewed at a convened IRB meeting. All IRB members are provided a copy of the IRB Incidence Form (if available) and supporting documents provided by the investigator. At least one IRB member is provided:

1. The currently approved protocol,
2. The currently approved consent document,
3. Previous reports of unanticipated problems involving risks to participants or others for the project.

If the IRB considers the event to not represent an unanticipated problem, the results of the review are recorded in the protocol record, communicated to the investigator, and no further action is taken.

If the IRB considers the event to represent an unanticipated problem, the IRB will consider the following actions:

1. Modification of the protocol,
2. Modification of the information disclosed during the consent process,
3. Providing additional information to current participants (This must be done whenever the information may relate to the participant's willingness to continue participation),
4. Providing additional information to past participants,
5. Requiring current participants to re-consent to participation,
6. Alteration of the frequency of continuing review,
7. Observation of the research or the consent process,
8. Requiring additional training of the investigator,
9. Notification of investigators at other sites,
10. Termination or suspension of the research according to Section 11.4, and/or
11. Obtaining additional information.

The results of the IRB review are recorded in the protocol record, communicated to the investigator, and referred to the ORCI to be handled according to the reporting procedures in Section 12.

#### **7.10.4 Protocol Deviations**

A protocol deviation is a variance from the approved study protocol that:

- Is generally noted or recognized after it occurs,
- Has no substantive effect on the risks to research participants,
- Has no substantive effect on the scientific integrity of the research plan or the value of the data collected, and
- Did not result from willful or knowing misconduct on the part of the investigator(s).

Some examples of protocol deviations include:

- Performing planned data collection on a different timetable than previously specified in the research protocol because of an unforeseen disruption such as a subject's vacation.
- A mechanical failure such as a recording device malfunction.

Deviations should be tracked by the investigator and reported to the IRB via email within 7 working days.

### **7.10.5 Protocol Violations**

A protocol violation is defined as a variance from the approved study protocol that:

- Has harmed or increased harm to one or more research participants,
- Has damaged the scientific integrity of the data collected for the study,
- Results from willful or knowing misconduct on the part of the investigator(s), and
- Demonstrates serious or continuing noncompliance with federal regulations, state laws, or university policies.

Some examples of protocol violations include:

- Proceeding with the protocol before obtaining final IRB approval,
- Failing to follow the established criteria or procedures that were approved by the IRB,
- Adding, removing, or modifying a research instrument (or adding to an existing instrument) in a survey study without prior IRB approval unless the changes are within a range of anticipated potential changes specified as acceptable within the IRB approval, or
- Implementing any change in the protocol without IRB approval.

### **7.10.6 IRB Notification and Response in case of protocol violations:**

- Upon receipt of a protocol violation, it is reviewed by a Chair and may be referred to IRB for review.
- If it is deemed a serious violation (e.g., one that affects subject safety) the Chair may suspend the study pending IRB review of the violation(s).
- Correspondence about serious violations should be copied to the Director of ORCI, the Institutional Official, and others as relevant.
- Violations should be reported within one (1) week of the investigator becoming aware of the event using the same mechanism used to report Unanticipated Problems and Adverse Events.

## **7.11 Appeal of IRB Decisions**

If a subcommittee of an IRB decides that the investigator believes to be unduly restrictive on the proposed research, the investigator has 30 days from the date of the IRB decision to appeal, in writing, for review by the convened IRB.

If the convened IRB makes a decision that the investigator believes to be unduly restrictive on the proposed research, the investigator should first discuss the matter with the Chair of the IRB or the Director, taking care to explain, with new information not available to the IRB initially, the reasons for believing that the proposed procedures are in compliance with university policy and with Federal regulations. If the issue cannot be resolved satisfactorily by negotiation, the investigator

may appeal the decision of the IRB, in writing. The IRB will reconsider the appeal based upon the new information provided and will continue to re-review the protocol if the investigator wishes to appeal. Following the review of the investigators written request, the IRB may request the investigators presence at the next scheduled IRB meeting for further discussion. The Institutional Official may not approve research if it has not been approved by the UNCG IRB.

## **7.12 Sponsored Projects**

- 1) Externally funded projects must be reviewed by the Office of Sponsored Programs:
  - a) The Office of Sponsored Programs, Contracts & Grants and the IRB will collaborate to ensure that there is an approved IRB protocol before research with human subjects is allowed to begin.
- 2) University funded projects (i.e., unit funds or research grants committees):
  - a) The IRB may request a copy of any proposal submitted to a university program (such as a faculty grant) to ensure that the IRB protocol and funded project description are consistent.
- 3) The Office of Sponsored Programs reviews funded projects against institutional policy and informs the sponsor of university policy. In some cases, this is done by signing assurance statements that accompany sponsored projects award documents. When there is a discrepancy the Office of Sponsored Programs negotiates directly with the sponsor.

## **8. Criteria for IRB Approval of Research**

In accordance with 45 CFR 46.111, to approve research, both federally funded and non-federally funded, the IRB must determine that all of the following requirements are satisfied:

- (1) Risks to participants are minimized: (i) by using procedures which are consistent with sound research design, and which do not unnecessarily expose participants to risk, and (ii) whenever appropriate, by using procedures already being performed on the participants for diagnostic or treatment purposes.
- (2) Risks to participants are reasonable in relation to anticipated benefits, if any, 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 participants 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) among the issues that fall within the purview of its responsibility.
- (3) Selection of participants is equitable. In making this assessment the IRB should take into consideration 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 disable persons, or economically or educationally disadvantaged persons.
- (4) Informed consent will be sought from each prospective participant or the participant'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 participants.
- (7) When appropriate, there are adequate provisions to protect the privacy of participants and to maintain the confidentiality of data.
- (8) When some or all participants 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 participants.

For **exempt research** subject to **limited IRB review**, the following criteria shall be applied:

1. For exempt categories 2(iii) and 3(iii) (See Section 3.2), the IRB may approve the research when it determines that there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.
2. For exempt category 7, the IRB may approve the research when it determines that the following criteria are satisfied:
  - a. Broad consent for storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens is obtained in accordance with the requirements of § .116(a)(1) - (4), (a)(6), and (d) (See Sections 8.1 and 8.3 below);
  - b. Broad consent is appropriately documented, or waiver of documentation is appropriate, in accordance with § .117 (See Sections 8.6 and 8.7 below); and
  - c. If there is a change made for research purposes in the way the identifiable private information or identifiable biospecimens are stored or maintained, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.
3. For exempt category 8, the IRB may approve the research when it determines that the following criteria are satisfied:
  - a. There are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data; and
  - b. The research to be conducted is within the scope of the broad consent obtained from subjects.

## **8.1 Risk/Benefit Assessment**

The goal of the assessment is to ensure that the risks to research participants posed by participation in the research are justified by the anticipated benefits to the participants or society. Toward that end, the IRB must:

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

The assessment of the risks and benefits of proposed research – one of the major responsibilities of the IRB - involves a series of steps:

1. **identify the risks** associated with the research, as distinguished from the risks of therapies the participants would receive even if not participating in research,

2. **determine whether the risks will be minimized** to the extent possible,
3. **identify the probable benefits** to be derived from the research,
4. **determine whether the risks are reasonable in relation to the benefits** to participants, if any, and assess the importance of the knowledge to be gained, and
5. **ensure that potential participants will be provided with an accurate and fair description** of the risks or discomforts and the anticipated benefits.

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.

**Risks to participants are reasonable in relation to anticipated benefits**, if any, and to the importance of the knowledge that may reasonably be expected to result.

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

### **8.1.1 Scientific Merit**

To assess the risks and benefits of the proposed research, the IRB must determine that:

- The research uses procedures consistent with sound research design,
- The research design is sound enough to reasonably expect the research to answer its proposed question, and
- The knowledge expected to result from this research is sufficiently important to justify the risk.

In making this determination, the IRB may draw on its own knowledge and disciplinary expertise, or the IRB may draw on the knowledge and disciplinary expertise of others, such as reviews by a funding agency, or departmental review.

## **8.2 Selection of participants is equitable.**

The IRB will review the inclusion/exclusion criteria for the research to ensure equitable selection of participants. In making this assessment the IRB considers the purposes of the research and the setting in which the research will be conducted and is particularly cognizant of the special problems of research involving vulnerable populations, such as children, prisoners, fetuses, pregnant women, human *in vitro* fertilization, persons who are cognitively impaired, or persons who are economically or educationally disadvantaged (see Vulnerable Populations).

### **8.2.1 Recruitment of Participants**

The investigator will provide the IRB with all recruiting materials to be used in identifying participants. The IRB must approve all advertisements and or recruitment scripts prior to posting, oral presentation, and/or distribution. The IRB will review:

1. The information contained in the advertisement.
2. The mode of its communication.
3. The final copy of advertisements (i.e., print, audio, video).
4. The final website recruiting participants.
5. The final oral script.

The criteria for advertisements are as follows:

- Do not state or imply a certainty of favorable outcome or other benefits beyond what is outlined in the consent document and the protocol.
- Do not include exculpatory language.
- Do not emphasize the payment or the amount to be paid, by such means as larger or bold type.
- Do not promise “free treatment” when the intent is only to say participants will not be charged for taking part in the investigation.
- Limit information to the prospective participants to assist them in determining their eligibility and interest, such as:
  - The name and address of the investigator or research facility.
  - The purpose of the research or the condition under study.
  - In summary form, the criteria that will be used to determine eligibility for the study.
  - A brief list of participation benefits, if any.
  - The time or other commitment required of the participants.
  - The location of the research and the person or office to contact for further information.

If you are utilizing email recruitment, please be aware of the Survey Harassment policy (see section 11.2).

### **8.2.1.1 Snowball Sample Recruitment**

“Snowball sampling” is a recruitment technique in which research participants are asked to assist researchers in identifying other potential subjects. The use of currently enrolled research participants to recruit additional research participants (sometimes referred to as “snowball sampling”) may be approved by the IRB under some circumstances and with justification for the use of this method in the context of the study and target population. The method that minimizes risk would be the preferred choice. For example, a researcher seeking to study patterns of informal leadership in a community may ask individuals to name others who are influential in a community.

If the topic is sensitive or personal, snowball sampling may be justified, but methods must ensure the privacy of potential subjects. The steps taken to minimize the risk of violating an individual’s privacy should be articulated in the recruitment section of the protocol. Current participants cannot receive incentives or compensation for referrals.

Acceptable alternatives that reach the same potential subjects include:

- The study team member may provide information to subjects and encourage them to pass it on to others who may be interested or eligible. The information provided to enrolled subjects (fliers, letters of explanation, etc.) must be approved by the IRB. Interested prospective participants could then contact the project for more info and possible inclusion.

- The study team member may ask subjects to obtain permission from others prior to disclosing their contact information. In this scenario, the researcher would not directly contact the referred/potential subject without permission from the potential subject and would not have access to any information about a potential subject without permission from that individual.

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

The IRB reviews the material to assure that the material is accurate and is not coercive or unduly optimistic, creating undue influence on the participant. Any advertisement to recruit participants should be limited to the information the prospective participants need to determine their eligibility and interest. When participants are being paid, the IRB will review both the amount of payment and the proposed method and timing of disbursement to assure that neither are coercive or present undue influence.

### **8.2.1.2 Recruitment from UNCG Classes**

When the PI is recruiting from UNCG classes, permission to recruit from classes must be secured from the department chair(s) (email permission should be included with the IRB submission). There are several options for facilitating this work, including:

1. The research becomes part of the course work, and all students enrolled in the course/section are required to complete the work. In this case, the consenting process includes only the request to utilize the course work for research purposes after the semester is over. This option requires planning and is more difficult if the semester has already started, since the inclusion of the research as part of the course grade necessitates inclusion of the item as part of the syllabus. If completion of the work is required by all students, but no grade is attached, inclusion in the syllabus is not required. If the PI is the IOR, additional issues must be addressed (please see section 8.2.1.3).
2. Recruiting out of classes with or without compensation for participation:
  - a. PIs can recruit from courses via Canvas, email or in person using recruitment materials approved by IRB. Students can elect to participate but no course credit is given and monetary remuneration may or may not be offered.
  - b. If either course credit or extra credit is given for research participation, a non-research option of equal credit must also be given.
  - c. Either course credit or monetary remuneration may be offered, but students cannot receive both options for participation. One or the other must be chosen.

### **8.2.1.3 Recruitment from UNCG Classes when PI is the Instructor of Record (IOR)**

When PIs are recruiting from a class where they are listed as the IOR, every effort must be made to remove implied or outright coercion due to power differentials between the IOR (faculty, staff, or graduate students) and students enrolled in the course. In this situation, 2 options are available for consenting students. These include:

1. A neutral third party (i.e., graduate student, department chair, other faculty) can explain the study to the class and collect informed consent. This person retains informed consent until the end of the semester and after the final grades are posted, the PI is made aware of which students agreed to participate and have their work

included as part of the research. This person should not have access or influence on the student's final grade.

2. The PI can recruit students from another section of the same course for which they are not the IOR.
3. If the IOR of the course is the PI on the IRB but a neutral third party is responsible for grades (i.e., a teaching assistant is responsible for all grading), the neutral third party can collect consent from students and add course or extra credit for research to the grades. However, if the PI is the IOR and is responsible for grading, no course or extra credit can be included for research participation since this does not allow for anonymity and coercion can be implied.
4. The research is completely anonymous, and the students are not identifiable. (example Qualtrics anonymized survey). In this case, the research can be completed without the above options.

#### **8.2.1.4 Recruitment of Employees/Students from other Universities**

When PIs are recruiting from other universities, they must document permission (i.e., an email or letter) to recruit student (or staff/faculty) participants at other institutions. This should be from the IRB. If no IRB exists, then the signatory that approves research on campus should provide permission.

It is not permissible for recruitment to occur by emailing publicly available email addresses of university employees or students either at UNCG or at other institutions, if the explicit intention of the initial email is to request distribution of recruitment/research information to students via university emails that are not publicly available.

### **8.3 Informed Consent**

The IRB will ensure that informed consent will be sought from each prospective participant or the participant's legally authorized representative in accordance with and to the extent required by 45 CFR 46.116 for non-exempt, unfunded, or federally and non-federally funded research. In addition, the Committee will ensure that informed consent will be appropriately documented in accordance with, and to the extent required by 45 CFR 46.117. See Section 9 below for detailed policies on informed consent.

### **8.4 Privacy and Confidentiality**

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

#### **Definitions**

- Privacy – having control over the extent, timing, and circumstances of sharing oneself (physically, behaviorally, or intellectually) with others.
- Confidentiality – methods used to ensure that information obtained by researchers about their participants is not improperly divulged.

## **Regulations**

46.102(f) Human participant means a living individual about whom an investigator conducting research obtains (1) data through intervention or interaction with the individual, or (2) identifiable private information.

- Private information – information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record).
- Identifiable information – information where the identity of the participant is or may readily be ascertained by the investigator or associated with the information.

## **Privacy**

The IRB must determine whether the activities in the research constitute an invasion of privacy. To make that determination, the IRB must obtain information regarding how the investigators gain access to participants or participants' information and the participants' expectations of privacy in the situation. Investigators must have appropriate authorization from relevant agencies or organizations to access the participants or the participants' information.

## **Confidentiality**

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

## **8.5 Vulnerable Populations**

The IRB determines if appropriate **additional safeguards** are in place to protect the rights and welfare of participants if they are likely to be members of a vulnerable population (e.g., persons with diminished autonomy). See Section 10 below for detailed policies on vulnerable populations.

## **9. Informed Consent**

### **9.1 Informed Consent Process**

No investigator may involve a human being as a participant in research without obtaining the legally effective informed consent of the participant or the participant's legally authorized representative unless a waiver of consent has been approved by the IRB in accordance with Section 9.3 of this policy. In general, the IRB considers individuals who are unable to consent for their own clinical care to be unable to consent for research participation. Tools or instruments such as the Mini Mental Exam can also be used to determine capability to consent. Investigators must obtain consent prior to entering a participant into a study and/or conducting any procedures required by the protocol, unless consent is waived by the IRB.

The following specific requirements for consent, whether written or oral, apply to research subject to the revised Common Rule:

1. Before involving a human subject in research, an investigator shall obtain the legally effective informed consent of the subject or the subject's legally authorized

representative (LAR),

2. An investigator shall seek informed consent only under circumstances that provide the prospective subject or the LAR sufficient opportunity to discuss and consider whether to participate or not, and that minimize the possibility of coercion or undue influence,
3. The information that is given to the subject or the LAR shall be in language understandable to the subject or the LAR. The prospective subject or the LAR must be provided with the information that a reasonable person would want to have to make an informed decision about whether to participate, and be given the opportunity to discuss that information,
4. Except for broad consent (See Section 8.3):
  - a. Informed consent must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject or LAR in understanding the reasons why one might or might not want to participate in the research. This part of the informed consent must be organized and presented in a way that facilitates comprehension. Generally, the beginning of an informed consent should include a **concise** explanation of the following:
    - i. The fact that consent is being sought for research and that participation is voluntary,
    - ii. The purposes of the research, the expected duration of the prospective subject's participation, and the procedures to be followed in the research,
    - iii. The reasonably foreseeable risks or discomforts to the prospective subject,
    - iv. The benefits to the prospective subject or to others that may reasonably be expected from the research, and
    - v. Appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the prospective subject.

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

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

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

negligence. A person knowledgeable about the consenting process and the research to be conducted (i.e., a member of the project's research team), must obtain the informed consent.

If someone other than the investigator conducts the interview and obtains consent, the investigator needs to formally delegate this responsibility and the person so delegated must have received appropriate training to perform this activity.

## 9.2 Basic Elements of Informed Consent

Informed consent must be sought from each potential participant or the participant's legally authorized representative, in accordance with, and to the extent required by 45 CFR 46.116.

### The basic elements of informed consent are:

1. a statement that the **study involves research**, an explanation of the **purposes** of the research and the expected duration of the participant's participation, a description of the **procedures** to be followed, and identification of any procedures that are experimental; a description of any reasonably foreseeable **risks** or discomforts to the participant,
2. a description of any **benefits** to the participant or to others which may reasonably be expected from the research,
3. a disclosure of appropriate **alternative procedures** or courses of treatment, if any, that might be advantageous to the participant,
4. a statement describing the extent, if any, to which **confidentiality** of records identifying the participant must be maintained,
5. for research involving more than minimal risk, an explanation as to the availability of medical treatment in the case of **research-related injury**, including who will pay for the treatment and whether other financial compensation is available,
6. an explanation of whom to **contact** for answers to pertinent questions about the research and research participants' rights, and whom to contact in the event of a research-related injury to the participant,
7. a statement that participation is **voluntary**, refusal to participate will involve no penalty or loss of benefits to which the participant is otherwise entitled, and the participant may discontinue participation at any time without penalty or loss of benefits to which the participant is otherwise entitled,
8. For research involving more than minimal risk, if medical treatments are available when injury occurred, an explanation as to what it consists of or where further information could be obtained,
9. When appropriate, the amount and schedule of payments,
10. For research that will follow the 2018 requirements: A statement that identifiers might be removed from the identifiable private information or identifiable biospecimens and that, after such removal, the information or biospecimens could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the participant or legally authorized representative, if this might be a possibility,
11. For research that will follow the 2018 requirements: A statement that if the participant's information or biospecimens collected as part of the research, even if identifiers are removed will not be used or distributed for future research studies.

### **Additional elements of informed consent to be applied, as appropriate:**

1. a statement that the particular treatment or procedure may involve risks to the participant (or to the embryo or fetus, if the participant is or may become pregnant) which are currently unforeseeable.
2. The consent form of a study that has undergone full committee review and is considered a “more than minimal risk study” by the nature that is being reviewed by the full committee, does not need to state that the study is “more than minimal risk”, but merely state the risks of the study.
3. anticipated circumstances under which the participant’s participation may be terminated by the investigator without regard to the participant’s consent.
4. any additional costs to the participant that may result from participation in the research,
5. the consequences of a participant’s decision to withdraw from the research and procedures for orderly termination of participation by the participant.
6. a statement that significant new findings developed during the course of the research, which may relate to the participant’s willingness to continue participation, must be provided to the participant.
7. the approximate number of participants involved in the study.
8. For research that will follow 2018 requirements: A statement that the subject’s biospecimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit.
9. For research that will follow 2018 requirements: A statement regarding whether clinically relevant research results, including individual results, will be disclosed to subjects, and if so, under what conditions.
10. For research following 2018 requirements: For research involving biospecimens, whether the research will (if known) or might include genome sequencing (i.e., sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen).

In addition to these federally mandated elements of informed consent UNCG requires that consent documents include the following:

11. If Identified data will be stored off UNCG campus this must be clearly stated on the informed consent document, and the location of data storage (e.g., student researcher’s home) must be specified.

UNCG also requires that participants sign a copy of the approved consent form that has been stamped as approved by the IRB Chair (or designee) or the ORCI. Investigators who wish to have this requirement waived must make formal request for such a waiver through an IRB application or modification application.

### **9.3 Waiver of Informed Consent**

#### *General waiver or alteration of consent*

(1) *Waiver*. An IRB may waive the requirement to obtain informed consent for research under paragraphs (a) through (c) of this section, provided the IRB satisfies the requirements of paragraph (f)(3) of this section. If an individual was asked to provide broad consent for the storage,

maintenance, and secondary research use of identifiable private information or identifiable biospecimens in accordance with the requirements at paragraph (d) of this section, and refused to consent, an IRB cannot waive consent for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.

(2) *Alteration.* An IRB may approve a consent procedure that omits some, or alters some or all, of the elements of informed consent set forth in paragraphs (b) and (c) of this section provided the IRB satisfies the requirements of paragraph (f)(3) of this section. An IRB may not omit or alter any of the requirements described in paragraph (a) of this section. If a broad consent procedure is used, an IRB may not omit or alter any of the elements required under paragraph (d) of this section.

(3) *Requirements for waiver and alteration.* For an IRB to waive or alter consent as described in this subsection, the IRB must find and document that:

- (i) The research involves no more than minimal risk to the subjects,
- (ii) The research could not practicably be carried out without the requested waiver or alteration,
- (iii) If the research involves using identifiable private information or identifiable biospecimens, the research could not practicably be carried out without using such information or biospecimens in an identifiable format,
- (iv) The waiver or alteration will not adversely affect the rights and welfare of the subjects, and
- (v) Whenever appropriate, the subjects or legally authorized representatives will be provided with additional pertinent information after participation.

(4) *Screening, recruiting, or determining eligibility.* An IRB may approve a research proposal in which an investigator will obtain information or biospecimens for the purpose of screening, recruiting, or determining the eligibility of prospective subjects without the informed consent of the prospective subject or the subject's legally authorized representative, if either of the following conditions are met:

- The investigator will obtain information through oral or written communication with the prospective subject or legally authorized representative, or
- The investigator will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable biospecimens.

### **9.3.1 Recruitment Consent Form Exclusion**

An IRB may approve a research proposal in which an investigator will obtain information or biospecimens for the purposes of screening, recruiting, or determining the eligibility of prospective participants without the informed consent of the participant or the participant's legally authorized representative, if either of the following conditions are met:

- The investigator will obtain information through oral or written communication with the prospective subject or legally authorized representative or,
- The investigator will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable specimens.

#### 9.4 Documentation of Informed Consent (Signed Consent)

Informed consent must be appropriately documented, in accordance with, and to the extent required by 45 CFR 46.117.

1. Informed consent is documented using a written consent form approved by the IRB and signed and dated by the participant or the participant's legally authorized representative at the time of consent.
2. A copy of the consent form (blank/unsigned) should be given to the person consenting to the study. If requested, a copy of the signed and dated consent form shall be provided.
3. The consent form may be:
  - a. a **written consent document** that embodies the elements of informed consent that can be read to the participant or the participant's legally authorized representative, but the participant or representative must be given adequate opportunity to read it before it is signed; or
  - b. a **short form written consent document** stating that the elements of informed consent have been presented orally to the participant or the participant's legally authorized representative.

When this method is used:

- 1) there must be a witness to the oral presentation, and
- 2) the IRB must approve a written summary of what is to be signed by the participant or representative, and
- 3) the witness must sign the short form.
- 4) the person obtaining consent must sign a copy of the oral script, and
- 5) a copy of the summary must be given to the participant or representative, in addition to a copy of the short form.

#### 9.5 Waiver of Documentation of Informed Consent (Waiver of Signed Consent)

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

1. only record linking the participant and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality, or  
**Note:** Participants must be asked whether they want documentation linking them with the research, and their wishes must govern. (e.g., domestic violence research where the primary risk is discovery by the abuser that the participant is talking to researchers.)
2. The research presents no more than minimal risk of harm to participants and involves no procedures for which written consent is normally required outside of the research context.

In cases in which the documentation requirement is waived, the IRB requires the investigator to provide in the application materials a written summary of information to be communicated to the participant or the legally authorized representative, including all elements of informed consent and the IRB will consider whether to require the investigator to provide participants with a written statement regarding the research or consent information.

### **9.5.1 When Signing Forms is not a Cultural Norm**

The IRB may waive the requirement for the investigator to obtain a signed consent form for some or all participants when:

1. The research involves no more than minimal risk,
2. The subjects or LARs are members of a distinct cultural group or community in which signing forms is NOT the norm,
3. There is an appropriate alternative mechanism for documenting that informed consent was obtained,
4. The investigator provides a written statement regarding the research that embodies the elements of consent, and/or
5. The research is not FDA regulated.

### **9.6 Review and Approval of the Informed Consent Form**

The IRB is responsible for the review and approval of the informed consent form prepared by the investigator for all research other than exempt unless the study qualifies for limited IRB review. The wording on the informed consent form must contain all the required elements and meet all other requirements as described in this section. If the wording of the informed consent has been initially prepared by an external entity (e.g., a pharmaceutical company or a cooperative study group, including National Cancer Institute (NCI) groups) rather than by a University Principal Investigator, the IRB needs to ensure that the wording of the consent meets all the requirements of, and has been reviewed by, the appropriate University committees and subcommittees such as the Institutional Biosafety Committee. The form must meet all requirements of the UNCG IRB, even if it was initially developed and/or approved at another institution. If the consent form is amended during the protocol approval period, the revised form must contain the version date in the footer of the document.

#### **9.6.1 Posting of Clinical Trial Consent Form**

- (1) For each clinical trial conducted or supported by a federal department or agency, one IRB-approved informed consent form used to enroll subjects must be posted by the awardee or the Federal department or agency component conducting the trial on a publicly available Federal website that will be established as a repository for such informed consent forms.
- (2) If the Federal department or agency supporting or conducting the clinical trial determines that certain information should not be made publicly available on a federal website (e.g. confidential commercial information), the federal department or agency may permit or require redactions to the information posted.
- (3) The informed consent form must be posted to a designated federal website after the clinical trial is closed to recruitment, and no later than 60 days after the last study visit by any subject, as required by the protocol.

See the [DHHS General Instructions on the Informed Consent Posting Requirement \(45 CFR 46.116\(h\)\)](#) and [FDA Guidance on Posting to ClinicalTrials.gov](#)

## 9.7 Parental Permission and Assent

See Section 10.1.3.1 for policies on parental permission and assent in research involving children.

## 9.8 Surrogate Consent

The regulations generally require that the investigator obtain informed consent from participants. Under appropriate conditions, investigators also may obtain informed consent from a *legally authorized representative* of a participant (surrogate consent). Surrogate consent is approved at the discretion of the IRB in consultation with University Counsel. This definition only applies to research conducted in North Carolina and may not apply in research conducted outside of North Carolina. When research is conducted outside of NC it the responsibility of the investigator to comply with local/state laws regarding the age of majority and document this in their research files.

**Definition: *Legally Authorized Representative (LAR)*:** An individual, judicial, or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research.

- **For research NOT subject to FDA regulations and NOT subject to 2018 requirements:** Where there is no applicable law addressing this issue, legally authorized representative means an individual recognized by institutional policy as acceptable for providing consent in the non-research context on behalf of the prospective human subject to the human subject's participation in the procedure(s) involved in the research.

Investigators are responsible for providing a plan to the IRB which outlines how they will determine who the research participant's legally authorized representative (LAR) is in accordance with the DHHS definition of LAR.

This policy is designed to protect human participants from exploitation and harm and, at the same time, make it possible to conduct essential research on problems that are unique to persons who are incompetent, or who have an impaired decision-making capacity.

Surrogate consent may be obtained from a court appointed guardian of the person **or** a health care agent appointed by the person in a Durable Power of Attorney for Health Care (DPAHC). For example, a participant might have designated an individual to provide consent regarding health care decisions through a durable power of attorney and have specified that the individual also has the power to make decisions on entry into research. Such consent may be requested and accepted only when the prospective research participant is incompetent or has an impaired decision-making capacity, as determined and documented in the person's medical record in a signed and dated progress note.

The determination must be made in accordance with the following requirements:

1. The practitioner may determine after appropriate medical evaluation that the prospective research participant lacks decision-making capacity and is unlikely to regain it within a reasonable period of time.
2. Consultation with a psychiatrist or licensed psychologist must be obtained when the determination that the prospective research participant lacks decision-making capacity is based on a diagnosis of mental illness.

The IRB will require investigators to conduct a **competency assessment** whenever there is a possibility of either impaired mental status or decision-making capacity in prospective participants.

If feasible, the investigator must explain the proposed research to the prospective research participant even when the surrogate gives consent. Under no circumstances may a participant be forced or coerced to participate in a research study.

### **9.9 Consent and Language Barriers**

It is imperative that all participants in research be able to access and understand consent forms and research materials. Researchers should be aware that barriers to access may be presented by language, illiteracy, or disability. The UNCG IRB requires that researchers consider whether consent forms and research materials will be accessible to all participants as they plan their research projects and include in the IRB application, descriptions and rationales regarding procedures for ensuring accessibility and qualifications of translators/interpreters. The UNCG IRB recognizes the unique nature of each research project with respect to accessibility of consent forms and materials and that procedures will vary across projects. However, researchers should attend to the following considerations when developing research protocols:

- Documents converted from English to a foreign language should be translated by a native speaker of the foreign language.
- Researchers who are conducting research in contexts in which participants (or parents/guardians consenting to children's participation) may not read English should provide copies of consent forms in the language(s) of known non-English speakers or develop plans to be sure that such individuals will be able to access consent forms.
- It is **never** acceptable to use computer software to translate consent forms or research documents.
- Translators/interpreters should understand the context/meaning of the material being translated/interpreted.
- Translators/interpreters should sign statements of confidentiality to be kept on file by the investigator.
- If the translator is in any way engaged in the recruitment of participants, this information must be stated in the application as he/she may require additional training in human subjects protection. The ORCI can provide these resources.
- Investigators should attend to the qualifications of translators/interpreters with respect to certification by an appropriate organization (e.g., Department of Social and Health Services, American Translators Association) and adherence to an appropriate ethical code (e.g., National Code of Ethics for Interpreters in Health Care).

Researchers should submit with the IRB application both English language and translated consent forms for proposals that include non-English-speaking participants. If necessary, the IRB may consult with language experts or require a “back-translation” into English. The investigator should provide documentation to verify the accuracy of the translation and back-translation.

If a non-English-speaking participant is enrolled unexpectedly, researchers may rely on an oral translation of the English language consent form but should take extra care in the informed consent process to ensure that the participant has understood the project. A statement in the research records (and on the English language consent form) should indicate that the translation took place, identify the translator, and document the translator's belief that the participant understood the study and the consent process. If the participant is a patient, a note about the translation should be made in the patient's research records as well. Researchers should try to provide a written translation of the vital emergency contact information.

Sometimes a participant understands English but does not read or write English. In such cases, an oral presentation of the consent form is acceptable. Again, an impartial witness should document that the participant understands the research and the consent process and consented to participate.

## **Vulnerable Populations**

When some or all the participants in a protocol are likely to be vulnerable to coercion or undue influence, the IRB should include additional safeguards to protect the rights and welfare of these participants. Some of the vulnerable populations that might be involved in research include children, pregnant women, fetuses, neonates, and prisoners, adults who lack the ability to consent, students, employees, or homeless persons.

The IRB should be particularly cognizant of the special problems with research that involves a category of subjects who are vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons.

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

In cases in which the IRB reviews research, whether unfunded, federally or non-federally funded, that involves categories of participants vulnerable to coercion or undue influence, the review process must include one or more individuals who are knowledgeable about or experienced in working with these participants. For example, an IRB should include one or more individuals who are knowledgeable about or experienced in working with children, prisoners, or adults with limited decision-making capacity when reviewing research that involves individuals from these populations. IRBs should examine their local context for other vulnerable populations that should be represented on the IRB.

45 CFR 46 has additional subparts designed to provide extra protections for vulnerable populations which also have additional requirements for IRBs.

- Subpart B - Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research.
- Subpart C - Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Participants.
- Subpart D - Additional Protections for Children Involved as Participants in Research.

The policies and procedures contained herein, which are based on the subparts, apply to all research, regardless of whether it is funded or unfunded.

## **10.1 Research Involving Children**

### **10.1.1 Definitions**

**Children** - persons who have not attained the legal age of majority (18) to consent to treatments or procedures involved in the research under the applicable law of the jurisdiction in which the research will be conducted.

**Investigators are responsible for providing a plan/documentation that potential participants in the research meet the DHHS definition of children. This is to be provided when research will be conducted outside of North Carolina.**

#### **North Carolina Law defines guardian as:**

A person lawfully invested with the power, and charged with the duty, of taking care of the person and managing the property and rights of another person, who, for defect of age, understanding, or self-control, is considered incapable of administering his own affairs. One who legally has responsibility for the care and management of the person, or the estate, or both, of a child.

**NOTE: Research conducted in jurisdictions including international settings and states other than North Carolina, must comply with the laws regarding the legal age of consent in all relevant jurisdictions. The University Counsel's Office will provide assistance and guidance regarding laws in other jurisdictions.**

- **Assent** - a child's affirmative agreement to participate in research. Mere failure to object, absent affirmative agreement, should not be construed as assent.
- **Permission** - the agreement of parent(s) or legal guardian to the participation of their child or ward in research.
- **Parent** - a child's biological or adoptive parent.
- **Guardian** – an individual with responsibility of both the estate and the person.
- **Guardian of the person** - an individual appointed solely for the purpose of performing duties relating to the care, custody, and control of a ward.

### **10.1.2 Allowable Categories**

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

1. Research not involving physical or emotional risk greater than that ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests (i.e., **minimal risk**). [45 CFR 46.404]
  - The IRB may find that the permission of one parent is sufficient.
2. Research involving greater than minimal risk but presenting the prospect of direct benefit to the individual participant. [45 CFR 46.405]
  - The risk is justified by the anticipated benefit to the participants,
  - The IRB may find that the permission of one parent is sufficient, and
  - Requires assent of the child.
3. Research involving greater than minimal risk and no reasonable prospect of direct benefit to the individual participant, but likely to yield generalizable knowledge about the participant's disorder or condition. [45 CFR 46.406]
  - The risk represents a minor increase over minimal risk,
  - The intervention or procedure presents experiences to participants that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations,
  - **Permission of either both parents, or legal guardian, is required- unless one parent is deceased, unknown, incompetent, or not reasonably available; or only one parent has legal responsibility for the care and custody of the child,** and
  - Requires assent of the child.
4. Research not otherwise approvable which presents an opportunity to understand, prevent, or alleviate serious problems affecting the health or welfare of children. [45 CFR 46.407]
  - Federally funded research in this category must be approved by the Secretary of Health and Human Services, requires consent of either both parents, or legal guardian, and 45 CFR 46 Subpart D will be applied.
  - For non-federally funded research, IRB will consult with a panel of experts in pertinent disciplines (for example: science, medicine, ethics, law). Based on the recommendation of the panel, the IRB may approve the research if:
    1. The research project satisfies the conditions of the previous categories, as applicable, or
    2. The following:
      - i. The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children,
      - ii. The research will be conducted in accordance with sound ethical principles, and
      - iii. Informed consent will be obtained in accordance with the provisions for informed consent and other applicable sections of this manual.

### 10.1.3 Parental Permission and Assent

#### 10.1.3.1 Parental Permission

In accordance with 45 CFR 46.408(b) the IRB must determine that adequate provisions have been made for soliciting the permission of each child's parent or guardian. Parents or guardians must be provided with the basic elements of consent as stated in 45 CFR 46.116(a) (1-8) and any additional

elements the IRB deems necessary. The IRB may find that the permission of one parent is sufficient for research to be conducted under 45 CFR 46.404 or 45 CFR 46.405. The IRB's determination of whether consent must be obtained from one or both parents will be documented in the consent checklist when a protocol receives expedited review, and in meeting minutes when reviewed by the convened IRB committee. Consent from both parents is required for research to be conducted under 45 CFR 46.406 and 45 CFR 46.407 unless

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

The IRB may waive the requirement for obtaining consent from a parent or legal guardian if:

- The research meets the provisions for waiver in 45 CFR 46.116(d)(1-4) and if the IRB determines that the research protocol is designed for conditions or a participant population for which parental or guardian permission is not a reasonable requirement to protect the participants (for example, neglected or abused children).
- An appropriate mechanism for protecting the children who will act as participants in the research is substituted, and that the waiver is not inconsistent with Federal State, or local law. The choice of an appropriate mechanism would depend upon the nature and purpose of the activities described in the protocol, the risk and anticipated benefit to the research participants, and their age, maturity, status, and condition.

Permission from parents or legal guardians must be documented in accordance with and to the extent required by 45 CFR 46.117.

### **10.1.3.2 Assent from Children**

Because “assent” means a child’s affirmative agreement to participate in research, (45 CFR 46.402(b)), the child must actively show his or her willingness to participate in the research, rather than just complying with directions to participate and not resisting in any way. When judging whether children are capable of assent, the IRB is charged with considering the age, maturity, and psychological state of the children involved. The IRB has the discretion to judge children’s capacity to assent for all the children to be involved in a proposed research activity, or on an individual basis.

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

The IRB presumes that children approximately age 5 and older should be given an opportunity to provide assent. Generally, oral assent using a script should be obtained from children 5-7 years of age. Written assent using a written document for the children to sign may be sought for older children (ages 7-17). However, the IRB can determine if assent is required regardless of the child's age. As children approach age 18 and/or become increasingly cognitively competent, the written assent document should increasingly resemble the informed consent document.

At times there may be inconsistency between parent consent and child assent. Usually a "no" from the child overrides a "yes" from a parent, but a child cannot decide to be in research over the objections of a parent. Obviously, there are individual exceptions to these guidelines (such as when the use of an experimental treatment for a life-threatening disease is being considered). The general idea, however, is that children should not be forced to be research participants, even when their parent(s) consent to it.

If the IRB determines that the capability of some or all of the children is so limited that they cannot reasonably be consulted or that the intervention or procedure involved in the research holds out a prospect of direct benefit that is important to the health or well-being of the children and is available only in the context of the research, the assent of the children is not a necessary condition for proceeding with the research. Even when the IRB determines that the participants are capable of assenting, the IRB may still waive the assent requirement under circumstances detailed in the Waiver of Informed Consent section of this manual.

### **10.1.3.3 The Assent Form**

Researchers should try to draft a form that is age appropriate and study specific, considering the typical child's experience and level of understanding, and composing a document that treats the child respectfully and conveys the essential information about the study. The assent form should:

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

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

### **10.1.3.4 Children Who are Wards**

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

1. related to their status as wards, or

2. conducted in schools, camps, hospitals, institutions, or similar settings in which most children involved as participants are not wards.

If the research meets the condition(s) above, an advocate must be appointed for each child who is a ward (one individual may serve as advocate for more than one child), in addition to any other individual acting on behalf of the child as legal guardian or in loco parentis. The advocate must be an individual who has the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except in the role as advocate or member of the IRB) with the research, the investigator(s), or the guardian organization. The IRB is provided with a copy of the regulations in hard/soft form to make the appropriate decision under these circumstances.

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

For research not funded by DHHS, no additional safeguards are required and there are no restrictions on the involvement of pregnant women in research where the risk to the fetus is no more than minimal (see 45 CFR 46 Subpart B for restrictions on DHHS-funded research). For research that involves more than minimal risk to fetuses, or which involves neonates, the following apply.

### **10.2.1 Definitions**

- **Dead fetus** - a fetus that exhibits neither heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, nor pulsation of the umbilical cord.
- **Delivery** - complete separation of the fetus from the woman by expulsion or extraction or any other means.
- **Fetus** - the product of conception from implantation until delivery.
- **Neonate** - a newborn.
- **Nonviable neonate** - a neonate after delivery that, although living, is not viable.
- **Pregnancy** encompasses the period of time from implantation until delivery. A woman is assumed to be pregnant if she exhibits any of the pertinent presumptive signs of pregnancy, such as missed menses, until the results of a pregnancy test are negative or until delivery.
- **Viable**, as it pertains to the neonate, means being able, after delivery, to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration.

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

Pregnant women or fetuses may be involved in research involving more than minimal risk to fetuses if all of the following conditions are met:

1. Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risks to pregnant women and fetuses,
2. The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus,
3. Any risk is the least possible for achieving the objectives of the research,
4. If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, then the consent of the pregnant woman is obtained in accord with the provisions for informed consent,

5. If the research holds out the prospect of direct benefit solely to the fetus, then the consent of the pregnant woman and the father is obtained in accordance with the provisions for informed consent, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest.
6. Each individual providing consent under paragraph 4. or 5. of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate,
7. For children who are pregnant, assent and permission are obtained in accord with the provisions of permission and assent,
8. No inducements, monetary or otherwise, will be offered to terminate a pregnancy,
9. Individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy, and
10. Individuals engaged in the research will have no part in determining the viability of a neonate.

### **10.2.3 Research involving neonates**

Neonates of uncertain viability and nonviable neonates may be involved in research if all of the following conditions are met:

1. Where scientifically appropriate, preclinical and clinical studies have been conducted and provide data for assessing potential risks to neonates.
2. Each individual providing consent is fully informed regarding the reasonably foreseeable impact of the research on the neonate.
3. Individuals engaged in the research will have no part in determining the viability of a neonate.
4. The requirements of Neonates of Uncertain Viability or Nonviable Neonates (see below in this section) have been met as applicable.

**Neonates of Uncertain Viability.** Until it has been ascertained whether a neonate is viable, a neonate may not be involved in research covered by this subpart unless the following additional conditions have been met:

The IRB determines that:

1. The research holds out the prospect of enhancing the probability of survival of the neonate to the point of viability, and any risk is the least possible for achieving that objective, or
2. The purpose of the research is the development of important biomedical knowledge which cannot be obtained by other means and there will be no added risk to the neonate resulting from the research, and
3. The legally effective informed consent of either parent of the neonate or, if neither parent is able to consent because of unavailability, incompetence, or temporary incapacity, the legally effective informed consent of either parent's legally authorized representative is obtained in accord with the provisions of permission and assent, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.

**Nonviable Neonates.** After delivery, nonviable neonates may not be involved in research covered by this subpart unless all of the following additional conditions are met:

1. Vital functions of the neonate will not be artificially maintained,

2. The research will not terminate the heartbeat or respiration of the neonate,
3. There will be no added risk to the neonate resulting from the research,
4. The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means, and
5. The legally effective informed consent of both parents of the neonate is obtained in accord with the provisions of permission and assent, except that the waiver and alteration of the provisions of permission and assent do not apply.
6. However, if either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the informed consent of one parent of a nonviable neonate will suffice to meet the requirements of this paragraph, except that the consent of the father need not be obtained if the pregnancy resulted from rape or incest. The consent of a legally authorized representative of either or both parents of a nonviable neonate will not suffice to meet the requirements of this paragraph.

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

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

1. Research involving, after delivery, the placenta; the dead fetus; macerated fetal material; or cells, tissue, or organs excised from a dead fetus, must be conducted only in accord with any applicable Federal, State, or local laws and regulations regarding such activities.
2. If information associated with material described above in this section is recorded for research purposes in a manner that living individuals can be identified, directly or through identifiers linked to those individuals, those individuals are research participants, and all pertinent sections of this manual are applicable.

#### **10.2.5 Research Not Otherwise Approvable**

If the IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates; and the research is not approvable under the above provisions, then the IRB will consult with a panel of experts in pertinent disciplines (for example: science, medicine, ethics, law). Based on the recommendation of the panel, the IRB may approve the research based on either:

- a. That the research in fact satisfies the conditions of Section 10.2.2, as applicable; or
- b. The following:
  - 1) The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates,
  - 2) The research will be conducted in accord with sound ethical principles, and
  - 3) Informed consent will be obtained in accord with the provisions for informed consent and other applicable sections of this manual.

Additionally, if the project is funded by DHHS 45 CFR 46 Subpart B will be applied.

### **10.3 Research Involving Prisoners**

Prisoners are another of the three classes that are deemed so vulnerable to exploitation in research that there are special rules protecting them. In the past, prisoners were viewed as a convenient

research population. They are housed in a single location, constitute a large and relatively stable population, and live a routine life. Unfortunately, all the things that make a prison and prisoners a convenient research population also make prisoners ripe for exploitation.

The concerns articulated in Subpart C and the policy based on Subpart C attempt to address whether prisoners have any real choice concerning participation in research or whether incarceration prohibits free choice.

### **10.3.1 Applicability**

This policy applies to all research conducted under the auspices of UNCG involving prisoners as participants. Even though a University IRB may approve a research protocol involving prisoners as participants according to this policy, investigators are still subject to the Administrative Regulations of the North Carolina Department of Corrections and any other applicable State or local law. [45 CFR 46.301]

- Per 2018 Revised Common Rule, New exempt provisions CAN apply to prisoners as long as research is aimed at involving a broader subject population that only incidentally includes prisoners (i.e., is not focused on prisoners).

### **10.3.2 Purpose**

Because prisoners may be under constraints because of their incarceration which could affect their ability to make a truly voluntary and uncoerced decision whether to participate in research, it is the purpose of this policy to provide additional safeguards for the protection of prisoners involved in research activities to which this subpart is applicable. [45 CFR 46.302]

### **10.3.3 Definitions**

[According to 45 CFR 46.303]

- **Prisoner** – any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures which provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing.
- **Minimal Risk** – the probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons.

### **10.3.4 Composition of the IRB**

[45 CFR 46.304]

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

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

2. At least one member of the IRB must be a prisoner, or a prisoner representative with appropriate background and experience to serve in that capacity, except that where a particular research project is reviewed by more than one IRB, only one IRB need satisfy this requirement.

### 10.3.5 Additional Duties of the IRB

[45 CFR 46.305]

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

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

Additionally, if the project is funded by DHHS 45 CFR 46 Subpart C will be applied.

### **10.3.6 Waiver for Epidemiology Research**

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

- (1) In which the sole purposes are
  - (i) To describe the prevalence or incidence of a disease by identifying all cases, or
  - (ii) To study potential risk factor associations for a disease, and
- 2) Where the IRB has approved the research and fulfilled its duties under 45 CFR 46.305(a)(2)–(7) and determined and documented that
  - (i) The research presents no more than minimal risk and no more than inconvenience to the prisoner-participants, and
  - (ii) Prisoners are not a particular focus of the research.

The specific type of epidemiological research participant to the waiver involves no more than minimal risk and no more than inconvenience to the human participant participants. The waiver would allow the conduct of minimal risk research that does not now fall within the categories set out in 45 CFR 46.306(a)(2). The range of studies to which the waiver would apply includes epidemiological research related to chronic diseases, injuries, and environmental health. This type of research uses epidemiologic methods (such as interviews and collection of biologic specimens) that generally entail no more than minimal risk to the participants.

For a study to be approved under this waiver, the IRB would need to ensure that, among other things, there are adequate provisions to protect the privacy of participants and to maintain the confidentiality of the data.

<http://www.hhs.gov/ohrp/special/prisoners/Prisoner%20waiver%206-20-03.pdf>

## **10.4 Persons with Mental Illness and/or Intellectual/Developmental Disabilities**

Research involving participants who are mentally ill or participants with impaired decision-making capacity warrants special attention. Research involving these populations may present greater than minimal risk; may not offer direct medical benefit to the participant; and may include a research design that calls for washout, placebo, or symptom provocation. In addition, these populations are considered to be vulnerable to coercion.

### **10.4.1 IRB Composition for Representation**

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

### **10.4.2 Approval Criteria**

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

1. Only incompetent persons or persons with impaired decision-making capacity are suitable as research participants. Competent persons are not suitable for the proposed research. The

investigator must demonstrate to the IRB that there is a compelling reason to include incompetent individuals or persons with impaired decision-making capacity as participants. Incompetent persons or persons with impaired decision-making capacity must not be participants in research simply because they are readily available.

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

#### **10.4.3 Additional Concerns**

Both investigators and IRB members must be aware that for some participants, decision-making capacity may fluctuate. For participants with fluctuating decision-making capacity or those with decreasing capacity to give consent, a re-consenting process with surrogate consent may be necessary. **It is the responsibility of investigators to monitor the decision-making capacity of participants enrolled in research studies and to determine if surrogate consent must be re-obtained.**

The IRB will require investigators to conduct a **competency assessment** whenever there is a possibility of either impaired mental status or decision-making capacity in prospective participants. Although incompetent to provide informed consent, some persons may resist participating in a research protocol approved by their representatives. Under no circumstances may participants be forced or coerced to participate.

**(National Bioethics Advisory Committee)**

## **11. Deception and Incomplete Disclosure in Research**

### **11.1 Overview**

UNCG ORCI recognizes that deception and/or incomplete disclosure fall on a continuum and that they are valuable and important methodologies for some research projects, but their use presents special challenges to ensure that the research is conducted ethically. Deception or incomplete disclosure is sometimes necessary in social and behavioral research to avoid study bias or test hypotheses that require withholding certain details or in some cases, misleading participants.

The regulations for obtaining informed consent from research participants (§45 CFR 46.116) generally require full disclosure of all elements relevant to the subject's decision about whether to participate in the research, including the purpose of the research. Thus, use of deceptive techniques must be justified by the study's prospective value AND there should be no reasonable alternative that would be equally effective—in other words, the researcher must demonstrate that the deception/incomplete disclosure is necessary to conduct the study. In alignment with the Belmont Report, studies utilizing deception or incomplete disclosure must not involve more than minimal risk to subjects and subjects must not be deceived about research that is reasonably expected to cause severe emotional distress or physical pain. Studies involving deception or incomplete disclosure are rarely permitted to be exempt and are usually reviewed as expedited (or full board).

Whenever possible (if study design allows), subjects should be told in the consent form that some information is being withheld or is incomplete and that additional information will be provided after their participation in the research is complete.

### 11.2 Definition

- Deception: Involves intentionally providing inaccurate or false information to subjects. This is also called **active** deception.
- Incomplete Disclosure: Involves withholding information about the study purpose and/or reason for specific procedures to prevent biasing the results. Withholding information may or may not be considered deception.

### 11.3 Examples

Example of deception:

- The subject is given a “cover story” which falsely describes the purpose or some key aspect of the study, but provides a plausible account of the researcher's objective.
- Subjects are told they are collaborating with another subject to complete research tasks, but their “collaborator” is a researcher (i.e., a confederate)

Example of incomplete disclosure:

- The subject is informed about the purpose of the study or a certain procedure in general terms that are true, but not detailed enough to reveal the researcher's main or specific objective.
- The subject is told they are completing a survey task to evaluate fictional job applicant qualifications when the survey is really evaluating subjects' discriminatory tendencies. This type of incomplete disclosure is known as **passive deception** since the deception involves *omission* of relevant study information.

### 11.4 Waiver of Consent

When a study is deemed to include deception or incomplete disclosure, a partial waiver of consent is necessary because the consent process does not meet the criteria of “fully informed consent”. UNCG ORCI will determine if the justification provided for the waiver meets the requirements to grant such waiver.

## **11.5 Debriefing**

The debriefing process is a required part of research involving deception or incomplete disclosure when the work is completed at UNCG. The debriefing process should be described in the study procedures section in Cayuse. The debrief should explain the deception or incomplete disclosure and why it was necessary. It should also provide an opportunity for subjects to ask questions and include a sentence that informs participants that they can withdraw from the study or choose not to include their data for some or all the research after being made aware of deception or incomplete disclosure.

There may be instances when debriefing would be inappropriate, presenting unreasonable risk of harm without a countervailing benefit. For example, if an individual were selected for participation in a study about group behavior based on a previously measured “negative” behavior or characteristic, it might not be appropriate for the debriefing to describe the selection process. In such cases, the IRB would not require detailed debriefing.

## **12. Complaints, Harassment, Non-compliance, and Suspension or Termination of IRB Approval of Research**

### **12.1 Complaints**

Complaints reported to the IRB will be evaluated as possible unanticipated problems involving risks to participants or others under Section 7.9. Additionally, any individual that is participating in a research study and wants to discuss a problem, concern, or if they have a question and would like to talk to someone not involved in the research study should contact the Assistant Director toll free at 855-251-2351. Participants may also contact this person to get more information on their rights as a research participant or to offer input.

The Chair of the IRB and the Assistant Director will promptly handle (or delegate staff to handle) and, if necessary, investigate all complaints, concerns, and appeals received by the IRB. This includes complaints, concerns, and appeals from investigators, research participants and others.

### **12.2 Survey/Contact Harassment**

When conducting survey research online researchers may only contact the potential participant three times. This should include the initial contact and two follow ups.

### **12.3 Non-compliance**

All members of the University community involved in human participant research are expected to comply with the highest standards of ethical and professional conduct in accordance with federal and state regulations and institutional and IRB policies governing the conduct of research involving human participants.

#### **12.3.1 Definitions**

- “**Non-compliance**” is defined as failure to comply with any of the regulations and policies described in this document and failure to follow the determinations of the IRB. Non-compliance may be minor or sporadic or it may be serious or continuing.

- **“Serious non-compliance”** is defined as failure to follow any of the regulations and policies described in this document or failure to follow the determinations of the IRB and which, in the judgment of either the IRB Chair or the convened IRB, increases risks to participants, decreases potential benefits, or compromises the integrity of the human research protection program. Generally, both OHRP and UNCG consider the collection of data for non-exempt human participants research project without IRB review and approval to constitute serious noncompliance.
- **“Continuing non-compliance”** is defined as a pattern of non-compliance that, in the judgment of the IRB Chair or convened IRB, suggests a likelihood that instances of non-compliance will continue without intervention. Continuing non-compliance also includes failure to respond to a request to resolve an episode of non-compliance.
- **“Allegation of Non-Compliance”** is defined as an unproved assertion of non-compliance.
- **“Finding of Non-Compliance”** is defined as an allegation of non-compliance that is found to be true or a report of non-compliance that is clearly true. (For example, a finding on an audit of an unsigned consent document, or an admission of an investigator of that the protocol was willfully not followed would represent reports of non-compliance that would require no further action to determine their truth and would therefore represent findings of non-compliance.)

### 12.3.2 Review of Allegations of Non-compliance

All allegations of non-compliance will be reviewed by the IRB Chair, Assistant Director and/or Director in accordance with 4.4.2. The IRB Chair, Assistant Director and/or Director will review:

1. All documents relevant to the allegation,
2. The last approval letter from the IRB,
3. The last approved IRB application and protocol,
4. The last approved consent document,
5. The grant, if applicable, and
6. Any other pertinent information (e.g., questionnaires, DSMB reports, etc.).

The IRB Chair, Assistant Director and/or Director will review the allegation and decide whether non-compliance had occurred. They may request additional information or an audit of the research in question.

If, in the judgment of the IRB Chair, Assistant Director and/or Director, non-compliance has not occurred, no further action will be taken. If, in the judgment of the IRB Chair, Assistant Director and/or Director, non-compliance has occurred, the non-compliance will be processed according to 12.3.3 Review of Findings of Non-compliance.

If, in the judgment of the IRB Chair, Assistant Director and/or Director, any allegation or findings of non-compliance warrants suspension or termination of the research before completion of any review or investigation to ensure protection of the rights and welfare of participants, the IRB Chair may terminate or suspend the research as described in below with subsequent review by the IRB.

### **12.3.3 Review of Findings of Non-compliance**

If, in the judgment of the IRB Chair, Assistant Director and/or Director, the reported finding of non-compliance is not serious, not continuing, and the proposed corrective action plan seems adequate, no further action is required, and the IRB is informed at the next convened meeting. Documentation concerning the noncompliance, and the proposed corrective action plan will be filed with the protocol. If, in the judgment of the IRB Chair, Assistant Director and/or Director, the reported finding is serious or continuing, an inquiry will occur (11.3.4).

### **12.3.4 Inquiry Procedures**

A determination may be made by the IRB Chair, Assistant Director and/or Director that an inquiry is necessary based on several issues that may include but are not limited to:

1. Participants' complaint(s) that rights were violated,
2. Report(s) that investigator is not following the protocol as approved by the IRB,
3. Unusual and/or unexplained adverse events in a study,
4. Repeated failure of investigator to report required information to the IRB, or
5. Data collected without IRB approval.

A subcommittee is appointed consisting of IRB members, and non-members if appropriate, to ensure fairness and expertise. The subcommittee is given a charge, which can include any or all of the following:

1. Review of protocol(s) in question,
2. Review of sponsor audit report of the investigator, if appropriate,
3. Review of any relevant documentation, including consent documents, case report forms, participant's investigational and/or medical files, etc. as they relate to the investigator's execution of her/his study involving human participants,
4. Interview of appropriate personnel if necessary,
5. Preparation of either a written report of the findings, which is presented to the full IRB at its next meeting, and/or
6. Recommend actions if appropriate.

### **12.3.5 Final Review**

The results of the inquiry will be reviewed at a convened IRB meeting. Prior to the meeting, all IRB members will receive the full protocol, if possible a copy of the current consent documents, and any other documented information from the PI. At the convened IRB meeting the IRB will receive a report from the subcommittee. If the results of the inquiry substantiate the finding of serious or continuing non-compliance, the IRB's possible actions could include, but are not limited to:

1. Request a correction action plan from the investigator,
2. Verification that participant selection is appropriate and observation of the actual informed consent,
3. An increase in data and safety monitoring of the research activity,
4. Request a directed audit of targeted areas of concern,
5. Request a status report after each participant receives intervention,
6. Modify the continuing review cycle,
7. Request additional Investigator and staff education,

8. Notify current participants if the information about the non-compliance might affect their willingness to continue participation,
9. Modification of the protocol,
10. Modification of the information disclosed during the consent process,
11. Requiring current participants to re-consent to participation,
12. Destruction of data,
13. Keep data but never use to contribute to generalizable knowledge,
14. Keep data and may use to contribute generalizable knowledge BUT must inform journal that the data was collected without an approved protocol,
15. Required to attend human subjects use workshop,
16. Suspend the study (See below), or
17. Terminate the study (See below).

The investigator is informed of the IRB determination and the basis for the determination in writing and is given a chance to respond. If the IRB determines that the non-compliance was serious or continuing, the results of the final review will be reported as described below in 11.5.

### 12.3.6 Additional Actions

A finding of serious or continuing non-compliance may also result in the following sanctions, among others:

1. Suspension or termination of IRB approval of specific research protocols or of all research involving human participants in which the investigator participates.
2. Sponsor actions. In making decisions about supporting or approving applications or proposals covered by this policy the Department of Health and Human Services or Agency head may take into account, in addition to all other eligibility requirements and program criteria, factors such as whether the applicant has been participant to a termination or suspension as described above, and whether the applicant or the person or persons who would direct or has/have directed the scientific and technical aspects of an activity has/have, in the judgment of the Department of Health and Human Services or Agency head, materially failed to discharge responsibility for the protection of the rights and welfare of human participants.
3. Institutional or individual action by the federal government OHRP. The OHRP may
  - withhold approval of all new UNCG studies by the IRB,
  - direct that no new participants be added to any ongoing studies,
  - terminate all ongoing studies, except when doing so would endanger the participants; and/or
  - notify relevant state, federal and other interested parties of the violations.
4. Individual **disciplinary action** of the investigator or other personnel involved in a study, up to and including dismissal, pursuant to university policies and procedures.

Failure to secure necessary UNCG IRB approval before commencing human participant research must be reported by the Director to the appropriate Department Chair/Unit Head, Dean, and Provost. Investigators who are UNCG employees should also be aware that, in general, UNCG **indemnifies** them from liability for adverse events that may occur in UNCG studies approved by the UNCG IRB. Failure to follow approved procedures may compromise this indemnification and

make the investigator **personally liable** in such cases. This does not apply to individuals who are not UNCG employees.

#### **12.4 Suspension or Termination**

Suspension of IRB approval is a directive of the convened IRB, IRB Chair or Assistant Director to stop temporarily or permanently some or all previously approved research activities. Suspended protocols remain open and require continuing review. Termination of IRB approval is a directive of the convened IRB to stop permanently all activities in a previously approved research protocol. Terminated protocols are considered closed and no longer require continuing review.

The IRB Chair, Assistant Director and/or Director may suspend research to ensure protection of the rights and welfare of participants. Suspension directives made by the IRB Chair, Assistant Director and/or Director must be reported to a meeting of the convened IRB. Research may only be permanently terminated by the convened IRB.

When study approval is suspended or terminated by the convened IRB or an authorized individual, in addition to stopping all research activities, the convened IRB or individual ordering the suspension or termination may notify any participants currently participating that the study has been suspended or terminated. The convened IRB or individual ordering the suspension or termination will consider whether procedures for withdrawal of enrolled participants are necessary to protect their rights and welfare of participants. These procedures might include transferring participants to another investigator; making arrangements for care or follow-up outside the research; allowing continuation of some research activities under the supervision of an independent monitor; or requiring or permitting follow-up of participants for safety reasons.

If follow-up of participants for safety reasons is permitted/required by the convened IRB or individual ordering the suspension or termination, the convened IRB or individual ordering the suspension or termination will require that the participants should be so informed and that any adverse events/outcomes be reported to the IRB and the sponsor.

#### **12.5 Reporting**

Serious or continuing noncompliance with regulations or the requirements or determinations of the IRB; and suspensions or terminations of IRB approval will be reported to the appropriate regulatory agencies and institutional officials according to the procedures in Section 12.

### **Reporting to Regulatory Agencies and Institutional Officials**

- 1) The ORCI will initiate the reporting procedures described here as soon as the IRB takes any of the following actions:
  - a) Determines that an event may be considered an unanticipated problem involving risks to participants or others,
  - b) Determines that non-compliance was serious or continuing,
  - c) Suspends or terminates approval of research.
- 2) The Director or designee prepares a letter that contains the following information:

- a) The nature of the event (Unanticipated problem involving risks to participants or others, serious or continuing non-compliance, suspension, or termination of approval of research),
  - b) Name of the institution conducting the research,
  - c) Title of the research project and/or grant proposal in which the problem occurred,
  - d) Name of the principal investigator on the protocol,
  - e) Number of the research project assigned by the IRB and the number of any applicable federal award(s) (grant, contract, or cooperative agreement),
  - f) A detailed description of the problem including the findings of the organization and the reasons for the IRB's decision,
  - g) Actions the institution is taking or plans to take to address the problem (e.g., revise the protocol, suspend participant enrollment, terminate the research, revise the informed consent document, inform enrolled participants, increase monitoring of participants, etc.),
  - h) Plans, if any, to send a follow-up or final report by the earlier of
    - (1) A specific date, or
    - (2) When an investigation has been completed or a corrective action plan has been implemented.
- 3) The letter is reviewed by the IRB Chair and the Director or Assistant Director of ORCI and modified as needed.
  - 4) The Director signs the letter.
  - 5) The ORCI sends a copy of the report to:
    - a) The IRB by including the letter in the next agenda packet as an information item,
    - b) The Vice Chancellor for Research and Engagement,
    - c) OHRP, if the study is subject to DHHS regulations or subject to UNCG's FWA,
    - d) If the study is conducted or funded by any Federal Agency other than DHHS that is participant to "The Common Rule," the report is sent to OHRP, or the head of the agency as required by the agency.
      - Reporting to a regulatory agency is not required if the event occurred at a site that was not subject to the direct oversight of the organization, and the agency has been notified of the event by the investigator, sponsor, another organization, or other mechanisms.
    - e) Principal investigator,
    - f) Sponsor, if the study is sponsored,
    - g) Department Chair, Dean, and other supervisors of the principal investigator, and
    - h) Others as deemed appropriate by the Director or Assistant Director.

The IRB Chair and Assistant Director ensures that all steps of this policy are completed within 15 days of the initiating action. For more serious actions, the reporting will be expedited.

(OHRP Guidance <http://www.hhs.gov/ohrp/policy/incidreport.htm>)

## **14. Investigator Responsibilities**

Principal Investigators are ultimately responsible for the conduct of research. Principal Investigators may delegate research responsibility. However, investigators must maintain oversight and retain ultimate responsibility for the conduct of those to whom they delegate responsibility.

**To satisfy the requirements of this policy, investigators who conduct research involving human participants must:**

- develop and conduct research that is in accordance with the ethical principles in the Belmont Report, which is achieved through training courses and data safety monitoring,
- develop a research plan that is scientifically sound and minimizes risk to the participants,
- have sufficient resources necessary to protect human participants, including supervision, sufficient numbers of appropriately trained staff persons, and appropriate support services,
- protect the rights and welfare of prospective participants,
- have plans to monitor the data collected for the safety of research participants,
- have a procedure to receive complaints or requests for additional information from participants and respond appropriately,
- ensure that pertinent laws, regulations, and institution procedures and guidelines are observed by participating faculty and research staff,
- obtain and document informed consent as required by the IRB and ensure that no human participant is involved in the research prior to obtaining his or her consent,
- ensure that all research involving human participants receives IRB review and approval in writing before commencement of the research,
- comply with all IRB decisions, conditions, and requirements,
- ensure that protocols receive timely continuing IRB review and approval,
- report unanticipated problems involving risk to participants or other or adverse events to the IRB,
- obtain IRB review and approval in writing before changes are made to approved protocols or consent forms, and
- seek IRB assistance when in doubt about whether proposed research requires IRB review.

## **14.1 Research Personnel**

### **Principal Investigators**

At UNCG, **faculty or staff members with full-time University-paid appointments** may serve as the principal investigator or as the Faculty Advisor on a research project involving human participants. Part-time faculty or staff may act as Faculty Advisors when approved by the undergraduate research office or the graduate school (i.e., the individual has an approved appointment with the graduate school and is permitted to act as the Chair of a thesis or dissertation committee). Student researchers can also be listed as Principal Investigators as of February 2013 via the submission of an IRB application through the online system.

The IRB recognizes one Principal Investigator (PI) for each study. The PI has ultimate responsibility for the research activities, however in the case of a Student PI, the Faculty Advisor has the ultimate responsibility for the research activities pursued by the student. Protocols that require skills beyond those held by the Principal Investigator must be modified to meet the investigator's skills or have one or more additional qualified faculty as Co-investigator(s).

### **Student Researchers**

Students can list themselves as Principal Investigators at the point of online submission; however, they must have a Faculty Advisor who fulfills the role as the responsible party for the student research. The student must also make sure contact information allows for the ORCI to reach them after graduation and should work with the ORCI to determine whether to close the studies on which they are listed as a PI or move the Faculty Advisor to the role of PI prior to leaving UNCG. The faculty advisor will also be contacted in the case that a student's research has lapsed in its renewal.

## **Research Team**

The PI, Research Assistants, and other individuals also known as key personnel, who contribute to the scientific development or execution of a project in a substantive, measurable way, regardless of whether they receive salaries or compensation from the protocol.

### **14.2 Protocol Development**

When developing a protocol, the Principal Investigator or a member of the protocol research team may contact the ORCI for a determination regarding whether the proposed project constitutes human participants research and, if so, what level of review would be required. Contact with the ORCI may be in the form of a telephone call or by email and must include a brief description of the proposed research. The ORCI will respond to the Principal Investigator or member of the research team by telephone or email.

Many journals and conferences require official documentation of a "not human subjects research determination" as part of the journal and/or conference submission. If it is determined that the proposed project does not meet the federal definition of research and/or human participant, it is highly recommended that the principal investigator submit a study application through the online system so that an official determination can be made and the "not human subjects research" determination is conveyed to the principal investigator by means of an official letter.

Using the IRB protocol application, the Principal Investigator must carefully develop a Description of Study (investigator/local research plan) and consent form(s), making sure that consent form information is consistent with the research plan.

The Protocol Application must, at a minimum, include enough information for reviewers to make determinations based upon the **Criteria for IRB approval of Research** [45 CFR 46.111].

**Note:** Investigators who have other individuals submit their protocols and responses to the IRB must recognize that the ultimate responsibility of any study lies with the Principal Investigator (PI) or Faculty Advisor. It is incumbent upon these responsible parties to check all material that is submitted to the IRB for review.

### **14.3 Changes to Approved Research**

Investigators must seek IRB approval before making any changes in approved research - even though the changes are planned for the period for which IRB approval has already been given - unless the change is necessary to eliminate an immediate hazard to the participant (in which case the IRB must then be notified at once).

A modification application should be completed thru Cayuse. Modifications to Exempt studies and minor modifications to Expedited or Full Board protocols may be approved by the IRB analyst and/or the IRB Chair or designee and an email will be sent to the PI thru Cayuse to indicate approval of the modification. Substantial modifications in expedited studies should be reviewed by an Analyst and the IRB Chair or an IRB reviewer. Major changes (e.g., changes that involve increased risk or discomfort) to any approved protocol may require full board review.

**Note:** IRB approved modifications to ongoing research do NOT extend the original approval expiration date.

#### **14.4 Data Storage**

The PI or Faculty Advisor is the primary custodian/steward of data generated in the context of a research study and has primary oversight for data security. By certifying an IRB submission, the PI or Faculty advisor accepts this role (see the UNCG [Access to and Retention of Research Data policy](#)). The University supports the PI or Faculty Advisor by making available the infrastructure and expertise needed to ensure the security of data.

For research data, the governing policy is the [Research Data Policy](#) which speaks to different data classification for types of research data. It is the research team's responsibility to make sure they are complying with University data security policies.

#### **14.5 Renewal of Studies**

Investigators must report the **progress of the research** (including multi-site studies) to the IRB in the manner and frequency prescribed by the IRB, but no less than once a year. When reporting the progress of a multi-site study the PI is responsible for assuring the UNCG IRB that all associated sites have valid initial and continual IRB approval.

When an approved research project is completed, the investigator must promptly notify the IRB and file with the IRB a **closure**, which includes the information required for continuing review of protocols for the last research project period.

Once data collection has been completed and the research is closed at either the University or other sites, the Principal Investigator is not required to submit any further reports of the research to the IRB.

#### **14.6 Investigator-Required Record Keeping**

Investigators must retain copies of approved IRB documents and implement a system to comply with approval expiration dates. Storage must comply with UNCG Data Classification policies and/or federal or sponsor regulations.

In addition to providing a copy of the consent form to each participant, the signed and dated copy must be stored securely by the Principal Investigator (PI) and retained for a minimum of 3 years after completion of the research. Completion of research is defined as the time at which a closure is filed with the IRB. When the minimum retention period has been met, the PI must destroy all identifiable data (consent forms, video/audio tapes, key to identifiers, etc.) according to measures approved in the IRB protocol unless their study application indicated otherwise, and they obtained

approval to store identifiable data for an extended **period**. Deidentified data may be kept indefinitely without the PI having an open IRB file for the project.

#### **14.6.1 Statements of Confidentiality and Human Subjects Training verification**

It is the responsibility of the PI or the Faculty Advisor to maintain on file copies of signed Statements of Confidentiality (for all persons who are not investigators or student researchers but have access to research data) and UNCG-accepted certificates of training in the protection of human research participants (for all persons who are not investigators or student researchers but who interact with research participants). Statements of confidentiality do not need to be submitted to the IRB but kept on file with the researchers.

All Principal Investigators and Faculty advisors need to submit documentation verifying completion of Human subjects training at submission. Any research personnel added after initial approval in a modification are required to submit documentation of human subject's research training at the time that they are added to the protocol.

#### **14.6.2 Biospecimen Storage**

When human specimens (e.g., blood/plasma) are collected they must be stored in accordance with OSHA regulated standards. Additionally, human specimens must be stored securely in a locked room with limited access, regardless of whether they are identified or deidentified.

### **14.7 Human Subjects Protection Training / Ongoing Education of Principal Investigator and Research Team**

One component of a comprehensive human research protection program is an education program for all individuals involved with research participants. UNCG is committed to providing training and an on-going educational process for investigators and members of their research teams related to ethical concerns and regulatory and institutional requirements for the protection of human participants.

#### **Education**

The PI, student researcher(s), and all co-investigator(s) must submit with IRB applications certificates of training in the protection of human research participants dated no earlier than five years prior to the date of submission. UNCG's IRB accepts only certificates of training from the following sources:

1. A Certificate of Completion from an ORCI-sponsored training session.
2. Certificate of Completion for the Researcher modules (faculty/staff) and the Student Researcher modules (students), and the required additional modules for a student researcher, in the CITI Course in the Protection of Human Research Participants indicating scores of a minimum of 80% of questions answered correctly for all included modules.

New research protocols and applications for continuing review will not be accepted from principal investigators who have not completed the education requirement or whose training has expired, which is determined by the CITI course website. While research protocols and applications for continuing review will be accepted and reviewed if the Principal Investigator holds a current certification of training, final approval will not be granted until all co-investigators have completed the initial education requirement. Investigators who are also IRB Chair, IRB members, or ORCI

staff will satisfy the training requirements for IRB members and staff described in this policy under Section 5.6.

### **Additional Resources**

Human research protection information will be made available on the ORCI website on an ongoing basis to ensure that the University research community is apprised of current regulatory and policy requirements and updated training opportunities.

### **Community Based Research Training**

Community-based research ethics training is offered as an alternative to Collaborative Institutional Training Initiative (CITI program) when it has been determined that CITI training is not the most appropriate or useful form of ethics training for community co-researchers. This could be for a variety of reasons, such as limited access to online training, intercultural differences in ethics, and language and literacy differences. In addition to serving as an alternative training format, this ethics training takes into consideration the unique principles and practices of community-engaged research, which engages community members as collaborators in all aspects of a research study, from design to implementation to analysis. There may be benefits to community-academic partnerships when they use this training, including:

- The language is adjusted so that there's less research jargon, and definitions provided, which can encourage a stronger sense of collective ownership for the research project.
- PIs and co-researchers may use specific examples related to their research project. This allows the research team to discuss ethics in a way that is specific to the project.
- The training is flexible (e.g., location, training dates, some content), allowing for considerations that may be unique to a specific community.
- The dialogic nature of the training process allows for greater rapport building and trust within the partnership.
- By inviting input from community research partners during the training, the process fosters more transparency about how information will be gathered, and results analyzed and disseminated.

**To qualify for the training, study team members must meet both criteria below:**

- Collaborating with a Lead Researcher/Principal Investigator at UNCG to complete research in the community;
- Member of a Community Organization or Agency or a member of the community in which the research will be conducted.

**AND one of the follow criteria:**

- Consenting people in the community to participate in human subjects research
- Observing and recording information about human subjects

- Collecting private information about human subjects
- Using, studying or analyzing identifiable private information or specimens provided by another institution or investigator
- Using data collected from human subjects for research purposes

\*For more information including the Procedures, PowerPoint template, eligibility requirement checklist, pledge statement, and training certification template, go to the Compliance drive, Department folder, Human Subjects Training folder, Community Based Research folder, UNCG folder

## **14.8 Participant Recruitment**

Investigators are responsible for recruiting research participants in a manner that is fair, ethical, and equitable. IRB approval is required for all recruitment procedures and materials. Recruitment materials must be consistent with the approved IRB protocol, accurate, and not coercive.

### **14.8.1 Online Survey Recruitment/Contact Harassment**

When conducting recruitment for an online research survey, researchers may only contact the potential participant a total of 3 times. This should include the initial contact and two follow ups.

## **14.9 Payment to Participants**

Payment to research participants may be an incentive for participation or a way to reimburse a participant for travel and other experiences incurred due to participation. However, payment for participation is not considered a research benefit. Regardless of the form of remuneration, investigators must take care to avoid coercion of participants. Payments should reflect the degree of risk, inconvenience, time required, or discomfort associated with participation. The amount of compensation must be proportional to the risks and inconveniences posed by participation in the study. Any amount paid as bonus for completion of the entire study should not be so great that it becomes coercive. The IRB must review both the amount of payment and the proposed method of disbursement to assure that neither entails problems of coercion or undue influence.

The consent form must describe the terms of payment and the conditions under which participants would receive partial payment or no payment (e.g., if they withdraw from the study before their participation is completed). If monies for payment are administered through the UNCG Controller's Office, the PI must follow the procedures or requirements of that office. In the event the payment through UNCG Controller's Office requires identification of the participant, this must be stated on the informed consent form.

It is prohibited for the following payments to occur:

- Payments to professionals in exchange for referrals of potential participants ("finder's fees").
- Payments designed to accelerate recruitment that are tied to the rate or timing of enrollment ("bonus payments") unless they are judged not to interfere with providing prospective participants with sufficient opportunity to consider whether to participate and does not increase the possibility of coercion or undue influence on investigators or participants.

#### **14.10 Investigator Concerns**

Investigators who have concerns or suggestions regarding UNCG's human research protection program should convey them to the Director or other responsible parties (e.g., Research Policy Committee) regarding the issue, when appropriate. The Director/Institutional Official will research the issue, and when deemed necessary, convene the parties involved to form a response for the investigator or make necessary procedural or policy modifications, as warranted. In addition, the Chair of the IRB or the Assistant Director will be available to address investigators' questions, concerns, and suggestions.

### **15. Health Insurance Portability and Accountability Act (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the creation of a Privacy Rule for identifiable health information. The resulting Privacy Rule, finalized in August 2002, set a compliance date of April 14, 2003. While the main impact of the Privacy Rule is on the routine provision of and billing for health care, the Rule also affects the conduct and oversight of research. Researchers, IRB staff and members, as well as research administration must be aware of these changes.

#### **15.1 Background**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is an expansive federal law, part of which is intended to protect the privacy of health care information. Personal health information (PHI) referred to as protected health information, generally refers to demographic information, medical history, test and laboratory results, insurance information and other data that is collected by a health care professional to identify an individual and determine appropriate care. The final Privacy Rule regarding such information was published on August 14, 2002. See the [NIH HIPAA Privacy Rule Booklet for Research](#) and the [NIH fact sheet on Institutional Review Boards and HIPAA](#) for more information on how HIPAA applies to research. Under HIPAA, patients have certain new rights. These include the right to receive a Notice of Privacy Practices, the right to access, inspect, and receive a copy of one's own PHI, the right to request an amendment to one's own PHI, and the right to an accounting of certain disclosures of PHI that occur outside the scope of treatment, payment and health care operations that have not been authorized.

#### **15.2 HIPAA and Research**

The final Privacy Rule published on August 14, 2002, included several changes in how the Rule applies to research. See the [NIH HIPAA Privacy Rule Booklet for Research](#) and the [NIH fact sheet on Institutional Review Boards and HIPAA](#) for more information on how HIPAA applies to research. See also [The HIPAA Privacy Rule: Lacks Patient Benefit, Impedes Research Growth](#).

The University of North Carolina at Greensboro is NOT a covered entity under HIPAA. However, researchers who are working with "Protected Health Information" (PHI) from other institutions that are covered entities will need to comply with the rules on HIPAA. UNCG does have three covered entities: the Psychology Clinic, Speech and Hearing Clinic, and Student Health Services. These covered entities have established policies and procedures that researchers must follow.

### **15.3 HIPAA and UNCG Documentation Requirements**

The IRB requires one of the following documents, and these are the *only* documents that would need to be submitted and reviewed: a HIPAA authorization form, a waiver of authorization form, or a de-identification form. These documents must be used whenever PHI from a covered entity is being utilized in the research. The covered entity should provide the researcher with their approved authorization form or waiver of authorization form. If the covered entity does not have these documents, the UNCG IRB will assist the researchers in developing them. A researcher who will use PHI must complete the application to use protected health information and submit it with the IRB protocol. The IRB does not require any information from a researcher regarding a Business Associate Agreement, as this item is obtained from the covered entity if the covered entity is collaborating with the researcher and is sharing PHI within that study.

### **15.4 HIPAA and Existing Studies**

Any research participant enrolled in a study that uses PHI from a covered entity must sign a HIPAA-compliant authorization form. This form is in addition to the existing Informed Consent document and is federally required. In a few cases, the Informed Consent document may be combined with a HIPAA authorization.

### **15.5 Waivers to HIPAA consent form**

In some cases, an IRB may approve a waiver of the HIPAA authorization form. This may occur when the IRB finds that the research could not be practically done without the waiver, and not without access to and use of the PHI, and that disclosure poses minimal risk to privacy. This waiver would generally come from the IRB of the covered entity that has “ownership” of the PHI, however, the UNCG IRB can grant a waiver when a student or faculty member is obtaining data from a covered entity.

## **16. Special Topics**

### **16.1 NIH Certificate of Confidentiality**

#### **16.1.1 Statutory Basis for Protection**

#### **Purpose**

Effective October 1, 2017, NIH has updated its policy for issuing Certificates of Confidentiality (Certificates) for NIH-funded and conducted research, as a result of the need to implement Section 2012 of the 21st Century Cures Act, P.L. 114-255, which states that the Secretary, HHS shall issue Certificates of Confidentiality to persons engaged in biomedical, behavioral, clinical or other research, in which identifiable, sensitive information is collected. These Certificates protect the privacy of subjects by limiting the disclosure of identifiable, sensitive information.

#### **Background**

Section 2012 of the 21st Century Cures Act, enacted December 13, 2016, enacts new provisions governing the authority of the Secretary of Health and Human Services (Secretary) to protect the privacy of individuals who are the subjects of research, including significant amendments to the

previous statutory authority for such protections, under subsection 301(d) of the Public Health Service Act. Specifically, the amended authority requires the Secretary to issue to investigators or institutions engaged in biomedical, behavioral, clinical, or other research in which identifiable, sensitive information is collected (“Covered Information”), a Certificate to protect the privacy of individuals who are subjects of such research, if the research is funded wholly or in part by the Federal Government. The authority also specifies the prohibitions on disclosure of the names of research participants or any information, documents, or biospecimens that contain identifiable, sensitive information collected or used in research by an investigator or institution with a Certificate. If the research is not federally funded, the Secretary may issue a Certificate to an investigator or institution engaged in such research, upon application.

### **Scope and Applicability**

The NIH Policy applies to all biomedical, behavioral, clinical, or other research funded wholly or in part by the NIH, whether supported through grants, cooperative agreements, contracts, other transaction awards, or conducted by the NIH Intramural Research Program, that collects or uses identifiable, sensitive information. For the purposes of this Policy, consistent with subsection 301(d) of the Public Health Service Act (42 U.S.C 241), the term “identifiable, sensitive information” means information about an individual that is gathered or used during the course of biomedical, behavioral, clinical, or other research, where the following may occur:

- An individual is identified; or
- For which there is at least a very small risk, that some combination of the information, a request for the information, and other available data sources could be used to deduce the identity of an individual.

The Policy also acknowledges that the NIH will continue to consider request for Certificates for non-federally funded research in which identifiable, sensitive information is collected or used.

### **Policy**

Effective October 1, 2017, all research that was commenced or ongoing on or after December 13, 2016, and is within the scope of this Policy is deemed to be issued a Certificate through this Policy and is therefore required to protect the privacy of individuals who are subjects of such research in accordance with subsection 301(d) of the Public Health Service Act. This Policy will be included in the NIH Grants Policy statement as a standard term and condition of award effective October 1, 2017, for new and non-competing awards. Institutions and their investigators are responsible for determining whether research they conduct is subject to this Policy and therefore issued a Certificate. Certificates issued in this manner will not be issued as a separate document. Previously, NIH provided these protections through the issuance of Certificates only upon receipt and approval of an application. However, to comply with the requirement in subsection 301(d) of the Public Health Service Act to minimize the burden to researchers, streamline the process, and reduce the time it takes to comply with the requirements associated with applying for a Certificate, NIH will now provide Certificates automatically to any NIH-funded recipients conducting research applicable to this Policy.

For the purposes of this Policy, NIH considers research in which identifiable, sensitive information is collected or used, to include:

- Human subjects research as defined in the Federal Policy for the Protection of Human Subjects (45 CFR 46), including exempt research except for human subjects research that is determined to be exempt from all or some of the requirements of 45 CFR 46 if the information obtained is recorded in such a manner that human subjects cannot be identified or the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects,
- Research involving the collection or use of biospecimens that are identifiable to an individual or for which there is at least a very small risk that some combination of the biospecimen, a request for the biospecimen, and other available data sources could be used to deduce the identity of an individual,
- Research that involves the generation of individual level, human genomic data from biospecimens, or the use of such data, regardless of whether the data is recorded in such a manner that human subjects can be identified or the identity of the human subjects can readily be ascertained as defined in the Federal Policy for the Protection of Human Subjects (45 CFR 46), or
- Any other research that involves information about an individual for which there is at least a very small risk, as determined by current scientific practices or statistical methods, that some combination of the information, a request for the information, and other available data sources could be used to deduce the identity of an individual, as defined in subsection 301(d) of the Public Health Service Act.

### **Recipient Responsibilities**

To determine if this Policy applies to research conducted or supported by NIH, investigators will need to ask, and answer the following question:

- Is the activity biomedical, behavioral, clinical, or other research?

If the answer to this question is no, then the activity is not issued a Certificate. If the answer is yes, then investigators will need to answer the following questions:

- Does the research involve Human Subjects as defined by 45 CFR Part 46?
- Are you collecting or using biospecimens that are identifiable to an individual as part of the research?
- If collecting or using biospecimens as part of the research, is there a small risk that some combination of the biospecimen, a request for the biospecimen, and other available data sources could be used to deduce the identity of an individual?
- Does the research involve the generation of individual level, human genomic data?

If the answer to any one of these questions is yes, then this Policy will apply to the research and therefore, in accordance with subsection 301(d) of the Public Health Service Act, the recipient of the Certificate shall not:

- Disclose or provide, in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding, the name of such individual or any such information, document, or biospecimen that contains identifiable, sensitive information about the individual and that was created or compiled for purposes of the research, unless such disclosure or use is made with the consent of the individual to whom the information, document, or biospecimen pertains, or
- Disclose or provide to any other person not connected with the research the name of such an individual or any information, document, or biospecimen that contains identifiable, sensitive information about such an individual and that was created or compiled for purposes of the research.

Disclosure is permitted only when:

- Required by Federal, State, or local laws (e.g., as required by the Federal Food, Drug, and Cosmetic Act, or state laws requiring the reporting of communicable diseases to State and local health departments), excluding instances of disclosure in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding,
- Necessary for the medical treatment of the individual to whom the information, document, or biospecimen pertains and made with the consent of such individual,
- Made with the consent of the individual to whom the information, document, or biospecimen pertains, or
- Made for the purposes of other scientific research that is in compliance with applicable Federal regulations governing the protection of human subjects in research.

As set forth in [45 CFR Part 75.303\(a\)](#) and [NIHGPS Chapter 8.3](#), recipients conducting NIH supported research applicable to this Policy are required to establish and maintain effective internal controls (e.g., policies and procedures) that provide reasonable assurance that the award is managed in compliance with Federal statutes, regulations, and the terms and conditions of award.

For studies in which informed consent is sought, NIH expects investigators to inform research participants of the protections and the limits to protections provided by a Certificate issued by this Policy.

Recipients of Certificates are required to ensure that any investigator or institution not funded by NIH who receives a copy of identifiable, sensitive information protected by a Certificate issued by this Policy, understand they are also subject to the requirements of subsection 301(d) of the Public Health Service Act. In accordance with [NIHGPS Chapter 15.2.1](#), recipients are also responsible for ensuring that any subrecipient that receives funds to carry out part of the NIH award involving a copy of identifiable, sensitive information protected by a Certificate issued by this Policy understand they are also subject to subsection 301(d) of the Public Health Service Act.

### **Non-NIH Funded Research**

The NIH will continue to consider requests for Certificates for specific project that are not funded by NIH or other HHS agencies that issues Certificates. Such requests need to be submitted through

the NIH online application system in accordance with current NIH procedures for issuing Certificates.

**(NIH Guidance, <https://humansubjects.nih.gov/coc/background>)**

The IRB may require investigators to apply for a Certificate of Confidentiality if the study is not NIH funded.

### **16.1.2 Limitations of a Certificate of Confidentiality**

The protection offered by a Certificate of Confidentiality is not absolute. A Certificate protects research participants only from legally compelled disclosure of their identity. It does **not** restrict voluntary disclosures.

For example, a Certificate does not prevent researchers from voluntarily disclosing to appropriate authorities such matters as child abuse, a participant's threatened violence to self or others, or from reporting a communicable disease. However, if researchers intend to make such disclosures, this should be clearly stated in the informed consent form which research participants are asked to sign.

In addition, a Certificate of Confidentiality does **not** authorize the person to whom it is issued to refuse to reveal the name or other identifying characteristics of a research participant if:

- the participant (or, if he or she is legally incompetent, his or her legal guardian) consents, in writing, to the disclosure of such information,
- authorized personnel of the Department of Health and Human Services (DHHS) request such information for audit or program evaluation, or for investigation of DHHS grantees or contractors and their employees, or
- information about a participant's psychological well-being or mental health.

**(NIH Guidance, <http://grants.nih.gov/grants/policy/coc/background.htm>)**

This list is not exhaustive. Researchers contemplating research on a topic that might qualify as sensitive should contact the ORCI for more information on applying for a certificate.

## **16.2 NIH Single IRB Policy**

### **Purpose**

The National Institutes of Health (NIH) is issuing this policy on the use of a single Institutional Review Board (IRB) for multi-site research to establish the expectation that a single IRB (sIRB) of record will be used in the ethical review of non-exempt human subjects research protocols funded by the NIH that are carried out at more than one site in the United States. The goal of this policy is to enhance and streamline the IRB review process in the context of multi-site research so that research can proceed as effectively and expeditiously as possible. Eliminating duplicative IRB review is expected to reduce unnecessary administrative burdens and systemic inefficiencies without diminishing human subjects protections. The shift in workload away from conducting redundant reviews is also expected to allow IRBs to concentrate more time and attention on the review of single site protocols, thereby enhancing research oversight.

## Background

The NIH published for public comment a proposed draft sIRB policy in a Notice in the NIH Guide for Grants and Contracts on December 3, 2014, (<https://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-026.html>) and in the Federal Register on January 6, 2015, (80 FR 511) (<https://federalregister.gov/a/2014-30964>). The NIH received 167 comments from a range of stakeholders, including individual researchers, academic institutions, IRBs, patient advocacy groups, scientific societies, healthcare organizations, Tribal Nation representatives, and the general public. A compilation of the public comments is available at <http://osp.od.nih.gov/sites/default/files/resources/sIRB%2007-21-2015.pdf>. The NIH appreciated the public interest in the draft policy and the time and effort stakeholders made to provide comments. The NIH carefully considered those comments in the development of the final policy.

### 16.3 NIH Definition of a Clinical Trial

In 2016, NIH launched a multi-faceted effort to enhance its stewardship over clinical trials. The goal of this effort is to encourage advances in the design, conduct, and oversight of clinical trials while elevating the entire biomedical research enterprise to a new level of transparency and accountability. The NIH definition of a clinical trial was revised in 2014 in anticipation of these stewardship reforms to ensure a clear and responsive definition of a clinical trial. [Learn more about why NIH has made changes to improve clinical trial stewardship.](#)

**Clinical Trial Definition:** A research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes.

The term “*prospectively assigned*” refers to a pre-defined process (e.g., randomization) specified in an approved protocol that stipulates the assignment of research subjects (individually or in clusters) to one or more arms (e.g., intervention, placebo, or other control) of a clinical trial.

An *intervention* is defined as a manipulation of the subject or subject’s environment for the purpose of modifying one or more health-related biomedical or behavioral processes and/or endpoints. Examples can include but is not limited to: drugs/small molecules/compounds, biologics, devices, procedures (e.g., surgical techniques), delivery systems (e.g., telemedicine, face-to-face interviews), strategies to change health-related behavior (e.g., diet, cognitive therapy, exercise, development of new habits), treatment strategies, prevention strategies, and diagnostic strategies.

*Health-related biomedical or behavioral outcome* is defined as the pre-specified goal(s) or condition(s) that reflect the effect of one or more interventions on human subjects’ biomedical or behavioral status or quality of life. Examples can include but is not limited to: positive or negative changes to physiological or biological parameters (e.g., improvement of lung capacity, gene

expression), positive or negative changes to psychological or neurodevelopmental parameters (e.g., mood management intervention for smokers; reading comprehension and /or information retention), positive or negative changes to disease processes; positive or negative changes to health-related behaviors, and positive or negative changes to quality of life.

Important features that distinguish a clinical trial from a clinical study are whether there is prospective assignment of an intervention, a study design that evaluates the effect of the intervention on the participants, and a health-related biomedical or behavioral outcome.

See NIH Policy for more information: <https://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-015.html>

### **16.3.1 Reporting on ClinicalTrials.gov**

At UNCG, the PI or PI designee will be responsible for all required reporting on ClinicalTrials.gov.

All NIH-funded clinical trials are expected to register and submit results information to [Clinicaltrials.gov](http://Clinicaltrials.gov), as per the “[NIH Policy on Dissemination of NIH-Funded Clinical Trial Information](#)“ for competing applications and contract proposals submitted on or after 1/18/2017.

In 2016, NIH published the NIH Policy on the Dissemination of NIH-Funded Clinical Trial Information in NIH Guide Notice [NOT-OD-16-149](#). This guide notice includes a summary, background/supplemental information, and an overview of the public comments and NIH response that shaped the policy.

For convenience, we provide the policy itself, excerpted below from [NOT-OD-16-149](#).

### **16.3.2 NIH Policy on Dissemination of NIH-Funded Clinical Trial Information**

#### **Purpose**

The National Institutes of Health (NIH) Policy on Dissemination of NIH-funded Clinical Trial Information establishes the expectation that all NIH-funded awardees and investigators conducting clinical trials, funded in whole or in part by the NIH, will ensure that their NIH-funded clinical trials are registered at, and that summary results information is submitted to, [ClinicalTrials.gov](http://ClinicalTrials.gov) for public posting<sup>1</sup> The purpose of the policy is to promote broad and responsible dissemination of information from NIH-funded clinical trials through [ClinicalTrials.gov](http://ClinicalTrials.gov). Disseminating this information supports the NIH mission to advance the translation of research results into knowledge, products, and procedures that improve human health.

This policy is complementary to requirements in the Clinical Trial Registration and Results Information Submission regulation at 42 CFR Part 11, hereinafter referred to as the regulation. Clinical trials that are subject to the regulation are, in general, clinical trials of drug, biological, and device products regulated by the Food and Drug Administration (FDA), except phase 1 trials of drug and biological products and small feasibility studies of device products. A pediatric post-market surveillance study of a device product required by the FDA is also subject to the regulation. Clinical trials subject to the regulation are generally called “applicable clinical trials.” Applicable clinical trials are required to be registered in [ClinicalTrials.gov](http://ClinicalTrials.gov) not later than 21 calendar days after the enrollment of the first participant. Results information from those trials

generally must be submitted not later than one year after the trial's primary completion date. Submission of results information can be delayed in certain circumstances for up to two additional years for trials of products regulated by the FDA that are unapproved, unlicensed, or uncleared or for trials of products for which approval, licensure, or clearance of a new use is being sought.

### **Scope and Applicability**

This policy applies to all NIH-funded clinical trials regardless of study phase, type of intervention, or whether they are subject to the regulation. For example, NIH-funded phase 1 clinical trials of an FDA-regulated product are covered by this policy as are clinical trials studying interventions not regulated by the FDA, such as behavioral interventions. As such, the policy encompasses all NIH-funded clinical trials, including applicable clinical trials subject to the regulation. All NIH-funded clinical trials will be expected to register and submit results information to ClinicalTrials.gov.

This policy applies to clinical trials funded in whole or in part through the NIH extramural and intramural programs. For the NIH extramural program, the policy applies to applications for funding including for grants, other transactions, and contracts submitted on or after the policy's effective date that request support for the conduct of a clinical trial that is initiated on or after the policy's effective date. For the NIH intramural program, the policy applies to clinical trials initiated on or after the policy's effective date.

This policy does not apply to a clinical trial that uses NIH-supported infrastructure but does not receive NIH funds to support its conduct.

### **Responsibilities**

As part of their applications or proposals, applicants and offerors seeking NIH funding will be required to submit a plan for the dissemination of NIH-funded clinical trial information that will address how the expectations of this policy will be met. NIH-funded awardees and investigators conducting clinical trials funded in whole or in part by the NIH will be required to comply with all terms and conditions of award, including following their plan for the dissemination of NIH-funded clinical trial information.

Consistent with those terms and conditions, the responsibilities of such awardees and investigators will fall within one of the three categories. The category depends on whether, under the regulation, the clinical trial is also an “applicable clinical trial” and the awardee or investigator is the “responsible party.”

1. If the NIH-funded clinical trial is an applicable clinical trial under the regulation and the awardee or investigator is the responsible party, the awardee or investigator will ensure that all regulatory requirements are met.
2. If the NIH-funded clinical trial is an applicable clinical trial under the regulation but the awardee or investigator is not the responsible party, the awardee or investigator will coordinate with the responsible party to ensure that all regulatory requirements are met.
3. If the NIH-funded clinical trial is not an applicable clinical trial under the regulation, the awardee or investigator will be responsible for carrying out the tasks and meeting the timelines described in regulation. Such tasks include registering the clinical trial in ClinicalTrials.gov and submitting results information to ClinicalTrials.gov.

In addition, informed consent documents for clinical trials within all three categories are to include a specific statement relating to posting of clinical trial information at ClinicalTrials.gov.

Each NIH-funded clinical trial should have only one entry in ClinicalTrials.gov that contains its registration and results information. Awardees and investigators need not and should not create a separate record of the applicable clinical trial to comply with this policy.

The NIH will publicly post registration information and results information in ClinicalTrials.gov.

### **Definitions**

***Clinical Trial.*** For purposes of this policy, a “clinical trial” means “a research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes.” This definition encompasses phase 1 trials of FDA-regulated drug and biological products, small feasibility studies of FDA-regulated device products, and studies of any intervention not regulated by the FDA, e.g., behavioral interventions. This definition of “clinical trial” is broader than the term “applicable clinical trial” as defined in the regulation.

***Responsible Party.*** In the policy, the awardee or the investigator is responsible for meeting the expectations of this policy. In the regulation, a “responsible party” means, in part, “with respect to a clinical trial, the sponsor of the clinical trial, as defined in 21 CFR 50.3 (or any successor regulation); or the principal investigator of such clinical trial if so designated by a sponsor, grantee, contractor, or awardee, so long as the principal investigator is responsible for conducting the trial, has access to and control over the data from the clinical trial, has the right to publish the results of the trial, and has the ability to meet all of the requirements under [42 CFR Part 11] for the submission of clinical trial information.”

***Primary Completion Date.*** In the policy, this term has the same meaning as the term “primary completion date” in the regulation, which is “the date that the final subject was examined or received an intervention for the purposes of final collection of data for the primary outcome, whether the clinical trial concluded according to the pre-specified protocol or was terminated.”

***Registration Information.*** In the policy, this term has the same meaning as the term “registration information” in the regulation. In the regulation, registration information consists of descriptive information, recruitment information, location and contact information, and administrative data.

***Results Information.*** In the policy, this term has the same meaning as the term “results information” in the regulation. In the regulation, results information includes participant flow, demographic and baseline characteristics, outcomes and statistical analyses, adverse events, the protocol and statistical analysis plan, and administrative information.

### **Compliance**

If the clinical trial is NIH-funded in whole or in part, expectations for clinical trial registration and summary results submission will be included in the terms and conditions of the award. Failure to comply with the terms and conditions of the NIH award may provide a basis for enforcement actions, including termination, consistent with 45 CFR 75.371 and/or other authorities, as

appropriate. If the NIH-funded clinical trial is also an applicable clinical trial, non-compliance with the requirements specified in 42 USC 282(j) and 42 CFR Part 11 may also lead to the actions described in 42 CFR 11.66.

**Effective Date** This policy is effective January 18, 2017.

#### **16.4 UNCG Policy on Required Study Registration and Reporting on ClinicalTrials.gov**

At UNCG, the PI or PI designee will be responsible for all required reporting on ClinicalTrials.gov.

**Registration of a clinical trial on ClinicalTrials.gov is required if a study meets any of the following criteria:**

- [Applicable Clinical Trials](#) (regardless of funding)
- [NIH-funded](#) as well as [any other externally funded](#) studies that meet the [NIH definition of clinical trial](#)
- A clinical trial subject to the [revised common rule](#) – a clinical trial [conducted or supported by a Federal department or agency \(45 CFR 46.116](#) (h) Posting of clinical trial consent form)
- [Billing insurance \(per CMS policy\)](#) – regardless of funding, although these almost always fall into one of the other categories

**NOTE:** If a researcher plans to submit to an [ICMJE journal](#) for publication, \*ICMJE requires, and recommends that all medical journal editors require registration of clinical trials in a public trials registry at or before the time of first participant enrollment as a condition of consideration for publication.

#### **16.5 Mandatory Reporting**

While preparing a research protocol, investigators must keep in mind that a specific professional group may have mandated reporting guidelines that will need to be followed. In addition, the state of North Carolina also has mandated reporting regulations. Guidance on these state regulations can be sought from university counsel. Investigators should consult appropriate sources to determine if potential participants should be advised of mandatory reporting requirements during the informed consent process.

#### **16.6 UNCG Students and Employees as Participants**

When UNCG students and/or employees are being recruited as potential participants, researchers must ensure that there are additional safeguards for these participants. Their participation must be voluntary and there must not be undue influence on their decision to participate. Researchers must emphasize to participants that neither their academic status or grades, nor their employment, will be affected by their participation decision.

To minimize coercion, investigators should avoid, whenever possible, the use of their students and employees in procedures that are neither therapeutic nor diagnostic. In these latter situations, investigators should solicit participants through means such as bulletin board notices, flyers, advertisements in newspapers, and announcements in classes **other than their own**. When entering a classroom to recruit students and conduct research (e.g., administer a survey) investigators must

do so at the end of the class period to allow non-participating students the option of leaving the classroom, thereby alleviating pressure to participate (please see 8.2.1.2 for guidelines about recruiting in classes).

### 16.6.1 Psychology Department Participant Pool

The Psychology Department of UNCG employs the use of a “participant pool” for student-participants.

The Department of Psychology participant pool consists of all students enrolled in PSY 121 (General Psychology) and PSY 122 (Careers in Psychology) courses as well as other participating courses during a given semester. As part of the course requirement, students are expected to earn Research Participation Credits (RPCs; with each credit corresponding to 0.5 hours of research participation) for PSY 121 and 4 RPCs for PSY 122, unless otherwise arranged between the Department Head and the Instructor. There are two methods by which students can earn their RPCs: 1) participating in the required number of hours of IRB-approved research studies for each course conducted under the supervision of Psychology faculty or 2) writing a research paper on a specified topic related to Psychology as an empirical science and its research methods. Students must earn all RPCs in either one of these two methods (i.e., the research paper counts towards all RPCs, so it is of no advantage to complete the research paper and participate in some experiments).

The Department of Psychology conducts all research and training in accordance with the ethical guidelines set forth by the American Psychological Association, and, as appropriate, with the approval of UNCG’s Institutional Review Board. Department policies governing the use and operation of the participant pool are reviewed, and revisions pertaining to research activities are submitted to IRB for approval. In addition, the Department of Psychology follows the OHRP guidance on [“Student Subject Pools and Use of Penalties for Students Who Fail to Show up for Scheduled Research Appointments”](#)

## 16.7 Student-led Research

Student-led research falls into three categories:

- **Research.** The purpose of the activity is to contribute to generalizable knowledge and data gathered may be shared with a research community or the public at large. This includes funded and unfunded projects as well as thesis/dissertations studies. When anticipated activities are research, IRB review and approval **must** be obtained prior to data collection.
- **Classroom Project.** The purpose of these types of activities is the education of an individual student or group of students through an inquiry or experiential approach to discover known principles or phenomena rather than generalizable knowledge. Data gathered may only be shared with the course professor or faculty sponsor, classmates, or in the case of an internship/practicum, the collaborating party. If the data gathered is intended to be presented in the classroom setting only, this does not contribute to generalizable knowledge, and is not considered research per the federal regulations.
- **Program Evaluation.** (See SOP Section 2, Definitions) Data gathered may ONLY be shared with the sponsor/client/requesting party and where appropriate, the faculty sponsor/professor, or used for internal decision making or informational purposes. It is not

necessary to submit an IRB application for program evaluation. The primary distinction between “research” and program evaluations is that in a program evaluation the study data and results may only be shared with the organization requesting the evaluation.

Faculty advisors must still be listed on the application and will also be fully responsible for that study.

### 16.7.1 Class Projects

The UNCG IRB recognizes that human participants may be harmed by unethical or careless activities resulting from evaluations, assessments, service, reporting, classroom assignments, educational inquiry, or practice. As a board that values the protection of human participants and the conduct of ethical behavior, the IRB strongly disapproves of such unethical behavior. Class projects are generally conducted for educational purposes and not as research. While some require submission of an IRB application or a determination that IRB approval is not required, many class projects require neither. Instructors and departments are encouraged to contact the IRB for guidance about ways to handle topics such as privacy, confidentiality, informed consent, and professional ethics when class projects are part of the course syllabus. IRB chairs and staff can share expertise related to managing risks of deductive disclosure, coercion-free recruiting, informed consent, and special considerations for projects that include potentially vulnerable individuals. These issues may remain even when IRB approval is not required, in which case instructors, advisors, departments and schools play an even greater role in providing the appropriate guidance and oversight.

It is the responsibility of the faculty member to determine, prior to assigning a project, whether the project is a classroom project or research. Faculty members are encouraged to consult with the ORCI in making such a determination. Should a class project be conducted that meets the definition of research but does not receive IRB review and approval, the faculty member will be considered to have engaged in IRB noncompliance and may be personally liable. If a student research project is originally conducted as a course assignment and does not have IRB approval, it can't be used as research later and can't be presented outside of the class setting (i.e., it can't be presented at conferences).

#### **All participants should be made aware of this activity as a class project.**

Research or class projects that involve vulnerable populations (see chart below), deception or incomplete disclosure should involve consultation with the IRB, Assistant Director or Director of the Office of Research Integrity and may require IRB review. When a study involves deception or incomplete disclosure, a debriefing is mandatory following the study.

<b>Vulnerable Populations</b>
Children
Prisoners
Elderly
Mentally or physically challenged individuals
Pregnant women
Individuals in foreign country
Immigrants

**The following class projects do not need to be submitted or reviewed by the IRB:**

- 1) **CLASS PROJECTS** involving **secondary data analyses** that are assigned and conducted as educational exercises, using data that are either publicly available data, de-identified or otherwise impossible to be linked to personal identities.
- 2) **CLASS PROJECTS** involving **secondary data analyses** that are assigned and conducted as educational exercises, and that use datasets that include private information and codes that link to identifiers, but the students do not have access to the identifiers.<sup>9</sup>
- 3) **CLASS PROJECTS or PRACTICA** that involve **direct interaction** (e.g., in person, via mail, email, web surveys, or telephone), but where the purpose is training, an educational exercise or professional development, and **not research**. The project or practicum is not “research” even if students ask people questions as part of learning how to conduct interviews or surveys, take histories, administer assessments, or perform “in-house” evaluations as requested by the practicum site.<sup>10</sup>

The following class project *would* need to be submitted and reviewed by the IRB:

**CLASS PROJECTS or PRACTICA** that **involve direct interaction** or **secondary analyses of sensitive, private identifiable data** and are undertaken as **both an educational experience and as research** (e.g., results of these activities will be presented publicly or otherwise disseminated, or the data will be stored and used by the students or others as research data).

**Submission Tip:**

Such projects may be very similar to one another. For example, each student may interview one or more persons for a group of oral histories or conduct telephone surveys as part of a yearly poll, but all in the class follow the same general script or guidelines. If class projects follow different protocols, a table or chart can describe these more individualized activities, under the umbrella of a single IRB application.

**Program Evaluation** – This is defined as a funded or unfunded evaluation of a specific program (formative, outcome, needs assessment, cost analysis, etc.) where the data and results will **ONLY** be shared with the organization/sponsor/client/requesting party or used for internal decision making or informational purposes. In this case, the work would not be considered “research” for IRB purposes.

Example 1: A researcher is conducting a program evaluation for an agency, program, or other organization. The work may include drawing a sample or sampling the entire

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<sup>9</sup> \*IRB review *may* be requested if instructor or students are unsure, or if documentation is required by gatekeepers (e.g., schools, businesses) for access to participants. Class instructor and department are responsible for providing the necessary training in respecting the privacy of the individuals and the confidentiality of any resulting information, along with training in the relevant professional ethics. Instructor provides information about the assignment for the students to distribute to people who participate in these class projects. List the instructor as the appropriate contact person should questions arise.

<sup>10</sup> Exception: If a student decides after the completion of a practicum activity to pursue additional activities with the same information for dissemination (e.g., master’s project, conference paper, article), then an IRB application describing research use of secondary data should be submitted for approval, as above.

population affected by the program, data collection, data analysis, and a written report. The organization may also require the PI to present the results at meetings with stakeholders or constituents. The PI has no intention of presenting results from this evaluation in any academic or professional publication or presentation other than that required by the organization. The PI also has no control over what the funding organization may do with the written report. In this case, the work would *not* be considered “research” for IRB purposes. Although the results may be intended to be generalized beyond the specific study sample, findings are not intended to be used or presented as generalizable beyond the scope of the particular program that is being evaluated. In this situation, **no IRB application** would be required.

Example 2: The situation is the same as in Example 1. However, in addition to sharing results with the organization, the researcher also intends to present the findings in an academic or professional setting other than that required by the agency. Depending on the content of the project, it may be considered “**research**” rather than solely “program evaluation,” and **an IRB application may be required**.

Example 3: A faculty member collects data to evaluate an academic program. The data and results will only be used by faculty within the department or School for internal decision-making or information sharing regarding the specific program. In this situation the work **would not be considered “research”** for IRB purposes, and **no IRB application** would be required.

Example 4: The situation is the same as in Example 3. However, the faculty plan to share evaluation data and results with an accrediting body or present the results from this evaluation in an academic or professional publication or presentation. As above, depending on the content of the data gathered, the project may be considered “**research**” rather than solely “program evaluation,” and **an IRB application may be required**.

### **16.7.2 Independent Doctoral Studies and Cornerstone Projects**

These research activities are considered to meet the federal definition of human participants research and must be independently submitted to the IRB by the student-researcher. However, when students conduct research as part of a course of study, *a faculty member ultimately is responsible for the protection of the participants*, even if the student is the primary researcher and directs the project. The Faculty Advisor is responsible for research that is conducted as part of a course.

Students may list themselves as Principal Investigators (PI) on an online submission. They must have a Faculty Advisor who fulfills the role of oversight of all research activities with the student as the affiliated student on the project. If the research activity is at another site and/or part of another research study outside of UNCG, the student will need a PI at UNCG and submit an application informing the IRB of their specific research question/study within the existing active study.

### **16.8 Oral History**

OHRP has determined that generally oral history projects are not designed to contribute to generalizable knowledge and therefore do not constitute research and thus do not require IRB review. However, if a project involving oral history includes additional components that do

constitute research and should be reviewed by the IRB. In addition, the definition of oral history is very specific and not all projects that investigators initially identify as oral history meet this definition. Investigators who believe they are conducting an oral history should submit an IRB application to the online system to the ORCI. Based on the information provided, the ORCI may issue a letter to the Investigator stating that the described project meets the definition of oral history and need not receive IRB review and approval. Investigators are advised to consult with the ORCI regarding whether their oral history project requires IRB review and to complete an IRB application to the online system to avoid potential liability should their project constitute research and require IRB review and approval.

## **16.9 Genetic Studies**

Although GINA (the Genetic Information Nondiscrimination Act) prohibits discrimination in health care coverage and employment based on genetic information, genetic research studies may create special risks to human participants and their relatives. These involve psychosocial, and economic risks, such as the possible loss of privacy, and insurability (i.e., life, disability, or long-term care), change in immigration status, and limits on education options, and may create a social stigma. Knowledge of one's genetic make-up may also affect one's knowledge of the disease risk status of family members.

Investigators need to ensure that they do not overstate the protections provided by GINA and specifically address the elements of informed consent related to; 1) description of any reasonably foreseeable risks or discomforts and 2) statements pertaining to the confidentiality of records. Investigators need to understand that GINA does not prohibit discrimination related to life insurance, disability insurance or long-term care insurance if information about the subject obtained as part of the research was disclosed to or sought by such insurers and investigators may want to state this if individual information will be given to subjects. In addition, GINA generally does not apply to employers with fewer than 15 employees and individuals who are or will be employed by such employers receive none of the GINA protections that prohibit discrimination in employment based on genetic information.

In studies involving genetic testing, several questions need to be addressed, including:

1. Will test results be given on an individual level? NIH supports not giving individual level results if no cure is available for the disease.
2. Will a change in a family relationship be disclosed, such as mistaken paternity?
3. Does the participant or family member have the option not to know the results? How will this decision be recorded?
4. Could other clinically relevant information be uncovered by the study? How will disclosure of this added information occur?
5. Is the participant permitted to participate in the study while refusing to have genetic testing (such as in a treatment study with a genetic testing component)?
6. Will disease risk be quantified, including the limits on certainty of the testing?

For DNA banking studies, several questions need to be addressed, including:

1. Will the stored DNA samples be de-identified? (See biospecimen section 13.6.2)
2. Will DNA be shared? If shared, will the participant's identity be known by the new recipient investigator?

3. Will the participant be contacted in the future by the investigator to obtain updated clinical information?
  - (1) Are re-contact provisions included in the original IRB for future studies not related to the original purpose of the collected DNA samples? If yes, what are the specifics included in the re-contact provisions?
4. How does the participant opt out of any distribution or subsequent use of his/her genetic material?

### **16.10 Coded Private Information or Biological Specimens**

UNCG procedures are based on the OHRP guidance document entitled, “**Guidance on Research Involving Coded Private Information or Biological Specimens**” (August 10, 2004, <http://www.hhs.gov/ohrp/policy/cdebiol.html>). This document:

- Provides guidance as to when research involving coded private information or specimens is or is not research involving human participants, as defined under DHHS regulations for the protection of human research participants (45 CFR part 46).
- Reaffirms OHRP policy that, under certain limited conditions, research involving **only** coded private information or specimens is not human participant research.
- Provides guidance on who should determine whether human participants are involved in research.

For purposes of this procedure document, *coded* means that: (1) identifying information (such as name or social security number) that would enable the investigator to readily ascertain the identity of the individual to whom the private information or specimens pertain has been replaced with a number, letter, symbol, or combination thereof (i.e., the code); and (2) a key to decipher the code exists, enabling linkage of the identifying information to the private information or specimens.

Under the definition of human participant in Section 2 of this policy, *obtaining* identifiable private information or identifiable specimens for research purposes constitutes human participant research. *Obtaining* means receiving or accessing identifiable private information or identifiable specimens for research purposes. This includes an investigator’s use, study, or analysis for research purposes of identifiable private information or identifiable specimens already in the possession of the investigator.

In general, private information or specimens are considered to be individually identifiable when they can be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems. Private information or specimens are not considered to be individually identifiable when they cannot be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems.

Research involving **only** coded private information or specimens do **not** involve human participants if the following conditions are both met:

- (1) the private information or specimens were not collected specifically for the currently proposed research project through an interaction or intervention with living individuals,

**and**

- (2) the investigator(s) cannot readily ascertain the identity of the individual(s) to whom the coded private information or specimens pertain because, for example:
  - (a) the key to decipher the code is destroyed before the research begins,
  - (b) the investigators and the holder of the key enter into an agreement prohibiting the release of the key to the investigators under any circumstances, until the individuals are deceased (note that the DHHS regulations do not require the IRB to review and approve this agreement),
  - (c) there are IRB-approved written policies and operating procedures for a repository or data management center that prohibit the release of the key to the investigators under any circumstances, until the individuals are deceased, or
  - (d) there are other legal requirements prohibiting the release of the key to the investigators, until the individuals are deceased.

In some cases, an investigator who obtains coded private information or specimens about living individuals under one of the conditions cited in 2(a)-(d) above may (1) unexpectedly learn the identity of one or more living individuals, or (2) for previously unforeseen reasons now believe that it is important to identify the individual(s). If, as a result, the investigator knows, or may be able to readily ascertain, the identity of the individuals to whom the previously obtained private information or specimens pertain, then the research activity now would involve human participants. Unless this human participant research is determined to be exempt (See Section 7.2), IRB review of the research would be required. Informed consent of the participants also would be required unless the IRB approved a waiver of informed consent (See Section 9.3).

**(OHRP guidance document “Guidance on Research Involving Coded Private Information or Biological Specimens” (August 10, 2004, <http://www.hhs.gov/ohrp/humanparticipants/guidance/cdebiol.pdf>)**

### **16.10.1 Who Determines Whether Coded Private Information or Specimens Constitutes Human Participants Research?**

The investigator will submit an IRB application via the online system which asks specific information about the information they will be using. Additionally, the system inquires about parameters of data use inclusive of written agreements between investigator and bearer of identifiable data/key. This will be submitted to the IRB reviewer who will determine if the research involving coded information or specimens requires IRB review. Formal documentation will be provided to the PI and a copy of the submitted materials and determination letter/email will be kept on file.

### **16.11 GDPR: General Data Protection Regulation: European Union Data Protection Laws**

EU General Data Protection Regulation

All studies being conducted in the EU will fall under the EU General Data Protection Regulation. For more information regarding this regulation, see: <https://eugdpr.org/>.

The UNCG IRB has developed a GDPR compliant consent form. Please contact the UNCG Office of Research Integrity at [ori@uncg.edu](mailto:ori@uncg.edu) regarding this template.

### **16.12 Research carried out at an International Location**

Research that is carried out in International Locations must include additional information that is relevant to the conduct of research in other countries. The Cayuse application asks researchers if they are completing International Research and contains a set of questions that should be completed. It should be noted that if research is being carried out with a university partner in an international location, the research may require approval by both UNCG and the university partner in the international location. It is the responsibility of the PI and/or faculty mentor to ensure that proper approval of all research in international locations is obtained through established channels in each country. If the research does not involve a university partner in the country where the research is to be conducted, the research must be approved by the UNCG IRB and any other official channels required by the international locations.

### **16.13 Research Activities in Private Residence**

Any research activities that are conducted in a private residence must have at least two research staff present at all times when inside of the private residence. Research staff must have been listed on the PI's approved IRB protocol.