

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures
Pre-2018 Requirements
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**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Ethical Principles of the IRB
Section Number: 1.1
Effective Date: January 1, 2005
Last Revision: May 21, 2012
Replaced SOP Revised On:

In the United States, regulations protecting human subjects first became effective on May 30, 1974. Promulgated by the Department of Health, Education and Welfare (DHEW), those regulations raised to regulatory status policies for the protection of human subjects. The regulations established the Institutional Review Board (IRB) as one mechanism through which human subjects would be protected.

GBMC encourages the conduct of research in and among its facilities, and in collaboration with other educational institutions, agencies, and organizations. While respecting the right of the researcher to full academic freedom in research, GBMC is firmly committed to adhering to the basic ethical principles underlying the acceptable conduct of research involving human subjects, as set forth in *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*.

The Belmont report sets forth the basic ethical principles underlying the acceptable conduct of research involving human subjects. These principles are now accepted as the three quintessential requirements for the ethical conduct of research involving human subjects:

Respect for persons involves recognition of the personal dignity and autonomy of individuals, and special protection of persons with diminished autonomy.

Beneficence entails an obligation to protect persons from harm by maximizing anticipated benefits and minimizing possible risks.

Justice requires that the benefits and burdens of research be distributed fairly.

The report also describes how these principles apply to the conduct of research. Specifically, the principle of *respect for persons* underlies the need to obtain informed consent; the principle of *beneficence* underlies the need to engage in a risk/benefit analysis and to minimize risks; and the principle of *justice* requires that subjects be fairly selected.

GBMC has set standards for the conduct of research which mandate well-conceived and well-conducted research. Research must also be in keeping with the GBMC Mission. The IRB is charged with assisting in maintaining both these standards, and the GBMC mission.

The mission of GBMC is to provide medical care and service of the highest quality to each patient leading to health, healing and hope with a vision phrase of “To every patient, every time, we will provide the care that we would want for our own loved ones” and dedicated to the Greater Values of Respect, Excellence, Accountability, Teamwork, Ethical Behavior and Results.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Authority of the IRB
Section Number: 1.2
Effective Date: January 1, 2005
Last Revision: July 1, 2024
Replaced SOP Revised On: November 20, 2017

The IRB is an independent administrative body established to protect the rights and welfare of human research subjects recruited to participate in research activities conducted under the auspices of GBMC. Ultimate oversight of the IRB belongs to GBMC’s Executive Vice President and Chief Medical Officer who serves as the GBMC IRB Signatory and Institutional Official.

The IRB has the authority to “approve, require modifications in (to secure approval), or disapprove all research activities” as stated in 45 CFR 46.109(a) and 21 CFR 56.109(a). Research that has been reviewed and approved by the IRB may be subject to further review and approval or disapproval by GBMC officials. However, those officials may not approve research if it has been disapproved by the IRB (45 CFR 46.112 and 21 CFR 56.112).

The IRB has the authority to “suspend or terminate approval of research that is not being conducted in accordance with the IRB’s requirements or that has been associated with unexpected serious harm to subjects” as stated in 45 CFR 46.113 and 21 CFR 56.113.

The GBMC IRB is a local IRB serving the employees of GBMC and its subsidiaries; however, as a courtesy, GBMC will extend the services of the IRB to the following individuals who wish to have their research reviewed by an expert body:

1. Non-employed GBMC medical staff affiliates.
2. Non-GBMC affiliated individuals in cooperation with a GBMC employed liaison.

Research submitted to the GBMC IRB by a non-GBMC employed/affiliated individual shall be reviewed on a case-by-case basis.

Research submitted to the GBMC IRB by a non-GBMC employed/affiliated individual and approved by the IRB can be suspended or terminated at any time at the discretion of the IRB.

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Federalwide Assurance and IRB Registration Process
Section Number: 1.3
Effective Date: August 18, 2014
Last Revision:
Replaced SOP Revised On:

The review of research at GBMC is conducted in accordance with its Federalwide Assurance (FWA). All organizations engaged in human subjects research that are federally-funded or subject to federal regulatory oversight must have a FWA. An FWA is an agreement between the organization and the Office for Human Research Protections (OHRP) in which the organization commits itself to the Health and Human Services (HHS) requirements set forth in 45 CFR 46 as well as Food and Drug Administration (FDA) requirements set forth in 21 CFR 50 and 56 to protect human subjects participating in research. Additionally, the organization commits to the ethical principles outlined in the Belmont Report and to the “Terms of Assurance” of the FWA.

Each organization’s FWA is identified by a number that is assigned by the OHRP. GBMC’s FWA number is FWA00003849. GBMC must renew its FWA at least every five years in order to maintain an active FWA. GBMC must update its FWA within 90 days after changes occur regarding the legal name of the institution, the designated Human Protections Administrator, or the designated Signatory Official.

Each FWA must list at least one designated IRB. All IRBs designated in a FWA must be registered with the OHRP. GBMC’s IRB is registered with the OHRP, and its registration number is IRB00002961. GBMC must renew its IRB registration at least every three years. GBMC must update its IRB registration within 90 days after changes occur regarding the contact person who provided the IRB registration information or the IRB chairperson.

The FWA and IRB registration numbers and expiration dates are posted for public view on the GBMC IRB webpage.

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Applicability of the Revised 2018 Common Rule (2018 Requirements)
Section Number: 1.4
Effective Date: January 21, 2019
Last Revision:
Replaced SOP Revised On:

On January 19, 2017 the U.S. Department of Health and Human Services along with fifteen other federal departments and agencies published in the Federal Register a final rule revising the Federal Policy for the Protection of Human Subjects, otherwise known as the Common Rule.

The revised 2018 Common Rule (hereinafter referred to as the “2018 Requirements”) is effective as of January 21, 2019, except for cooperative research requirements which do not go into effect until January 20, 2020.

This policy outlines GBMC’s procedural response to the 2018 Requirements in relation to its applicability to human subjects research activities conducted at GBMC HealthCare, Inc. or its subsidiaries.

45 CFR 46.101(a) states that the 2018 Requirements apply “to all research involving human subjects conducted, supported, or otherwise subject to regulations by any Federal department or agency that takes appropriate action to make the policy applicable to such research”. However, institutions are given the flexibility to voluntarily extend the 2018 Requirements to all research activities, regardless of funding.

To assure that all research subjects are equally protected and to maintain continuity for the review and oversight of research, GBMC applies the 2018 Requirements to all research, regardless of funding; therefore, all proposed research, regardless of funding, to be conducted at GBMC HealthCare, Inc. or its subsidiaries, shall be submitted to and undergo GBMC IRB review prior to initiation.

All research projects initially approved or determined to be exempt by the GBMC IRB on or after January 21, 2019 shall be subject to and comply with the 2018 Requirements in accordance with 45 CFR 46.101(l)(4).

All research projects initially approved or determined to be exempt by the GBMC IRB prior to January 21, 2019 shall continue to be subject to and comply with the pre-2018 Requirements in accordance with 45 CFR 46.101(l)(3).

45 CFR 46.101(l)(3) permits an institution to decide, on a study-by-study basis, whether or not to apply the 2018 Requirements to a research project initially approved or determined to be exempt prior to January 21, 2019. GBMC recognizes the IRB Chairperson as the only individual having the authority to make this decision. Should this determination be made, it shall remain permanent and be formally documented in correspondence to the project's principal investigator, other key project personnel as appropriate and IRB meeting minutes.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Membership Requirements
Section Number: 2.1
Effective Date: January 1, 2005
Last Revision: June 18, 2012
Replaced SOP Revised On:

The IRB shall consist of at least five members. The IRB members shall have varying backgrounds to promote complete and adequate review of the research activities conducted at GBMC. The IRB shall be sufficiently qualified through the experience, expertise, and diversity of its members, including considerations of race, gender, cultural backgrounds, and sensitivity to such issues as community attitudes. The members shall also be knowledgeable about institutional commitments and regulations, applicable law, and standards of professional conduct and practice. If the IRB were to regularly review research that involves a vulnerable category of subjects, such as, children, prisoners, pregnant women, or handicapped or mentally disabled persons, consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these subjects. Every nondiscriminatory effort will be made to ensure that the membership does not consist entirely of men or entirely of women. No IRB may consist entirely of members of one profession. The IRB shall have at least one member whose primary concentration is in scientific areas and at least one member whose primary concentration is in nonscientific areas. The IRB shall include 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. No IRB member shall participate in the review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. (45 CFR 46.107)

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Appointment of Members
Section Number: 2.2
Effective Date: January 1, 2005
Last Revision: April 17, 2017
Replaced SOP Revised On: September 15, 2014

Individuals expressing an interest in serving on the IRB shall be invited to attend at least one convened meeting to see firsthand how the meetings are conducted and meet the IRB members. Once an individual firmly decides to pursue membership, he/she shall be presented to the convened IRB and approved for membership by a majority vote.

The IRB shall have a Chairperson and up to two Vice Chairpersons.

The Chairperson shall be appointed by the GBMC Executive Vice President/Chief Medical Officer. The duties of the Chairperson shall include but not be limited to the following:

- Presiding over the IRB meetings
- Reviewing all IRB submissions
- Conducting expedited, facilitated and administrative reviews
- Making exempt and not research determinations
- Being available for consult as needed

Vice Chairpersons shall be selected by the Chairperson and approved as Vice Chairperson by a majority vote of the convened IRB. In the event that two Vice Chairpersons are appointed, one shall be the designated Primary Vice Chairperson and the other shall be the designated Secondary Vice Chairperson.

The Primary Vice Chairperson shall assume the duties of the Chairperson in the absence of the Chairperson and in the event the Chairperson is unable to perform his duties due to a conflict of interest.

The Secondary Vice Chairperson shall assume the duties of the Chairperson in the absence of both the Chairperson and the Primary Vice Chairperson.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Alternate Members
Section Number: 2.3
Effective Date: January 1, 2005
Last Revision: September 15, 2014
Replaced SOP Revised On:

The IRB may approve alternate members for any of its primary members, limited in number to no more than one alternate per member. The role of the alternate member is to serve as a voting member of the IRB when the regular member is unable to attend a convened meeting. The alternate members shall have similar qualifications to the members that they are representing and comply with the same training requirements as described in Section 2.6. Alternate members shall be given the same IRBNet access as primary members. Alternate members shall have the same voting rights as primary members and shall be counted when determining the existence of a quorum at a meeting. The alternate member shall not be counted as a voting member unless the primary member is absent. The IRB minutes shall document when an alternate member replaces a primary member.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Consultants
Section Number: 2.4
Effective Date: January 1, 2005
Last Revision: September 15, 2014
Replaced SOP Revised On:

The IRB may, at its discretion, invite individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote. [45 CFR 46.107(f)]

Whenever possible the IRB shall identify consultants from within GBMC Healthcare, Inc., or GBMC-related health systems. Consultants shall be appointed by the IRB Chairperson (or designee). Consultants may be asked to provide their expertise regarding a specific issue or provide general comments regarding a protocol. Consultants shall not be given access to IRBNet. If the consultant requires documents that are contained in the project's electronic file, they shall be supplied to the consultant in hard copy. As needed, a consultant may be asked to provide his/her comments in writing. Written consultant comments shall be retained in the project's electronic file in the form of a posted board document. Consultants may be asked to attend a convened IRB meeting but shall be excused prior to any voting. Consultants are not considered to be members of the IRB and are not included in determining or establishing a quorum at a convened meeting. However, consultants shall be subject to the conflicting interest rules applicable to IRB members and be required to disclose and document any conflicts of interest by signing a conflict of interest statement as described in SOP Section 2.7—Conflicts of Interest.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Length of Service, Attendance and Removal
Section Number: 2.5
Effective Date: January 1, 2005
Last Revision: September 15, 2014
Replaced SOP Revised On:

Members shall serve on the IRB for an indefinite period of time but no less than two years. Members are expected to attend two thirds of the IRB meetings per year.

Members may resign by providing written notice to the IRB Chairperson. If the resigned member has an alternate, the alternate shall be given the option of becoming a primary member. The alternate may attend meetings and have full voting rights until a new primary member is found.

Members may be removed for good cause, including failure to meet the above stated attendance requirements. Members are removed by a majority vote of the convened IRB and shall be notified in writing of the cause for removal and termination date.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Member Training Requirements
Section Number: 2.6
Effective Date: January 1, 2005
Last Revision: March 18, 2019
Replaced SOP Revised On: November 19, 2012

All new appointees to the IRB shall be obligated to receive basic training in human subjects research. This training shall consist of the “Biomedical Research – Basic/Refresher” course made available on the Collaborative Institutional Training Initiative’s (CITI) on-line training website. This course is made up of nine modules plus two elective modules. New IRB members shall select the following two elective modules: 1) Records-Based Research and 2) Research Involving Children. New members must complete the training within 90 days of appointment. It is the responsibility of the new IRB member to submit a copy of their completion certificate to the IRB Office. Members who have not completed the training within the 90 day period can no longer vote until the training requirements are fulfilled and a copy of their completion certificate has been received by the IRB Office.

If the new appointee has completed comparable training within the past three years, this may be accepted in lieu of the above-mentioned GBMC specific CITI course. A letter or certificate of completion as proof must be turned in to the IRB Office within 90 days of appointment.

New IRB members shall be supplied with the following documents in electronic format (PDF) within five working days of their appointment to the IRB:

- GBMC IRB Standard Operating Policies and Procedures (SOPs) Pre-2018 Requirements
- GBMC IRB Standard Operating Policies and Procedures (SOPs) 2018 Requirements
- GBMC IRB Bylaws with SOP Cross References
- *Belmont Report*
- 45 CFR 46 Pre-2018 Requirements (HHS)
- 45 CFR 46 2018 Requirements (HHS)
- 21 CFR 50 (FDA)
- 21 CFR 56 (FDA)

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Conflicts of Interest
Section Number: 2.7
Effective Date: January 1, 2005
Last Revision: April 17, 2017
Replaced SOP Revised On: October 20, 2014

Federal regulations require IRB members to abstain from participating in the review of research projects in which the member has a conflicting interest, except to provide information requested by the IRB [45 CFR 46.107(e)]. A conflicting interest is defined as any interest in a research project that would make it difficult for the member to objectively review the project in relation to the protection of human research subjects according to federal regulations. Conflicting interests can be financial or non-financial.

Each year, the IRB office staff shall prepare and distribute to each member a personalized conflict of interest statement. New IRB members shall be presented with a personalized conflict of interest statement within five working days of their appointment to the IRB. Each member shall complete and return their conflict of interest statement to the IRB office within 30 days of receipt. Completed conflict of interest statements shall be maintained in each member's file located in the IRB office. Members who fail to complete their conflict of interest statement by the designated deadline shall be brought to the attention of the IRB chairperson who shall determine what disciplinary action shall be taken (e.g. suspension or termination of membership).

When an IRB member abstains from participating in a project review being conducted by the convened IRB, quorum as defined in SOP Section 3.3 must be maintained. If quorum fails, no further action or voting may take place. If the abstaining member has an alternate and the alternate is present, the alternate may participate in the review and vote in their stead. Any abstentions, alternate voting and quorum failures shall be documented in the meeting minutes.

The IRB Coordinator shall identify members with conflicting interests prior to assigning expedited reviews. The IRB Coordinator shall assign expedited reviews to a designated reviewer who does not have a conflict with the project involved.

In addition to expedited reviews, the IRB Coordinator shall not assign to any designated reviewer with a conflicting interest any reviews for exempt determination, not human subjects

research determinations, requests for a waiver of IRB jurisdiction or any type of administrative review.

The above-mentioned requirements apply to all initial reviews, continuing reviews, enrollment status changes, and reviews of amendments/revisions.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Compensation of Members
Section Number: 2.8
Effective Date: January 1, 2005
Last Revision: September 15, 2014
Replaced SOP Revised On:

While it is acknowledged that service on the IRB requires a significant investment of time, IRB members do not receive financial compensation. IRB members who are not affiliated with GBMC shall receive compensation for parking in the form of one GBMC complimentary parking ticket for each meeting they attend to be distributed to them at the time of the meeting.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Membership Roster
Section Number: 2.9
Effective Date: January 1, 2005
Last Revision: September 15, 2014
Replaced SOP Revised On:

The IRB shall maintain a roster of IRB members that includes the following information with respect to each member:

- Name
- Gender
- Earned degrees
- Representative capacity (scientific or non-scientific)
- Title and/or area of expertise
- Affiliation with GBMC (affiliated or non-affiliated)
- Membership status (primary or alternate)
- If alternate, who they substitute for

The roster is available from the IRB office upon request.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Meeting Schedule
Section Number: 3.1
Effective Date: January 1, 2005
Last Revision: October 20, 2014
Replaced SOP Revised On:

The IRB shall have up to twelve scheduled meetings per year, or as needed to adequately review initial and ongoing project submissions. The IRB meets on the third Monday of the month. A meeting schedule shall be posted for view on the GBMC IRB webpage.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Agenda and Meeting Materials
Section Number: 3.2
Effective Date: January 1, 2005
Last Revision: November 19, 2018
Replaced SOP Revised On: October 20, 2014

Convened meetings of the IRB shall have an agenda which clearly shows the topics and items that the members will review at the meeting. The agenda is constructed by the IRB office staff and posted on IRBNet prior to each scheduled meeting. The agenda shall also be printed out and distributed to the members in hard copy at the time of the meeting. The agenda is routinely divided into fourteen sections:

- Welcome and General Announcements
- Review of Previous Minutes
- New Project Presentations
- Continuing Reviews for Renewal
- Project Closures
- Enrollment Status Changes
- Amendments and Revisions
- Adverse Events
- Deviations
- Reports—Updates—Follow-up
- NCI-CIRB and Other Ceded Project Reviews
- Reviews Performed by the Chairman
- Review Board Business
- Adjournment and Next Meeting Date

Meeting materials are received via IRBNet in the form of electronic submission “packages”. Submission packages are electronically “shared” with the members over the course of several weeks prior to the scheduled meeting date. It is the responsibility of each member to access IRBNet and review the shared submission packages. IRB members shall review the submission materials in advance of the meeting in enough depth to be familiar with the materials and prepared to discuss them at the meeting.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Quorum Requirements
Section Number: 3.3
Effective Date: January 1, 2005
Last Revision: November 19, 2018
Replaced SOP Revised On: October 20, 2014

The IRB shall, except when an expedited review procedure is used, review proposed research at convened meetings at which a majority of the IRB members are present, including at least one member whose primary concerns are in nonscientific areas [45 CFR 46.108(b) and 21 CFR 56.108(c)]. When the IRB reviews FDA regulated research, there shall be at least one member present who is a licensed physician. The IRB Chairperson and Vice Chairperson shall be voting members and count toward quorum. Quorum is defined as being fifty percent of the primary voting membership (including alternate members who may replace primary voting members) plus one.

The IRB meeting shall not convene until quorum is established. It is the responsibility of the IRB Coordinator to inform the IRB Chairperson when quorum has been established. It shall also be the responsibility of the IRB Coordinator to inform the membership if quorum is lost during a meeting (e.g. a member who abstains from voting due to a conflict of interest). If quorum fails, no further action or voting may take place unless quorum is re-established.

Every effort shall be made to convene meetings at which all members are physically present; however, members who are not able to be physically present during a convened meeting may participate by telephone conference call. Members participating via teleconferencing shall be counted as part of the quorum, as long as they have had opportunity to review all of the meeting materials.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Voting, Decisions and Actions
Section Number: 3.4
Effective Date: January 1, 2005
Last Revision: January 21, 2019
Replaced SOP Revised On: April 17, 2017

The IRB shall review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities [45 CFR 46.109(a) and 21 CFR 56.109(a)].

Voting shall take place during a convened meeting where quorum as defined in SOP Section 3.3—Quorum Requirements has been established. The only individuals who may vote shall be primary IRB members and alternates in the absence of their designated primary member. The IRB Chairperson and Vice Chairperson shall be voting members. Members participating via teleconferencing may vote, as long as they have had opportunity to review all of the meeting materials.

The following submission types, when reviewed by the convened IRB, must undergo a formal voting and/or approval process:

1. New Projects,
2. Continuing Review/Progress Reports,
3. Enrollment Status Changes,
4. Amendment/Modifications, and
5. Response/Follow-ups when in response to an approval with conditions

In order for research to be approved by the convened IRB, “it shall receive the approval of a majority of those members present at the meeting” [45 CFR 46.108(b) and 21 CFR 56.108(c)]. Majority is defined as being fifty percent of the members present plus one.

All research proposals are submitted and reviewed via IRBNet in the form of electronic submission “packages”. In accordance with 45 CFR 46.109(a) and 21 CFR 56.109(a) cited above and the choices available in IRBNet, the IRB shall take one of the following fourteen actions in response to each submission “package” received:

1. Acknowledged -- signifies that the IRB has acknowledged the submission and corresponding documents as received. No further action is required.

[This determination applies only to submissions that do not undergo a formal voting and/or approval process.]

2. Approved -- signifies that the IRB has approved the submission and corresponding documents as received. No further action is required.

3. Approved with conditions -- signifies that the IRB has approved the submission and corresponding documents but specific conditions must be satisfactorily met to secure full approval.

[This determination applies only to submissions that undergo a formal voting and/or approval process.]

When a submission is approved with conditions, the principal investigator shall be notified as to the pending approval and the conditions that must be met to secure full approval.

The IRB shall designate a member who will be responsible for reviewing responsive material and determining whether or not the conditions of the approval have been satisfactorily met. This designation is not necessary if it is determined that the matter will go back to a meeting of the convened IRB.

Upon the determination that the approval conditions have been satisfactorily met, the designated reviewer of the responsive material shall notify the IRB Coordinator of the effective date of the decision, indicating that the research activities may be initiated. The principal investigator shall be notified regarding the determination, and the action taken shall be reported back to the convened IRB at the next scheduled meeting.

Research activities may not proceed as set forth in the submission until the specified conditions have been satisfactorily met and full approval from the IRB has been granted, unless dictated otherwise by the IRB.

If no responsive action is taken by the principal investigator within 90 days of being notified of the approved with conditions decision, the submission shall be administratively withdrawn by the IRB office staff, and it must be resubmitted in its entirety to be reconsidered.

4. Closed -- signifies that a project has been permanently closed and all research activities have ceased.
5. Exempt -- signifies that the IRB Chairperson or Vice Chairperson has determined that the submission and/or proposed research activity qualifies for an exemption from IRB review under 45 CFR 46.101(b).
6. Information Required -- signifies that the IRB has accepted the submission and corresponding documents but additional information is being requested.

The principal investigator shall be notified as to the additional information being requested.

If no responsive action is taken by the principal investigator within 90 days of being notified, the submission shall be administratively withdrawn by the IRB office staff, and it must be resubmitted in its entirety.

7. Modifications Required -- signifies that the IRB has accepted the submission and corresponding documents but specific modifications are being requested.

The principal investigator shall be notified as to the modifications being requested.

If no responsive action is taken by the principal investigator within 90 days of being notified, the submission shall be administratively withdrawn by the IRB office staff, and it must be resubmitted in its entirety.

8. Not Approved -- signifies that the IRB has found significant and sufficient fault with a submission to warrant its disapproval.

In the event that this occurs, the principal investigator shall be notified as to the reason for the disapproval and the corrective action, if any, that could be taken to secure approval. No further action will be taken by the IRB. Any decision to appeal in accordance with SOP Section 4.7—Appeal of Review Actions and Determinations or resubmit rests with the principal investigator.

[This determination applies only to submissions that undergo a formal voting and/or approval process by the convened IRB.]

9. Not Research -- signifies that the IRB Chairperson or Vice Chairperson has determined that the submission and/or proposed research activity does not meet the definition of human subjects research as stated in 45 CFR 46.102.
10. Referred to Full Board -- signifies that the IRB Chairperson or Vice Chairperson has determined through an expedited review procedure that the submission and/or proposed research activity is more appropriately suited for review by the convened IRB.
11. Suspended -- signifies that IRB approval has been suspended and a temporary cessation of some or all research activities has taken place as described in SOP Section 9.
12. Tabled Without Action -- signifies that the IRB was unable to initiate voting. This most commonly takes place when quorum is lost but may also take place under other circumstances.

In the event that quorum is lost, the principal investigator shall be notified that the submission was tabled without action. If the submission and/or proposed research activity meets the criteria for an expedited review, it shall be presented to the IRB Chairperson or Vice Chairperson for review. If the submission does not meet the criteria for an expedited review, it shall be placed on the agenda for the next scheduled meeting of the convened IRB.

In the event that a submission is tabled without action with a directive from the IRB, the principal investigator shall be notified of the directive. If no responsive action is taken by the principal investigator within 90 days of being notified, the submission shall be administratively withdrawn by the IRB office staff, and it must be resubmitted in its entirety.

13. Terminated -- signifies that IRB approval has been terminated and a permanent cessation of all research activities has taken place.
14. Withdrawn -- signifies that the IRB office staff has withdrawn the submission “package”. No further action will be taken on the submission.

All voting, decisions and actions shall be documented in the IRB meeting minutes as described in SOP Section 3.5—Minutes of the Meeting.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Minutes of the Meeting
Section Number: 3.5
Effective Date: January 1, 2005
Last Revision: January 21, 2019
Replaced SOP Revised On: April 17, 2017

In accordance with Federal regulations; the IRB meeting minutes “shall be in sufficient detail to show attendance at the meetings; actions taken by the IRB; the vote on the actions including the number of members voting for, against, and abstaining; the basis for requiring changes in or disapproving research; and a written summary of the discussion of controverted issues and their resolution” [45 CFR 46.115(a)(2) and 21 CFR 56.115(a)(2)].

The IRB Coordinator and IRB Assistant shall attend the IRB meetings and take sufficiently detailed notes to document IRB discussions and determinations. A draft version of the minutes shall be prepared by the IRB Assistant. The IRB Coordinator shall then review, edit and finalize the meeting minutes.

Prior to the next scheduled IRB meeting the finalized minutes shall be posted electronically on IRBNet for review by the IRB members. The minutes shall then be presented for consideration and acceptance at the next scheduled IRB meeting. If any corrections are warranted, the minutes shall be edited by the IRB Coordinator and brought back to the convened IRB at the next scheduled meeting. Once the minutes are formally accepted by the convened IRB, they shall not be altered by anyone.

The IRB shall, in accordance with 45 CFR 46/103(b)(4)(i), report back to “the institution” (GBMC) its “findings and actions” by submitting a copy of all IRB meeting minutes on a monthly basis to the Chief Medical Officer and Signatory Official on GBMC’s Federalwide Assurance.

The IRB meeting minutes shall be kept both in hard copy and electronically in IRBNet indefinitely.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Confidentiality
Section Number: 3.6
Effective Date: November 17, 2014
Last Revision:
Replaced SOP Revised On:

Proceedings of IRB meetings and all shared materials relating to the meetings are considered confidential. IRB members shall not discuss, disclose, or reproduce any confidential IRB information, except as necessary to perform legitimate duties as an IRB member.

Each IRB member shall agree to and sign an Institutional Review Board Member Confidentiality Agreement. Signed confidentiality agreements shall be maintained in each member's file located in the IRB office.

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Criteria for Project Approval
Section Number: 4.1
Effective Date: January 1, 2005
Last Revision: December 30, 2014
Replaced SOP Revised On:

Federal regulations have established criteria for IRB approval of human subjects research. The GBMC IRB reviews and approves research in accordance with the criteria defined by Federal regulations.

Federal regulations define research as meaning “a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.” [45 CFR 46.102(d)]

A human subject is defined as “a living individual about whom an investigator (whether professional or student) conducting research obtains 1) Data through intervention or interaction with the individual, or 2) Identifiable private information. Intervention includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject’s environment that are performed for research purposes. Interaction includes communication or interpersonal contact between investigator and subject. 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 medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.” [45 CFR 46.102(f)]

In order to approve research involving human subjects, the IRB shall determine that all of the following regulatory criteria taken from [45 CFR 46.111(a)(1-7)] are satisfied:

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

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

3. Selection of subjects is equitable. In making this assessment, the IRB should take into account the purposes of the research and the setting in which the research will be conducted and should be particularly cognizant of the special problems of research involving vulnerable populations, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons.
4. Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by [46.116](#).
5. Informed consent will be appropriately documented, in accordance with, and to the extent required by [46.117](#).
6. When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects.
7. When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.”

All IRB members shall review enough information so they will be able to determine whether the research meets the above regulatory criteria for approval.

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Submission Deadlines and Requirements
Section Number: 4.2
Effective Date: January 1, 2005
Last Revision: November 19, 2018
Replaced SOP Revised On: December 30, 2014

GBMC uses IRBNet for the electronic administration and management of its IRB. All submissions for review by the IRB must be sent electronically via IRBNet. Paper submissions are not accepted.

Submissions are due the first Monday of every month unless otherwise indicated. A schedule of IRB meeting dates with corresponding submission deadlines shall be posted on the GBMC IRB webpage. Posted submission deadlines apply to submissions requiring full board review only. All other submission types (e.g. expedited reviews, exempt determinations) are handled on an ongoing basis and not subject to submission deadlines.

All submission forms and templates shall be made available and maintained by the IRB Coordinator within IRBNet under “Forms and Templates” located on the “Submission Manager” page. Submissions are sent to the IRB Office via IRBNet in the form of electronic submission “packages.”

The IRB office staff shall perform preliminary reviews of all submission packages for determination of completeness and accuracy. A submission package shall not be assigned for final review by the IRB until it is determined to be complete by the IRB office staff. In the event that a package is incomplete and/or requires revisions, the individual who submitted the package shall be notified via email and/or an internal IRBNet communication by the IRB office staff, and the package shall be “unlocked” so the required revisions can be completed. If no responsive action is taken within 90 days of being notified, the submission package shall be administratively withdrawn by the IRB office staff, and it must be resubmitted in its entirety.

All submission packages must be electronically signed by the principal investigator of the project. The IRB office staff shall not process any package that has not been signed by the principal investigator. Signatures made on behalf of the principal investigator are not acceptable.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Review Fees
Section Number: 4.3
Effective Date: January 1, 2005
Last Revision: July 1, 2024
Replaced SOP Revised On: December 30, 2014

A review fee shall be charged for continuing and independent annual reviews performed by the GBMC IRB, and reviews for projects ceded to an external IRB.

The fees collected vary according to the type of review (e.g., full board, expedited, ceded) as follows:

Projects Approved Prior to July 1, 2024

FULL BOARD REVIEWS	CONTINUING REVIEWS AND INDEPENDENT ANNUAL REVIEWS
Sponsored	\$500
Non-funded	\$25
EXPEDITED REVIEWS	
Sponsored	\$100
Non-funded	\$25
CEDED REVIEWS	
External IRB Oversight	\$100

No review fees shall be charged for the following:

- Permanent project closures
- Enrollment status change notifications
- Amendments/revisions
- Adverse event and safety reports
- Deviation reports
- General reporting/information only submissions

Review fees shall apply to the following individuals who use the GBMC IRB to evaluate their research (See SOP Section 1.2—Authority of the IRB):

3. Non-GBMC employed medical staff affiliates
4. Non-GBMC affiliated individuals in cooperation with a GBMC employed liaison

The IRB shall waive the review fees for all employees of GBMC and its subsidiaries conducting research as part of their employment. A department, as a whole, shall not be charged review fees.

The IRB shall waive the review fees for residents, fellows and other graduate students affiliated with GBMC.

All fees collected must be in the form of a check (payable to GBMC IRB). No cash or charge payments will be accepted. Payment is due upon receipt of invoice. IRB review fees are not refundable.

The fee schedule shall be subject to change without advance notice by a majority vote of the convened IRB.

The fee schedule shall be posted on the GBMC IRB webpage.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Investigator Conflicts of Interest
Section Number: 4.4
Effective Date: January 1, 2005
Last Revision: January 21, 2019
Replaced SOP Revised On: January 19, 2015

Individuals directly involved in the conduct, design or reporting of research involving human subjects should not have more than a minimal personal or financial interest in the company that sponsors the research or owns the product(s) being used as a part of the research.

Relationships with research sponsors can create, or appear to create, conflicts of interest. While having a conflict of interest does not imply wrongdoing or inappropriate activity, conflicts do require review and management to ensure that the conflict does not improperly influence, or appear to improperly influence, the research. It is, therefore, critical that all conflicts be disclosed promptly and thoroughly. It is the responsibility of the IRB, under the guidance of the GBMC Corporate Compliance Officer, to determine if a disclosed conflict of interest is significant enough to affect the design, conduct or reporting of the research.

All principal investigators, co-investigators and sub-investigators shall complete a project-specific conflict of interest statement:

1. At time of initial application,
2. Annually at time of continuing review until the project is permanently closed, and
3. Within 30 days of discovering and/or acquiring a new conflict of interest.

Only GBMC IRB conflict of interest statement forms will be accepted.

If the research is funded, either directly or indirectly, by the public health service, the directives as set forth in the GBMC compliance policy “Policy on Financial Conflicts of Interest in Public Health Service Funded Research” shall be followed in compliance with 42 CFR 50, subpart F.

If the research is a non-funded retrospective chart review, the requirement for submitting a formal conflict of interest statement is waived.

All completed conflict of interest statements shall be submitted to the IRB for review via IRBNet. If the IRB determines that a significant conflict of interest has been disclosed, a formal management plan shall be developed and implemented in cooperation with the GBMC compliance and legal departments. The plan shall specify the actions that have been, and shall be, taken to manage the disclosed significant conflict of interest. The conditions or restrictions that may be applied include, but are not limited to:

1. Disclosure of the conflict of interest to research participants (e.g. declaration statement incorporated into the informed consent document);
2. Change in responsibilities (e.g. removal as principal investigator) or disqualification from participating in all or a portion of the research (e.g. no involvement with recruiting and/or consenting participants);
3. Modification of the research plan;
4. Appointment of an independent monitor capable of taking measures to protect the design, conduct, and reporting of the research against bias resulting from the conflict of interest;
5. Reduction or elimination of the conflict of interest (e.g. sale of an equity interest);
6. Severance of relationships that create the conflict of interest; or
7. Public disclosure of the conflict of interest (e.g. when presenting or publishing the research)

Whenever the IRB implements a management plan, the IRB shall monitor investigator compliance on an ongoing basis until the completion of the research project.

If the investigator believes that a determination made by the IRB is not appropriate or is based on erroneous information, the investigator may request an appeal by submitting a written request to the IRB Chairperson.

Failure to comply with the IRB's recommendations as set forth in the formal management plan may result in suspension of the involved research project and other applicable sanctions.

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Investigator Qualifications, Responsibilities and Training Requirements
Section Number: 4.5
Effective Date: March 2, 2016
Last Revision: January 21, 2019
Replaced SOP Revised On:

Principal investigators are obligated to design and conduct human subjects research in accordance with the ethical principles of the Belmont Report, federal regulations, state and local laws, and GBMC institutional policies, including those policies specific to the IRB. Principal investigators should not undertake responsibility for human subjects research unless they understand these requirements and are willing to uphold them.

An IRB approved principal investigator can be any of the following:

- employees of GBMC and its affiliates
- physicians who are a member of GBMC’s medical staff
- residents or fellows affiliated with GBMC
- non-affiliated individuals who have a designated GBMC liaison

Principal investigators shall have the appropriate education, training, and experience to assume full responsibility for the conduct of their human subjects research. Although the principal investigator may delegate study-related tasks to appropriately qualified and trained study personnel, the principal investigator shall maintain oversight of and retain ultimate responsibility for the conduct of those who perform delegated functions.

Principal investigators are responsible for but are not limited to:

- Designing and conducting research in a manner that minimizes risk and maximizes benefit, using sound research design and generally accepted scientific and/or scholarly standards.
- Ensuring that adequate resources and facilities are available to carry out the proposed research project.
- Submitting and obtaining IRB approval prior to the initiation of any research-related activities.
- Ensuring that all members of the research staff, and all others directly involved in the conduct of the research project, are qualified by education, training, and experience to perform their research responsibilities.
- Recruiting subjects in a fair and equitable manner, weighing the potential benefits of the research to the participants against their vulnerability and the risks to them.

- Not enrolling subjects prior to IRB approval of the research project or after expiration of IRB approval.
- Ensuring that legally effective and approved informed consent has been obtained, using an adequate and appropriate consent process, and ensuring the consent process is documented appropriately unless the IRB has granted a waiver of informed consent or documentation of informed consent.
- Ensuring that the informed consent process is led only by individuals who have appropriate training and knowledge of the research, including any investigational product involved, in order to discuss the risks and benefits of the research with prospective subjects.
- Conducting the research project in strict accordance with the current IRB-approved research protocol except where a change may be necessary to eliminate an apparent immediate hazard to a given human research subject.
- Reporting promptly to the IRB proposed changes in the research.
- Implementing no changes in the approved protocol, informed consent or other IRB approved research related documents without prior IRB approval, except in an emergency when it is necessary to safeguard the well-being or human subjects.
- Obtaining continuing review and approval of ongoing research at the interval determined by the IRB (at least annually) to avoid expiration of IRB approval and cessation of all research activities.
- Promptly reporting to the IRB any serious & unexpected adverse events, unanticipated problems involving risks to subjects and/or others, or any changes made to eliminate apparent immediate hazards to subjects.
- Reporting promptly to the IRB any deviations from the currently approved research protocol.
- Complying with all IRB policies, decisions, conditions, and requirements.

As mentioned above, principal investigators are responsible for ensuring that all members of the research staff, and all others directly involved in the conduct of the research, are qualified by education, training, and experience to perform their research responsibilities. This includes human subjects research training.

Federal regulations for the protection of human subjects do not require investigators and research staff to obtain training in the protection of human subjects in research. However, the OHRP strongly recommends that an institution holding an OHRP-approved Federalwide Assurance (FWA) and their designated IRB establish training oversight mechanisms appropriate to the nature and volume of their research.

In response to this federal recommendation, the IRB has made it policy that all principal investigators, co-investigators and designated research project coordinators receive and maintain certification in human subjects research and comply with the following by:

1. Including evidence of human subjects research training in all new project submission packages (exempt studies excluded).

2. Including evidence of human subjects research training in all continuing review submission packages.
3. Including evidence of human subjects research training in all amendment submission packages requesting a study team change and/or addition involving the principal investigator, co-investigator or project coordinator.
4. The evidence of human subjects research training submitted shall be current with a completion date within the past three years.
5. The evidence of human subjects research training shall consist of the appropriate GBMC IRB approved training course(s) or documented equivalent training obtained elsewhere.

Submission packages that do not contain the above-mentioned, required evidence of human subjects research training shall not be processed until such evidence is included.

The IRB has approved three training courses in human subjects research. These courses are made available on the Collaborative Institutional Training Initiative’s (CITI) on-line training website. The web address and instructions for accessing the training courses is available on the GBMC IRB webpage.

The IRB approved training courses and modules are as follows:

Basic Course in Biomedical Research
History and Ethics of Human Subjects Research
Basic Institutional Review Board (IRB) Regulations and Review Process
Informed Consent
Research and HIPAA Privacy Protections
Populations in Research Requiring Additional Considerations and/or Protections
Genetic Research in Human Populations
FDA-Regulated Research
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research
Conflicts of Interest in Research Involving Human Subjects

Elective Modules
Records-Based Research
Social and Behavioral Research (SBR) for Biomedical Researchers
Research Involving Children
Research Involving Pregnant Women, Human Fetuses, and Neonates
Research with Older Adults
Stem Cell Research Oversight (Part 1)
Stem Cell Research Oversight (Part 2)
Avoiding Group Harms—U.S. Research Perspectives

All nine of the “Basic Course in Biomedical Research” modules plus two “Elective Modules” must be completed with a score of at least 80% on all quizzes to pass the entire course.

Investigators who limit their activities to records-based research may limit their human subjects research training to the following course and modules:

Basic Course in Records-Based Research
All modules must be completed with a score of at least 80% on all quizzes to pass the entire course.
History and Ethics of Human Subjects Research
Basic Institutional Review Board (IRB) Registration and Review Process
Records-Based Research
Research and HIPAA Privacy Protections

Investigators who limit their research activities to the use of surveys and/or questionnaires may limit their human subjects research training to the following course and modules:

Basic Course in Survey/Questionnaire Research
All modules must be completed with a score of at least 80% on all quizzes to pass the entire course.
History and Ethics of Human Subjects Research

Basic Institutional Review Board (IRB) Registration and Review Process
Social and Behavioral Research (SBR) for Biomedical Researchers
Informed Consent
Research and HIPAA Privacy Protections

The following modules are available for general interest and do not count toward the completion of the above-mentioned required courses:

Supplemental Modules
Consent and Subject Recruitment Challenges: Remuneration
Consent with Subjects Who Do Not Speak English
Cultural Competence in Research
Gender and Sexuality Diversity (GSD) in Human Research
Humanitarian Use Devices (HUDs)
I Have Agreed to be an IRB Community Member. Now What?
International Studies
The IRB Administrator’s Responsibilities
The IRB Member Module – What Every New IRB Member Needs to Know
Phase 1 Research: Understanding Phase 1 Research
Phase 1 Research: Protecting Phase 1 Subjects
Research and Decisionally Impaired Subjects
Research Involving Subjects at the End of Life
Research with Critically Ill Subjects
Research with Persons who are Socially and Economically Disadvantaged
Single Institutional Review Board (sIRB) Use & Administration: Authorization Agreements
Single Institutional Review Board (sIRB) Use & Administration: When Relying on a sIRB
Single Institutional Review Board (sIRB) Use & Administration: When Serving as a sIRB of Record
Students in Research
Vulnerable Subjects—Research Involving Workers/Employees

The IRB will accept evidence of comparable human subjects research training from an outside source provided the completion date is within the current three years; however, the IRB prefers that the above-mentioned GBMC IRB approved course(s) and modules be taken.

The IRB can, at its discretion, require an investigator or other research staff member to take any combination of the above-mentioned courses and/or individual modules regardless of the human subjects research training evidence provided.

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Notification and Documentation of Review Actions and Determinations
Section Number: 4.6
Effective Date: January 1, 2005
Last Revision: January 21, 2019
Replaced SOP Revised On: October 17, 2016

The IRB is obligated to report “its findings and actions to the investigator and the institution” as stated in 45 CFR 46.103(b)(4) and comparably stated in 21 CFR 56.109(e). Therefore, the GBMC IRB shall notify in writing the principal investigator and institutional officials of its actions and determinations relative to approval, disapproval, required modifications, suspensions, terminations and other information and matters for which such disclosure is required.

All research proposals are submitted and reviewed via IRBNet in the form of electronic submission “packages”. In accordance with 45 CFR 46.109(a) and 21 CFR 56.109(a) which states that the IRB “shall review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities” and in line with the choices available in IRBNet, the IRB shall take one of the following 14 actions in response to each submission “package” received:

1. Acknowledged
2. Approved
3. Approved with Conditions
4. Closed
5. Exempt
6. Information Required
7. Modifications Required
8. Not Approved
9. Not Research
10. Referred to Full Board
11. Suspended
12. Tabled without Action
13. Terminated
14. Withdrawn

For definitions and more complete details regarding these 14 actions, see SOP Section 3.4—Voting, Decisions and Actions.

All IRB actions and determinations are conveyed by IRB office staff to the principal investigator and other key project personnel as soon as possible after a convened meeting of the IRB or any

review performed by the IRB Chairperson or his designee. Each action is recorded within the appropriate electronic submission “package” and triggers a brief (action only) auto-generated email notification via IRBNet. Each action notification is then followed by a detailed letter addressed to the principal investigator. Follow-up letters are drafted by the IRB Assistant and include, at a minimum, the following information:

1. Project title
2. Submission type (e.g. new project, continuing review)
3. Action
4. Approval/Effective date
5. Review type (e.g. Full Board, Expedited)
6. New expiration date (for continuing reviews)

If a determination is made by the IRB requiring a response from the principal investigator, it shall be stated within the body of the letter.

All draft letters are reviewed, edited as appropriate, electronically signed and published in IRBNet as a board document by the IRB Coordinator. The act of publishing a board document triggers an auto-generated email to key project personnel alerting them that there is a document available for review. It is the responsibility of the appropriate study personnel to access IRBNet and review published board documents.

IRB actions and determinations are reported back to institutional (GBMC) officials on a monthly basis in the form of meeting minutes. The minutes are submitted to the Chief Medical Officer and Signatory Official on GBMC’s Federalwide Assurance. (See also SOP Section 3.5—Minutes of the Meeting)

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Appeal of Review Actions and Determinations
Section Number: 4.7
Effective Date: January 1, 2005
Last Revision: January 15, 2018
Replaced SOP Revised On: November 21, 2016

IRB review actions and determinations are conveyed by IRB office staff to the principal investigator and other key project personnel as soon as possible after a convened meeting of the IRB or any review performed by the IRB Chairperson or his designee (See SOP Section 4.6—Notification and Documentation of Review Actions and Determinations).

If the principal investigator disagrees with an action taken by the IRB, he/she may make an appeal to the IRB. The appeal must be submitted within 30 days from the date of the decision letter. The appeal must be made via IRBNet as a “subsequent package” and contain the rationale for the appeal and any supporting information and/or documents. If no appeal is made within the 30 day timeframe, the IRB’s original decision shall be considered final.

The IRB office staff shall place submitted appeal “packages” on the agenda for the next scheduled meeting of the convened IRB. The principal investigator may be required to attend the meeting to present his/her appeal to the IRB and be available to answer questions.

The IRB shall take one of the following three actions after considering the appeal:

1. Approve the appeal as presented
2. Approve the appeal as presented with conditions
3. Disapprove/not approve the appeal

The IRB’s action in response to the appeal shall be conveyed by the IRB office staff to the principal investigator as soon as possible after the convened meeting of the IRB. The action shall be recorded within the appeal submission “package” and trigger a brief (action only) auto-generated email notification via IRBNet. The action notification shall then be followed by a detailed letter addressed to the principal investigator. If the appeal receives an “approved with conditions” determination by the IRB requiring a response from the principal investigator, the conditions shall be stated within the body of the letter. If no responsive action is taken by the principal investigator within 30 days of being notified of the IRB’s “approved with conditions” determination, the appeal package shall be administratively withdrawn and the IRB’s original decision shall be considered final. Only one appeal shall be allowed on a given matter. The concluding determination made by the IRB regarding the appeal is final and not subject to further appeal.

IRB actions and determinations are reported back to institutional (GBMC) officials on a monthly basis in the form of meeting minutes. The minutes are submitted to the Chief Medical Officer and Signatory Official on GBMC's Federalwide Assurance. (See also SOP Section 3.5—Minutes of the Meeting)

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Initial Full Committee Reviews
Section Number: 5.1
Effective Date: January 1, 2005
Last Revision: November 19, 2018
Replaced SOP Revised On: December 18, 2017

Research projects involving greater than minimal risk to human subjects, that do not qualify for expedited review (See SOP Section 5.2—Expedited Reviews) or an exempt determination (See SOP Section 5.3—Exempt Determinations) must be reviewed by the convened IRB at a regularly scheduled meeting. Research activities cannot be initiated until the project has been reviewed and approved by the IRB.

In order to approve research, the IRB must receive project information in sufficient detail to determine that all regulatory criteria for the approval of research cited at 45 CFR 46.111(a)(1-7) and/or 21 CFR 56.111(a)(1-7) are satisfied (See also SOP Section 4.1—Criteria for Human Subjects Research Approval)

All project information must be sent electronically via IRBNet as described in SOP Section 4.2—Submission Deadlines and Requirements. The electronic submission “package” for an initial full committee review shall contain but not be limited to the following documents:

1. Application for New Research Project
2. Research Plan/Protocol
3. Informed Consent Form
4. HIPAA Research Authorization (unless combined with informed consent form)
5. Conflict of Interest Statements
6. Evidence of Human Subjects Research Training
7. Curriculum Vitae of Principal Investigator (unless already on file)

All research projects shall have one designated principal investigator who will have full responsibility for the conduct of the research and the research personnel.

The principal investigator or a qualified substitute must attend the initial convened IRB meeting in person to present a brief overview of the research. The IRB shall use this time to ask the principal investigator questions to clarify or explain any issues that are unclear or about which they may have concern. At the conclusion of the presentation and question and answer period, the principal investigator shall be excused while the IRB further discusses the proposed research, votes and makes a formal decision as described in SOP Section 3.4—Voting, Decisions and Actions. The IRB’s decision shall be conveyed by the IRB office staff to the principal

investigator and other key project personnel as soon as possible after the convened meeting as described in SOP Section 4.6—Notification and Documentation of Review Actions and Determinations.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Expedited Reviews
Section Number: 5.2
Effective Date: January 1, 2005
Last Revision: February 20, 2017
Replaced SOP Revised On:

In accordance with federal regulations 45 CFR 46.110 and 21 CFR 56.110, expedited review procedures may be used for certain kinds of research involving no more than minimal risk. "Minimal risk means the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves from those ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests" [45 CFR 46.102(j) and 21 CFR 56.102(i)].

In order to be eligible for expedited review, the proposed research activity must fall within one or more of the following expedited review categories:

1. Clinical studies of drugs and medical devices only when condition (a) or (b) is met.
 - a. research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.)
 - b. research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.
2. Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:
 - a. from healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or
 - b. from other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

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

Examples: (a) hair and nail clippings in a non-disfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra- and sub-gingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.

4. Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.)

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

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

interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (Note: Some research in this category may be exempt from the HHS regulations for the protection of human subjects [[45 CFR 46.101](#)](b)(2) and (b)(3)]. This listing refers only to research that is not exempt.)

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

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

(Source for above list: Federal Register, November 9, 1998, Volume 63, Number 216)

Expedited review procedures may also be used for “minor changes in previously approved research during the period (of one year or less) for which approval is authorized” [[45 CFR 46.110\(b\)\(2\)](#)]. The term “minor changes” is not defined by either the OHRP human subjects regulations (45 CFR 46) or FDA human subjects regulations (21 CFR 50); however, minor changes should have no substantive effect upon an approved protocol and should not increase risk to the subject. The following are examples of changes that may be viewed as minor by the GBMC IRB:

- A reduction in physical and/or psychological risk/discomfort to participants
- Minor editorial modifications that do not alter meaning or procedure
- Adding a questionnaire or instrument similar to the one already approved
- Removing questions from a questionnaire or instrument
- Narrowing the range of inclusion criteria
- Broadening the range of exclusion criteria
- Minor changes to the recruiting, screening or consent documents
- Alteration in drug administrative dosage form (e.g. tablet to liquid) but not the route
- An increase in the length of confinement or number of study visits for safety purposes
- Minor increase/decrease in subject number
- Minor change in remuneration amount or type
- Change in funding source(s)

- Changes in study personnel
- Addition of qualified key personnel
- Any change that does not alter the risk benefit ratio

As stated in 45 CFR 46.110(b) and 21 CFR 56.110(b), expedited reviews “may be carried out by the IRB chairperson or by one or more experienced reviewers designated by the chairperson from among members of the IRB.” The GBMC IRB recognizes the following two individuals as having the authority to perform expedited reviews:

1. IRB Chairperson
2. IRB Vice Chairperson

The above named designated reviewers shall “exercise all of the authorities of the IRB except that the reviewers may not disapprove the research” [45 CFR 46.110(b) and 21 CFR 56.110(b)].

All new project, continuing review, and amendment/modification submissions shall be screened by the IRB Coordinator to determine whether a submission may qualify for expedited review. (Note: Continuing review and amendment/modification submissions, as a rule, are assigned to a convened IRB meeting unless circumstances are such that an expedited review is necessary.) If the IRB Coordinator determines that a submission meets the regulatory criteria for expedited review, the submission shall be forwarded to the IRB Chairperson for review. If the IRB Chairperson has a conflict of interest with the proposed research activity, the submission shall then be forwarded to the IRB Vice Chairperson.

As with a full board review, expedited reviews are subject to the same regulatory criteria for the approval of research as set forth in 45 CFR 46.111(a)(1-7) (See also SOP 4.1). The only difference between a full board review and an expedited review is the number of IRB members who participate in the review.

The expedited reviewer shall take one of the following three actions:

1. Approve
2. Approve with conditions
3. Refer to full board

If the reviewer recommends that the proposed research be disapproved, the submission shall be referred back to the full board and placed on the agenda for the next regularly scheduled meeting of the convened IRB.

The reviewer/IRB’s decision shall be conveyed by the IRB office staff to the principal investigator and other key project personnel as soon as possible after the expedited review as described in SOP Section 4.6.

The reviewer shall report the expedited review decision back to the convened IRB at the next scheduled meeting.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Exempt Determinations
Section Number: 5.3
Effective Date: January 1, 2005
Last Revision: March 20, 2017
Replaced SOP Revised On:

In accordance with federal regulations 45 CFR 46.101(b) and 21 CFR 56.104, some human subjects research may be exempt from federal and institutional review board oversight. In order to be eligible for exempt status, the proposed research activity must fall within one or more of the following categories found at 45 CFR 46.101(b):

1. Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
 - (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

3. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if:
 - (i) the human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

4. Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

5. Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine:
 - (i) Public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.
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.

FDA regulated research does not qualify for exemption unless it falls under the FDA's emergency use provision for the use of a test article [21 CFR 56.104(c)] or taste and food quality evaluations and consumer acceptance studies [21 CFR 56.104(d)].

All new projects being submitted for possible exemption shall be screened by the IRB Coordinator. If the IRB Coordinator finds that the proposed research project meets the regulatory criteria for an exemption, the submission shall be forwarded to the IRB Chairperson for final review and determination. If the IRB Chairperson has a conflict of interest with the proposed research, the submission shall then be forwarded to the IRB Vice Chairperson.

The GBMC IRB recognizes the following two individuals as having the authority to make an exempt determination:

1. IRB Chairperson
2. IRB Vice Chairperson

The exempt reviewer shall take one of the following two actions:

1. Exempt
2. Defer

If the reviewer determines that the proposed research does not qualify for an exemption and defers the submission, the submission shall then be reviewed by expedited review procedures or by the convened IRB, whichever is more appropriate for the research activity.

The reviewer/IRB's decision shall be conveyed by the IRB office staff to the principal investigator and other key project personnel as soon as possible as described in SOP Section 4.6.

If the principal investigator proposes to make any changes to the project once an exemption is granted, the proposed change must be submitted to the IRB for review prior to implementation to ensure that the project still qualifies for exempt status. The IRB Coordinator shall forward the submission to the IRB Chairperson for review. If the IRB Chairperson has a conflict of interest with the research project, the submission shall then be forwarded to the IRB Vice Chairperson.

The GBMC IRB recognizes the following two individuals as having the authority to perform a review to determine whether or not a research project still qualifies for exempt status:

1. IRB Chairperson
2. IRB Vice Chairperson

The reviewer shall take one of the following two actions:

1. Exempt (meaning that the project still qualifies for exempt status)
2. Defer (meaning that the project no longer qualifies for exempt status)

If the reviewer determines that the research project no longer qualifies for exempt status and defers the submission, the principal investigator shall be informed of the decision as soon as possible, and the principal investigator must resubmit the revised research project in its entirety. The resubmitted, revised project shall then be reviewed by expedited review procedures or by the convened IRB, whichever is more appropriate for the research activity.

Research that is determined to be exempt under 45 CFR 46.101(b) is not required to undergo continuing review as set forth in 45 CFR 46.109(e). However, to keep the GBMC IRB Office files current, exempt research shall be given a three year expiration date. If the principal investigator wishes to continue the research after the three year period, the principal investigator must request an extension. If the principal investigator does not request an extension within 30 days of the expiration date, the research project shall be administratively closed.

Principal investigators, co-investigators and research project coordinators on the study team of a research project that is determined to be exempt are also exempt from the GBMC IRB's human subjects research training requirements as described in SOP Section 4.5.

All determinations and actions made solely by the IRB Chairperson or IRB Vice Chairperson in regards to exemptions shall be reported back to the convened IRB at the next scheduled meeting.

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Not Human Subjects Research
Section Number: 5.4
Effective Date: March 20, 2017
Last Revision:
Replaced SOP Revised On:

All activities that fall under the federal regulatory definitions of human subjects research are required to undergo Institutional Review Board review. However, activities that fail to meet the federal definition of research or do not involve human subjects are excluded from Institutional Review Board review.

Determining whether or not an activity meets the federal definition of human subjects research is a two-step process that involves answering two specific questions:

Step 1 – Is it research?

Federal regulations define research as “a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge” [45 CFR 46.102(d)].

Step 2 – Does it involve human subjects?

Federal regulations define a human subject as “a living individual about whom an investigator (whether professional or student) conducting research obtains (1) data through intervention or interaction with the individual, or (2) identifiable private information” [45 CFR 46.102(f)].

The process of determining whether or not an activity meets the federal definitions of human subjects research can be complex and involve assessing the activity’s intent, design, expected outcomes and dissemination of results. The GBMC IRB recognizes the following two individuals as having the authority to make a not research determination:

1. IRB Chairperson
2. IRB Vice Chairperson

All newly proposed activities that may qualify for a not research determination shall be screened by the IRB Coordinator. If the IRB Coordinator finds that there is sufficient evidence to qualify the activity for a not research determination, the information provided shall be forwarded to the IRB Chairperson for final review and determination. If the IRB Chairperson is not available to perform the final review and determination, the information provided shall then be forwarded to the IRB Vice Chairperson. A formal IRBNet submission is not routinely required, and a final

determination of not research is not reported back to the convened IRB as the proposed activity is not research and IRB review and oversight is not required.

If it is determined that the proposed activity does meet the federal definitions of human subjects research, then the information provided must be formally submitted to the IRB via IRBNet. The submission shall then be reviewed for a possible exempt determination, by expedited review procedures or by the convened IRB, whichever is more appropriate for the proposed activity.

The following are examples of activities that typically would not need GBMC IRB review and would be considered not human subjects research:

- QI/QA activities that are systematic, data-guided and designed to implement promising ways to improve clinical care, patient safety and health care operations. The activity is designed to bring about immediate positive changes in the delivery of health care, programs, services or business practices in the local (GBMC) setting.
- Surveys issued or completed by GBMC personnel with the intent and purpose of improving GBMC services and programs or for developing new GBMC services or programs, as long as the privacy of the individuals is protected, the confidentiality of individual responses is maintained and survey participation is voluntary.
- Evidence based practice activities designed to utilize existing generalizable knowledge to implement local (GBMC) practice changes and/or answer a local (GBMC) practice question. These activities may include implementing practice changes on a pilot unit and evaluating processes and outcomes.
- Coded private information or biological specimens that were not collected for the currently proposed activity as long as the investigator cannot link the coded data/specimens back to individual subjects.
- Research involving cadavers, autopsy material or bio-specimens from now deceased individuals.
- Case history reports involving less than three individual medical records which are published and/or presented at national or regional meetings if there is no intent to form a research hypothesis, draw conclusions or generalize findings.
- Oral histories—Interviews that collect, preserve and interpret the voices and memories of people, communities, and participants in past events as a method of historical documentation.
- Information-gathering interviews of individuals where questions focus on things, products, or policies, rather than on people or their opinions or experiences.
- Innovative or novel procedures or treatments designed solely to enhance the well being of an individual patient or client.
- Activities involving the use of publicly available data.
- Data collection for GBMC internal departmental and/or administrative purposes only.

The above list contains only examples of activities that may not need to undergo GBMC IRB review. This list is not comprehensive. Only the GBMC IRB Chairperson or Vice Chairperson can make a final not research determination.

A not research determination is not the same as an exemption from IRB review and oversight. A determination of not research means that the activity does not meet the federal human subjects or research definitions and, therefore, does not require IRB review and oversight. An exempt determination means that the activity does meet the federal human subjects and research definitions but does not require IRB review and oversight as the activity falls under one or more of the federal regulatory exemption categories (See SOP Section 5.3—Exempt Determinations).

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Continuing Reviews
Section Number: 5.5
Effective Date: January 1, 2005
Last Revision: January 21, 2019
Replaced SOP Revised On: May 15, 2017

In accordance with federal regulations 45 CFR 109(e) and 21 CFR 56.109(f), the IRB shall conduct continuing review of research “at intervals appropriate to the degree of risk, but not less than once per year”. The IRB shall also follow written procedures for conducting continuing review of research [45 CFR 46.103(b)(4)(i) and 21 CFR 56.108(a)(1)].

This policy outlines the procedures followed for continuing reviews.

Federal regulations have established criteria for IRB approval of human subjects research, and the IRB shall apply the same regulatory approval criteria to continuing reviews as it does to initial reviews (See SOP Section 4.1).

Except when an expedited review procedure is used, the IRB shall conduct continuing reviews “at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concerns are in nonscientific areas. In order for research to be approved, it shall receive the approval of a majority of those members present at the meeting.” [45 CFR 46.108(b) and 21 CFR 56.108(c)]

The IRB shall have no member participate in a continuing review who has a conflicting interest in the project undergoing review, except to provide information requested by the IRB [45 CFR 46.107(e) and 21 CFR 56.107(e)]. This applies to continuing reviews conducted by the convened IRB and continuing reviews where expedited review procedures are used.

The GBMC IRB uses expedited review procedures for continuing reviews on only the rarest of occasions when a continuing review cannot be conducted in a timely fashion in relation to when a meeting of the convened IRB is scheduled. On the occasion when a continuing review is conducted using expedited review procedures, the review is conducted as set forth in SOP Section 5.2—Expedited Reviews. The following projects are eligible for expedited continuing review:

1. Any project that was initially approved via expedited review, unless the project has changed or will change such that expedited review would no longer be permitted for continuing review.
2. Any project initially approved by the convened IRB:

- a. where (i) the research is permanently closed to the enrollment of new subjects; (ii) all subjects have completed all research-related interventions; and (iii) the research remains active only for long-term follow-up of subjects; or
 - b. where no subjects have been enrolled and no additional risks have been identified; or
 - c. where the remaining research activities are limited to data analysis
3. Any project not involving an investigational new drug application or investigational device exemption where certain expedited review categories do not apply but the IRB had determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

(Source for the above list: 63 FR 60364-60367, November 9, 1998)

The GBMC IRB recognizes the following two individuals as having the authority to perform continuing reviews using expedited review procedures:

1. IRB Chairperson
2. IRB Vice Chairperson

At the time of initial review, whether it be by the convened IRB or expedited review procedures, all projects are given an approval expiration date indicating when the project must undergo a continuing review. Typically, the IRB initially approves a research project or continuation request for a period of one year. However, approval may be granted for less than one year (e.g. six months) in some circumstances. The IRB determines the frequency of continuing review by considering the following factors recommended by the OHRP:

- The nature of any risks posed by the research project
- The degree of uncertainty regarding the risks involved
- The vulnerability of the subject population
- The experience of the investigators in conducting research
- The IRB's previous experience with the investigators (e.g., compliance history, previous problems with the investigator obtaining informed consent, or prior complaints from subjects about the investigator)
- The projected rate of enrollment; and
- Whether the research project involves novel interventions

(Source for the above list: Guidance on IRB Continuing Review of Research dated 11/10/10)

The actual date of approval expiration necessitating continuing review shall be calculated as follows and applies to both initial and continuing reviews:

- For research projects reviewed and approved without conditions by the convened IRB, the approval expiration date shall be calculated from the date of the convened meeting.

- For research projects reviewed via expedited review procedures without conditions, the approval expiration date shall be calculated from the date approval is granted by the person (IRB Chairperson or Vice Chairperson) authorized to perform the review.
- For research projects approved with conditions, whether it be by the convened IRB or expedited review procedures, the approval expiration date shall be calculated from the date the project was approved with conditions, not the effective date when full approval was ultimately granted.

It is the responsibility of the principal investigator to submit for a continuing review prior to the approval expiration date with sufficient time for the continuing review to be performed by the IRB. Federal regulations (45 CFR 46 and 21 CFR 56) make no provision for any grace period extending the conduct of research beyond the expiration date of IRB approval.

As a courtesy, continuing review reminder emails shall be sent out automatically via IRBNet 60 and 30 days prior to a project's approval expiration date. If the project does not undergo a continuing review prior to the approval expiration date, IRBNet will send a final notice on the date of approval expiration. In conjunction with this final notice of expiration, the IRB Coordinator shall inform the principal investigator and any other key project personnel that the project's approval has expired and all research activities must cease. Research activities that must cease include but are not limited to contact with currently enrolled subjects, data collection and data analysis. Currently enrolled subjects may continue participating in the research if it is determined that the research interventions hold out the prospect of direct benefit to the subjects or when withholding those interventions poses increased risks to the subjects. The principal investigator shall request in writing special consideration from the IRB Chairperson to continue to follow currently enrolled subjects in the event that the approval expires. The IRB Chairperson shall consider such requests on a case-by-case basis. No new subjects may be enrolled.

Once a project's approval expires, the principal investigator shall have 30 days to submit for a continuing review. If the project is not submitted for a continuing review within this 30 day period, the project shall be administratively closed at the next scheduled meeting of the convened IRB, and the project must be resubmitted in its entirety to be reconsidered.

In the event that a continuing review submission is received by the IRB office staff after the project's approval has expired, it shall be screened by the IRB Coordinator to determine if the submission qualifies for an expedited review. If the submission qualifies for an expedited review, the procedures as described in SOP Section 5.2—Expedited Reviews shall be followed. If the submission does not qualify for an expedited review, the submission shall be placed on the agenda for the next regularly scheduled meeting of the convened IRB. Regardless of the circumstances, the new approval expiration date for an expired project shall be calculated from the current approval expiration date, not from the effective date when the continuing review was performed and approval was granted to continue the research.

All continuing review submissions must be sent electronically via IRBNet as described in SOP Section 4.2—Submission Deadlines and Requirements. The IRB recommends that continuing review requests be submitted for review at the convened IRB meeting scheduled in the month

prior to the project's approval expiration date. The electronic submission "package" for a continuing review shall contain but not be limited to the following documents:

1. Continuing review submission form
2. Conflict of interest statements from the principal investigator and all co-investigators on the study team
3. Evidence of current human subjects research training from the principal investigator, co-investigators and study coordinator

The continuing review submission form shall contain but not be limited to the following information:

1. Project status
2. Enrollment data
3. Summary of any subject withdrawals
4. Summary of any subject complaints
5. Description of any unanticipated problems that have not been reported to the IRB since the last review.

The project's complete IRBNet file can be accessed at any time by the IRB members to aid in conducting the continuing review. The IRBNet file includes but is not limited to the following as applicable:

- Current protocol and any previously submitted versions
- Current informed consent form and any previously submitted versions
- Current investigator brochure and any previously submitted versions
- Previously submitted revisions/amendments and corresponding documents
- Adverse event and/or unanticipated problem reports
- Deviation reports
- All previous continuing reviews and corresponding documents

As part of the continuing review process, federal regulations require an IRB to determine "which projects need verification from sources other than the investigator that no material changes have occurred since previous IRB review" [45 CFR 46.103(b)(4)(ii) and 21 CFR 56.108(a)(2)]. The need for verification shall be determined by the IRB on a case-by-case basis. Source verification shall be required when the:

- Investigator is providing inconsistent information that cannot be resolved
- IRB doubts the investigator's veracity
- IRB doubts the investigator has sufficient relevant knowledge
- IRB perceives that the investigator is intentionally not providing necessary information

If the IRB determines that a need for source verification exists, the IRB may request an independent assessment. The scope and extent of the assessment shall be determined by the IRB on a case-by-case basis. Sources for information could include but not be limited to site visits

conducted by authorized personnel, literature searches, or a directed audit. The IRB has the “authority to observe or have a third party observe the consent process and the research” [45 CFR 46.109(e) and 21 CFR 56.109(f)].

Once a continuing review has been completed, the IRB’s decision shall be conveyed by the IRB office staff to the principal investigator and other key project personnel as soon as possible as described in SOP Section 4.6—Notification and Documentation of Review Actions and Determinations. Continuing review follow-up letters shall clearly state the period of time for which the project is approved and the new approval expiration date.

IRB actions and determinations are reported back to institutional (GBMC) officials on a monthly basis in the form of meeting minutes. The minutes are submitted to the Chief Medical Officer and Signatory Official on GBMC’s Federalwide Assurance. (See also SOP Section 2.5—Minutes of the Meeting)

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Permanent Project Closures
Section Number: 5.6
Effective Date: May 15, 2017
Last Revision: January 21, 2019
Replaced SOP Revised On:

Principal investigators have the responsibility of informing the IRB when a project has been completed. The GBMC IRB requests that, upon the completion of a project, a “Closure of Project (Permanent) Reporting Form” be submitted as a final report.

A project may be closed if any of the following conditions apply:

- All research-related interventions or interactions with human subjects have been completed and/or all data collection and analysis of identifiable private information have been finished
- All that remains is the analysis of aggregate data sets without individual subject identifiers or identifiable private information and with no identifying links or codes to the data
- The project sponsor agrees to or recommends closure
- The project has been open for one or more years, no subjects have been enrolled, and the principal investigator sees no likelihood of doing so
- The project was never initiated
- The principal investigator plans to terminate employment/affiliation with GBMC and/or be removed from the project team without transferring the research to another investigator

If the project does not meet any of the above criteria for closure, the project must remain open and undergo continuing review as determined by the IRB.

Regardless of initial review type (full or expedited), all closure of project submissions shall be reviewed by the convened IRB and acknowledged. The IRB’s acknowledgement shall be formally conveyed by the IRB office staff to the principal investigator and other key project personnel as soon as possible after the convened meeting as described in SOP Section 4.6— Notification and Documentation of Review Actions and Determinations. IRB office records shall be coded to indicate that the project is now permanently closed.

In the event that the principal investigator seeks to resume research activities for a project that has been permanently closed, the project can be reactivated by one of the following two ways:

1. If the project has been closed for six months or less, the principal investigator may request that the project be reopened by submitting a “Revisions and Amendments Submission Form”
2. If the project has been closed for more than six months, the project must be resubmitted in its entirety to be reconsidered and will be reviewed as a new project as described in SOP Section 5.1—Initial Full Committee Reviews

The GBMC IRB may administratively close a project without the approval of the principal investigator in the following two instances:

1. A project’s approval has expired and no continuing review submission is made within 30 days of the approval expiration date as set forth in SOP Section 5.5—Continuing Reviews
2. It is determined that the principal investigator has terminated employment and/or affiliation with GBMC without notifying the IRB and requesting the research be transferred to another investigator

Projects that are administratively closed by the IRB cannot be reopened. To resume research activities, the project must be resubmitted in its entirety.

Once a project is permanently closed, the IRB shall retain individual project files for six years in accordance with federal regulations which state that an IRB shall maintain “copies of all research proposals reviewed, scientific evaluations, if any, that accompany the proposals, approved sample consent documents, progress reports submitted by investigators, and reports of injuries to subjects” [45 CFR 46.115(a)(1) and 21 CFR 56.115(2)] and that these records “shall be retained for at least 3 years after completion of the research.” [45 CFR 46.115(a)(7) and 21 CFR 56.115(7)(b)]

Once the six year retention time frame has elapsed, the project files (both hard copy and those maintained electronically in IRBNet) shall be permanently deleted and/or destroyed.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Enrollment Status Changes
Section Number: 5.7
Effective Date: June 19, 2017
Last Revision:
Replaced SOP Revised On:

Principal investigators have the responsibility of informing the IRB when a project's enrollment status changes. An enrollment status change is considered a change in research activity that must be reported to the IRB in accordance with federal regulations at 45 CFR 46.103(b)(4)(iii) and 21 CFR 56.108(a)(3-4).

The GBMC IRB considers the following enrollment status changes to be reportable:

- Permanent closure to enrollment
- Temporary closure to enrollment
- Reactivation of enrollment to entire project
- Permanent closure of a project arm to enrollment
- Temporary closure of a project arm to enrollment
- Reactivation of enrollment to project arm

Enrollment status changes should be submitted to the IRB for review and approval prior to implementation; however, the IRB acknowledges that sponsors of multi-site studies may announce enrollment status changes before IRB review and approval can be obtained. When this is the case, it is the responsibility of the principal investigator to notify the IRB as soon as possible after the enrollment status change is announced.

Enrollment status change submissions shall be handled as set forth in SOP Section 5.8.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Changes in Research Activity: Revisions and Amendments
Section Number: 5.8
Effective Date: June 19, 2017
Last Revision: January 21, 2019
Replaced SOP Revised On:

In accordance with federal regulations 45 CFR 46.103(b)(4)(iii) and 21 CFR 56.108(a)(3-4), the IRB shall have written procedures “for 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 subject.”

This policy outlines the procedures followed for the prompt reporting to the IRB of proposed changes in research activity.

A proposed change in research activity can be as simple as a slight wording change to a consent document or as complex as the addition of a new arm to a project.

A change in research activity can be referred to as a modification, revision or amendment. Typically, a revision refers to a change in something that already exists (e.g. increase in number of subjects to be enrolled) while an amendment refers to something that is added (e.g. new person on the project team).

Proposed changes in research activity can be broken down into two categories:

- Major changes
- Minor changes

Major changes are changes that may have a substantive effect on the conduct of the research, increase the research population’s risk or are of questionable risk. Examples of major changes include but are not limited to the following:

- An increase in physical and/or psychological risk/discomfort to subjects
- A major change in research design or methodology
- Substantive changes to the protocol, consent and/or other documents
- Adding a new consent form, questionnaire or other instrument
- Significant new findings that may affect subjects’ willingness to participate
- Addition of serious unexpected adverse events to the informed consent
- Broadening the range of inclusion criteria

- Narrowing the range of exclusion criteria
- Alterations in the use and/or administration of study drugs, devices or biologics
- Additions or deletions of laboratory tests, monitoring procedures, etc.
- Project team changes involving the principal investigator
- Enrollment status changes (e.g. closure to enrollment) (See also SOP Section 5.7—Enrollment Status Changes)
- Any change that may alter the risk/benefit ratio

All major changes shall be reviewed by the convened IRB.

Minor changes are changes that have no substantive effect upon an approved protocol or reduce the risk to the subject. Examples of minor changes include but are not limited to the following:

- A reduction in physical and/or psychological risk/discomfort to participants
- Minor editorial modifications to documents that do not alter meaning or procedure
- Removing questions from a questionnaire
- Narrowing the range of inclusion criteria
- Broadening the range of exclusion criteria
- New or changed recruitment/advertising methods and/or materials (flyers, Internet, etc.)
- New or changed patient materials (diaries, medical alert cards, etc.)
- An increase in the number of study visits for safety purposes
- Minor increase/decrease in the number of subjects to be enrolled
- Minor change in remuneration amount or type
- Additions or deletions of project team members (not including principal investigator)
- Any change that does not alter the risk/benefit ratio

Federal regulations at 45 CFR 46.110(b)(2) and 21 CFR 56.110(b)(2) permit IRBs to use expedited review procedures to review “minor changes in previously approved research during the period (of 1 year or less) for which approval is authorized”; however, the GBMC IRB has opted to review all proposed changes in previously approved research regardless of how minor at convened meetings.

The GBMC IRB will use expedited review procedures in urgent cases when time is of the essence. On the occasion that a review of minor changes in previously approved research is conducted using expedited review procedures, the review shall be conducted as set forth in SOP Section 5.2—Expedited Reviews.

The GBMC IRB recognizes the following two individuals as having the authority to review minor changes in previously approved research using expedited review procedures:

1. IRB Chairperson
2. IRB Vice Chairperson

Regardless of whether changes in previously approved research are reviewed by the convened IRB or expedited review procedures, the criteria for approval of changes to previously approved research are the same as those for initial review. The IRB must determine that, in light of the proposed changes, research continues to satisfy 45 CFR 46.111 and/or 21 CFR 56.111, as applicable.

When proposed changes to previously approved research are reviewed by the convened IRB, a primary reviewer shall be appointed. The IRB Assistant shall assign each change in research activity submission to a qualified IRB member for review. The IRB member shall summarize and present the nature of the proposed changes to the convened IRB. The IRB Assistant shall not assign a change in research activity submission to any IRB member who has a conflict of interest with the proposed research activity.

As appropriate, the convened IRB shall determine whether re-consenting of currently enrolled subjects is necessary. This determination shall be based on any new information provided that could possibly affect a subject's decision to continue with the research activities. The convened IRB shall also decide whether subjects who have concluded active treatment, are in long-term follow-up or have completed all study requirements should be contacted and provided with additional information.

All decisions made by the IRB regarding a submission for a proposed change to previously approved research, regardless of whether the review was performed by the convened IRB or expedited review procedures, shall be conveyed by the IRB office staff to the principal investigator and other key project personnel as soon as possible as described in SOP Section 4.6—Notification and Documentation of Review Actions and Determinations.

Principal investigators shall not implement any change in research activity without prior IRB review and approval. The only exception to this requirement is in instances when the change is “necessary to eliminate apparent immediate hazards to the subject” [45 CFR 46.103(b)(4)(iii) and 21 CFR 56.108(a)(4)].

If a principal investigator implements a non-IRB approved change to previously approved research to eliminate apparent hazards to a subject, the change shall be reported to the IRB within 48 hours of implementation as a protocol deviation/violation as described in SOP Section 5.10—Protocol Deviations/Violations.

If the principal investigator of a project previously determined to be exempt by the IRB proposes to make a change in research activity to the project, the proposed change in research activity must be submitted to the IRB prior to implementation to ensure that the project still qualifies for exempt status in accordance with federal regulations 45 CFR 46.101(b) and 21 CFR 56.104 and as set forth in SOP Section 5.3—Exempt Determinations.

IRB actions and determinations are reported back to institutional (GBMC) officials on a monthly basis in the form of meeting minutes. The minutes are submitted to the Chief Medical Officer

and Signatory Official on GBMC's Federalwide Assurance. (See also SOP Section 3.5—
Minutes of the Meeting)

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Adverse Events and Unanticipated Problems
Section Number: 5.9
Effective Date: September 19, 2016
Last Revision: April 21, 2025
Replaced SOP Revised On:

Federal regulations 45 CFR 46.103(b)(5) and 21 CFR 56.108(b)(1-3) require the IRB to follow written procedures for ensuring the prompt reporting to the IRB, appropriate institutional officials, and governmental departments and/or agency heads of any:

1. unanticipated problems involving risks to subjects or others
2. serious or continuing noncompliance with Federal regulations
3. serious or continuing noncompliance with requirements or determinations of the IRB
4. suspension or termination of IRB approval

This policy outlines the procedures for prompt reporting.

Definitions

Adverse Event (AE): An AE is defined as “any untoward or unfavorable medical occurrence in a human subject, including any abnormal sign (for example, abnormal physical exam or laboratory finding), symptom, or disease, temporally associated with the subject’s participation in the research, whether or not considered related to the subject’s participation in the research. Adverse Events encompass both physical and psychological harms. They occur most commonly in the context of biomedical research, although on occasion, they can occur in the context of social and behavioral research.”

Serious Adverse Event (SAE): A SAE is defined as “any adverse event temporally associated with the subject’s participation in research that meets any of the following criteria:

1. results in death;
2. is life-threatening (places the subject at immediate risk of death from the event as it occurred);
3. requires inpatient hospitalization or prolongation of existing hospitalization;
4. results in a persistent or significant disability/incapacity;
5. results in a congenital anomaly/birth defect; or
6. any other adverse event that, based upon appropriate medical judgment, may jeopardize the subject’s health and may require medical or surgical intervention to prevent one of the other outcomes listed in this definition”

Unanticipated Problem (UP): An unanticipated problem is defined as “any incident, experience, or outcome that meets all of the following criteria:

1. unexpected (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent document; and (b) the characteristics of the subject population being studied;
2. related or possibly related to participation in the research; and
3. suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.”

Possibly related to the research means that “there is a reasonable possibility that the adverse event, incident, experience or outcome may have been caused by the procedures involved in the research”.

Internal Adverse Event: An adverse event that occurs in study participants who were enrolled through GBMC or a GBMC affiliated study site.

External Adverse Event: An adverse event that occurs in study participants who were not enrolled through GBMC or a GBMC affiliated study site.

Reporting Requirements for Internal Adverse Events

All internal adverse events that meet the above-definition of a serious adverse event or an unanticipated problem shall be reported to the IRB within 5 business days of the investigator becoming aware of the event.

All internal events that meet the above-definition of an adverse event but do not meet the above-definition of a serious adverse event or unanticipated problem shall be reported to the IRB within 10 business days of the investigator becoming aware of the event.

All internal adverse events that are reported to an outside entity (e.g. sponsor, FDA) with study oversight shall be reported to the IRB within 10 business days of the investigator becoming aware of the event.

All subject deaths that occur while on study shall be reported to the IRB within 48 hours of the investigator becoming aware of the event unless the event is clearly unrelated to the study procedures or related to natural progression of a disease process.

Reporting Requirements for External Adverse Events

The “OHRP advises that it is neither useful nor necessary under the HHS regulations at 45 CFR part 46 for reports of individual adverse events occurring in subjects in multicenter studies to be distributed routinely to investigators or IRBs at all institutions conducting the research.”

Only external adverse events that meet the following criteria need to be reported to the GBMC IRB:

1. events that are determined by the sponsor to be an unanticipated problem involving risks to subjects or others
2. events that result in a modification to the protocol, informed consent document and/or investigator brochure
3. events that result in suspension of all or parts of the research
4. events that result in early termination of the research

External adverse events shall be reported to the GBMC IRB within 10 business days of the investigator becoming aware of the event.

Other Reportable Events

In addition to the above-mentioned adverse events, serious adverse events, and unanticipated problems, the IRB considers the following to be reportable events:

1. new or updated safety information relating to the study or study product
2. DSMB/DMC or other independent safety monitoring group report
3. any sponsor imposed suspension or termination of the research due to new or increased risks
4. a breach of confidentiality or violation of HIPAA
5. unresolved participant complaints
6. adverse external audit results or enforcement actions
7. external audit of research investigator and the outcome
8. any other problem indicating that the research places subjects or others at an increased risk of harm or otherwise adversely affects the rights, welfare or safety of subjects or others

The above mentioned other reportable events shall be reported to the IRB within 10 business days of the investigator becoming aware of the event.

For reasons of confidentiality, subject names must not be included in any reportable event submission. Subject identifiers such as enrollment numbers should be used instead.

IRB Review Process for Reported Events

All reported events shall be screened by the IRB office staff. The IRB office staff shall either place the submitted item on the agenda for the next scheduled meeting of the convened IRB or forward it to the IRB Chairperson or his designee for review.

The following internal events shall be promptly forwarded to the IRB Chairperson or his designee for immediate review:

1. Death of a subject or life-threatening circumstances
2. Serious adverse events
3. Unanticipated problems resulting in risks to subjects or others
4. Serious or continuing noncompliance with Federal regulations
5. Serious or continuing noncompliance with requirements or determinations of the IRB
6. Any other event involving risks to subjects or others

The IRB Chairperson or designee shall report the review findings back to the convened IRB at the next scheduled meeting. The principal investigator shall be notified of all review findings and if any corrective action is required or additional information is needed.

If the IRB determines that corrective action is necessary, the required action may include:

1. Changes to the research protocol
2. Modification of informed consent documents
3. Notification of previously enrolled subjects of new information
4. Notification of currently enrolled subjects of new information
5. Frequent progress or status reports to the IRB
6. More frequent intervals of continuing review
7. Suspension of all or parts of the research
8. Termination of the research
9. Other actions as determined by the IRB

If the IRB determines that the event is of a magnitude that it must be reported to other appropriate authorities, those authorities may include:

1. GBMC institutional officials
2. The Office for Human Research Protection (OHRP)
3. The Food and Drug Administration (FDA)
4. Other governmental departments or agency heads as appropriate

The IRB Coordinator shall be responsible for notifying the following GBMC officials regarding the reportable event within 5 business days of the IRB's determination:

1. Chief Medical Officer
2. Vice President for Legal Affairs and General Counsel
3. Vice President for Quality and Patient Safety

The IRB Chairperson shall be responsible for notifying all appropriate governmental departments and/or agencies within 15 business days of GBMC officials being notified of the reportable event. A copy of all correspondence and/or reports shall be forwarded to the above-mentioned GBMC officials.

[All quoted passages within this policy have been taken from the OHRP "Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events" dated 1/15/07]

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Protocol Deviations/Violations
Section Number: 5.10
Effective Date: September 19, 2016
Last Revision:
Replaced SOP Revised On:

As previously stated in Section 5.9, Federal regulations 45 CFR 46.103(b)(5) and 21 CFR 56.108(b)(1-3) require the IRB to follow written procedures for ensuring the prompt reporting to the IRB, appropriate institutional officials, and governmental departments and/or agency heads of any:

1. unanticipated problems involving risks to subjects or others
2. serious or continuing noncompliance with Federal regulations
3. serious or continuing noncompliance with requirements or determinations of the IRB
4. suspension or termination of IRB approval

This policy outlines the procedures for prompt reporting.

The term “protocol deviation” is not defined by either OHRP human subjects regulations (45 CFR 46) or FDA human subjects regulations (21 CFR 50). For GBMC IRB purposes, a protocol deviation is any modification or departure from the defined procedures and treatment plans set forth in the IRB-approved protocol. All planned protocol deviations require IRB approval prior to implementation except in emergency situations where changes are deemed “necessary to eliminate apparent immediate hazards to the subject” [45 CFR 46.103(b)(4)(iii)].

Protocol deviations/violations range in seriousness according to how the changes may impact subject safety. The GBMC IRB has divided protocol deviations/violations into two categories—major and minor.

A major protocol deviation/violation is defined as any change that may impact subject safety or alter the risk/benefit ratio, compromise the integrity of the study data, and/or affect a subject’s willingness to participate in the study. Major protocol deviations/violations include but are not limited to the following:

- Enrollment of a subject before IRB approval of study
- Enrollment of a subject after IRB approval of study has expired
- Enrollment of a subject who did not meet inclusion/exclusion criteria
- Failure to obtain informed consent prior to initiating study procedures
- Inappropriate documentation of informed consent (e.g. missing subject signature)
- Use of a non-IRB approved informed consent (e.g. consent missing IRB approval stamp)

- Use of an invalid informed consent (e.g. outdated version)
- Failure to perform a study specific procedure (impacting subject safety)
- Out of window visit and/or procedure (impacting subject safety)
- Performing study procedures not approved by the IRB
- Drug/study medication dispensing or dosing error
- Incorrect storage/handling of study drug/medication, biological samples, etc.
- Loss or destruction of samples or data
- Failure to follow protocol safety and monitoring requirements
- Any lapse in study approval where there is a continuation of research activities
- Any event requiring prompt reporting according to the protocol or study sponsor
- Any other deviation impacting subject safety

A minor protocol deviation/violation is defined as a one-time change that does not significantly affect the safety of the subject. Minor protocol deviations/violations include but are not limited to the following:

- Use of recruitment method and/or material not approved by the IRB
- Missing original signed and dated informed consent (copy available)
- Copy of signed informed consent not given to subject
- Missing pages of executed informed consent
- Failure to perform a study specific procedure (not impacting subject safety)
- Out of window visit and/or procedure (not impacting subject safety)
- Failure of subject to return unused study drug/medication
- Improper investigational product accountability
- Failure to follow Federal regulations
- Failure to follow requirements or determinations of the IRB

Minor protocol deviations/violations that occur repetitively may be determined to be a major deviation by the IRB and require corrective action.

All major protocol deviations/violations shall be reported to the IRB within 5 business days of the investigator becoming aware of the event.

All major protocol deviations/violations resulting in the death of a subject shall be reported to the IRB within 48 hours of the investigator becoming aware of the event.

All minor protocol deviations/violations shall be submitted to the IRB on an individual basis or no less than every quarter (every 90 days) in the form of a summary report.

All emergency situations involving the implementation of a non-IRB approved protocol deviation to eliminate apparent immediate hazards to a subject shall be reported to the IRB within 48 hours of the event taking place.

Protocol deviations/violations that occur at a non-GBMC affiliated site in a multi-center research study do not need to be reported to the IRB.

All protocol deviations/violations shall be screened by the IRB office staff. The IRB office staff shall either place the submitted item on the agenda for the next scheduled meeting of the convened IRB or forward it to the IRB Chairperson or his designee for review.

The following protocol deviations/violations shall be promptly forwarded to the IRB Chairperson or his designee for immediate review:

1. All major deviations/violations that could possibly be classed as a:
 - a. serious noncompliance,
 - b. continuing noncompliance, or
 - c. unanticipated problem involving risks to subjects or others
2. All major deviations/violations resulting in the death of a subject
3. All deviations/violations being conducted under an emergency situation

The IRB Chairperson or his designee shall report the review findings back to the convened IRB at the next scheduled meeting. The principal investigator shall be notified of all review findings and if any corrective action is required or additional information is needed.

If the IRB determines that corrective action is necessary, the required action may include:

1. Changes to the research protocol
2. Monitoring of the informed consent process
3. Re-consenting of currently enrolled subjects
4. Monitoring of research activities
5. More frequent intervals of continuing review
6. Suspension of all or parts of the research
7. Termination of the research
8. Other actions as determined by the IRB

If the IRB determines that the event is of a magnitude that it must be reported to other appropriate authorities, those authorities may include:

1. GBMC institutional officials
2. The Office for Human Research Protection (OHRP)
3. The Food and Drug Administration (FDA)
4. Other governmental departments or agency heads as appropriate

The IRB Coordinator shall be responsible for notifying the following GBMC officials regarding the reportable event within 5 business days of the IRB's determination:

1. Chief Medical Officer

2. Vice President for Legal Affairs and General Counsel
3. Vice President for Quality and Patient Safety

The IRB Chairperson shall be responsible for notifying all appropriate governmental departments and/or agencies within 15 business days of GBMC officials being notified of the reportable event. A copy of all correspondence and/or reports shall be forwarded to the above-mentioned GBMC officials.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: General Reports
Section Number: 5.11
Effective Date: June 19, 2017
Last Revision: January 15, 2018
Replaced SOP Revised On:

Federal regulations make no reference to “general reports”. This is terminology that has been adopted solely by the GBMC IRB.

General reports refer to submissions that do not fall into any of the other primary submission types (e.g. new project, continuing review/progress report, amendment/modification).

Examples of what would be categorized as a general report include but are not limited to the following:

- Annual status reports
- Final reports received after permanent project closure
- General sponsor correspondence with directives to submit to the IRB

All general reporting submissions shall be reviewed by the convened IRB.

All general reporting submissions shall be acknowledged as soon as possible after the convened meeting as described in SOP Section 4.6—Notification and Documentation of Review Actions and Determinations.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Records-Based Research (Chart Reviews)
Section Number: 5.12
Effective Date: June 19, 2017
Last Revision:
Replaced SOP Revised On:

Research based on the review of patient medical records is considered to be human subjects research and must undergo IRB review and approval prior to initiation. There are two types of medical record/chart reviews:

- Retrospective
- Prospective

A retrospective chart review evaluates patient data that is existing at the time the project is submitted to the IRB for initial review.

A prospective chart review evaluates patient data that does not yet exist at the time the project is submitted to the IRB for initial review.

A project can involve the collection of data both retrospectively and prospectively.

Records-based research is reviewed by the GBMC IRB through one of three ways:

- Expedited Review
- Exempt Determination
- Full Board/Convened IRB Review

The above three review methods are described as follows:

1. Expedited Review

A majority of retrospective and prospective chart reviews involving little to no risk to subjects will qualify for expedited review if the IRB finds that the following criterion [45 CFR 46.110 Category 5) is met:

“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).”

If a retrospective or prospective chart review qualifies for an expedited review, the procedures as described in SOP Section 5.2 shall be followed.

2. Exempt Determination

A retrospective chart review involving little to no risk to subjects may qualify for an exempt determination if the IRB finds that the following criteria [45 CFR 46.101(b)(4)] are met:

“Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.”

The term “existing” in the above mentioned criteria is interpreted by the Office for Human Research Protection (OHRP) to mean that all of the data, documents records, etc., used in the research are in existence prior to IRB review and were collected for purposes other than the proposed research. Additionally, the terminology “in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects” means that there is no possibility of re-linking (e.g. via coded list) the data to the original medical record and/or subject.

If a retrospective chart review qualifies for an exempt determination, the procedures as described in SOP Section 5.3 shall be followed.

3. Full Board/Convened IRB Review

Retrospective and prospective chart reviews that do not qualify for an expedited review or an exempt determination shall be reviewed by the convened IRB. This occurs on only rare occasions. Circumstances under which this may occur include but are not limited to the following:

- The data to be collected is of a sufficiently sensitive nature that additional safeguards may be necessary to protect the subjects’ rights
- Research findings may result in a change to GBMC policies and/or procedures for patient care

If a retrospective or prospective chart review does not qualify for either an expedited review or exempt determination and must be reviewed by the convened IRB, the procedures as described in SOP Section 5.1 shall be followed.

Records-based research projects that are reviewed under expedited review procedures or are reviewed by the convened IRB are subject to all applicable federal regulations, including regulations regarding informed consent. Federal regulations at 45 CFR 46.116 state that “... no investigator may involve a human being as a subject in research ... unless the investigator has

obtained the legally effective informed consent of the subject or the subjects' legally authorized representative.” However, in the case of records-based research, an IRB may grant a waiver of informed consent if the following regulatory criteria [45 CFR 46.116(d)] are met:

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

If the above regulatory criteria cannot be met, the IRB may determine that written consent is required. This most often occurs in the case of prospective records-based research.

The IRB also has the option of waiving the requirement to obtain a signed consent form for some or all of the subjects if the following regulatory criteria [45 CFR 46.117(c)] are met:

1. That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or
2. That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

If the IRB waives the requirement to obtain a signed consent form, the IRB may require the principal investigator to provide subjects with a written statement regarding the research or present the information orally in instances where subjects are contacted via telephone.

In addition to being subject to informed consent regulatory requirements, records-based research is also subject to HIPAA privacy rule requirements. A retrospective chart review typically involves the use of protected health information (PHI) for research purposes without seeking written permission from the subject. This type of access must occur under a full waiver of HIPAA research authorization. In order to qualify for a full waiver of HIPAA research authorization, the following privacy rule criteria [45 CFR 164.512(i)(2)(ii)] must be met:

1. The use or disclosure of the PHI involves no more than minimal risk to the privacy of individuals based on, at least, the presence of the following elements:
 - a. An adequate plan to protect health information identifiers from improper use and disclosure.
 - b. An adequate plan to destroy identifiers at the earliest opportunity consistent with conduct of research (absent a health or research justification for retaining them or a legal requirement to do so).
 - c. Adequate written assurances that the PHI will not be reused or disclosed to (shared with) any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of the PHI would be permitted under the Privacy Rule.

2. The research could not practicably be conducted without the waiver.
3. The research could not practicably be conducted without access to and use of the PHI.

If the above HIPAA privacy rule criteria cannot be met, the IRB may determine that HIPAA research authorization must be obtained from the project subjects. This most often occurs in the case of prospective records-based research.

All IRB decisions shall be conveyed by the IRB office staff to the principal investigator and other key personnel as soon as possible as described in SOP Section 4.6.

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Overview of Cooperative Research Using an External IRB
Section Number: 6.1
Effective Date: January 1, 2005
Last Revision: January 20, 2020
Replaced SOP Revised On:

Cooperative research projects are those projects that involve more than one institution or site (also referred to as multi-site). Each institution or site is responsible for safeguarding the rights and welfare of human subjects. Federal regulations allow for the use of an external IRB and, under certain circumstances, mandate the use of a single IRB of record for multi-site, cooperative research projects (45 CFR 46.114 and 21 CFR 56.114).

It is the preference of GBMC that the GBMC IRB be the IRB of record and have oversight of all research conducted at GBMC; however, GBMC acknowledges that there have been instances when the use of an external or central IRB has been necessary and/or mandated to participate in proposed cooperative research. GBMC has in the past reviewed and approved cooperative research projects using an external IRB of record on a case-by-case basis.

This policy outlines the post-approval responsibilities for cooperative research projects reviewed and approved by the GBMC IRB prior to January 20, 2020.

GBMC principal investigators of previously approved cooperative research projects shall have the responsibility to comply with the IRB reliance agreement, study contract and any other applicable documents and/or determinations and requirements as dictated by the external IRB of record, lead principal investigator, coordinating center and/or study sponsor.

Even though GBMC does not provide IRB oversight when an external IRB is the IRB of record, the GBMC IRB shall remain responsible for all research that takes place at GBMC. The GBMC principal investigator shall have reporting obligations to the GBMC IRB that include but not be limited to the following:

1. Undergoing an independent annual review that shall include the submission of annual conflict of interest statements and evidence that current training in human subjects research is being maintained (See SOP Section 6.4—Independent Annual Reviews).
2. Submitting matters of local context (e.g. study team changes) for approval or acknowledgement (See SOP Section 6.6—Matters of Local Context).

3. Notifying the GBMC IRB of all adverse events, other reportable events and unanticipated problems occurring at GBMC (See SOP Section 6.7—Adverse and Other Reportable Events).
4. Notifying the GBMC IRB of protocol deviations occurring at GBMC (See SOP Section 6.8—Protocol Deviations/Violations).
5. Notifying the GBMC IRB of permanent project closures (See SOP Section 6.5—Permanent Project Closures).

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Independent Annual Reviews
Section Number: 6.4
Effective Date: January 20, 2020
Last Revision:
Replaced SOP Revised On:

The external IRB of record shall have the responsibility for conducting continuing review of ceded research projects in accordance with 45 CFR 46 (Federal Policy for the Protection of Human Subjects--Common Rule), 21 CFR 56 (Food and Drug Administration) and other regulations and laws as applicable; however, the GBMC IRB has determined that research ceded to an external IRB shall be subject to a local “independent annual review” that shall correspond with the annual continuing review performed by the external IRB of record.

At the time of GBMC IRB initial review and approval of cooperative research, all ceded projects shall be given an approval expiration date indicating when the project must undergo a local independent annual review. Independent annual review expiration dates are calculated to correspond with the approval expiration date as determined by the external IRB of record. It is the responsibility of the principal investigator to submit for an independent annual review prior to the GBMC IRB determined annual review due date or as soon as possible after receiving documentation of the external IRB’s continuing review approval.

As a courtesy, independent annual review reminder emails in the form of a “Project Expiration Reminder” shall be sent out automatically via IRBNet 60 and 30 days prior to a project’s annual review due date. If the project does not undergo an independent annual review prior to the GBMC IRB determined annual review due date, IRBNet will send a final notice on the due date of the annual review. Failure to submit for the independent annual review may result in a directive to cease all research activity until the independent annual review has been performed by the GBMC IRB.

Independent annual reviews are performed by the convened IRB.

All independent annual review submissions must be sent electronically via IRBNet as described in SOP Section 4.2—Submission Deadlines and Requirements. The electronic submission “package” for an independent annual review shall contain but not be limited to the following documents:

1. Request for independent annual review of projects with external IRB oversight
2. Conflict of interest statements from the principal investigator and all co-investigators on the study team
3. Evidence of current human subjects research training from the principal investigator, co-investigators and study coordinator

4. Copy of external IRB continuing review approval letter

Once an independent annual review has been completed, the GBMC IRB's action shall be conveyed by the IRB office staff to the principal investigator and other key project personnel as soon as possible as described in SOP Section 4.6—Notification and Documentation of Review Actions and Determinations. Independent annual review follow-up letters shall clearly state the due date for the next annual review.

IRB actions and determinations are reported back to institutional (GBMC) officials on a monthly basis in the form of meeting minutes. The minutes are submitted to the Chief Medical Officer and Signatory Official on GBMC's Federalwide Assurance. (See also SOP Section 3.5—Minutes of the Meeting)

Review Fee

The GBMC IRB shall charge a review fee of \$100 for all independent annual reviews of cooperative research using an external IRB (See SOP Section 4.3—Review Fees).

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Permanent Project Closures
Section Number: 6.5
Effective Date: January 20, 2020
Last Revision:
Replaced SOP Revised On:

Principal investigators have the responsibility of informing the GBMC IRB when a project ceded to an external IRB of record has been completed. The GBMC IRB requests that, upon the completion of a project, a “Request for Review of Project Closure (Permanent)” form be submitted as a final report.

All closure of project submissions shall be reviewed by the convened GBMC IRB and acknowledged. The IRB’s acknowledgement shall be formally conveyed by the IRB office staff to the principal investigator and other key project personnel as soon as possible after the convened meeting as described in SOP Section 4.6—Notification and Documentation of Review Actions and Decisions. IRB office records shall be coded to indicate that the project is now permanently closed.

Once a project is permanently closed, the IRB shall retain individual project files for six years. Once the six year retention time frame has elapsed, the project files (both hard copy and those maintained electronically in IRBNet) shall be permanently deleted and/or destroyed.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Matters of Local Context
Section Number: 6.6
Effective Date: January 20, 2020
Last Revision:
Replaced SOP Revised On:

Principle investigators have the responsibility of submitting to the GBMC IRB for review all changes in research that are matters of local context. Matters of local context include but are not limited to the following:

1. Project team changes
2. Revisions/amendments
3. Updates/reports

The GBMC IRB requests that the matters of local context be submitted using a “Request for Review of Matters of Local Context” form. All matters of local context shall be reviewed by the convened GBMC IRB.

When matters of local context requiring a vote are reviewed by the convened IRB, a primary reviewer shall be appointed. The IRB Assistant shall assign each matters of local context submission to a qualified IRB member for review. The IRB member shall summarize and present the nature of the local matter to the convened IRB. The IRB Assistant shall not assign a matters of local context submission to any IRB member who has a conflicting interest in the local matter and/or project undergoing review.

All decisions made by the GBMC IRB regarding a submission for matters of local context shall be conveyed by the IRB office staff to the principal investigator and other key project personnel as soon as possible as described in SOP Section 4.6—Notification and Documentation of Review Actions and Determinations.

IRB actions and determinations are reported back to institutional (GBMC) officials on a monthly basis in the form of meeting minutes. The minutes are submitted to the Chief Medical Officer and Signatory Official on GBMC’s Federalwide Assurance. (See also SOP Section 3.5—Minutes of the Meeting)

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Adverse and Other Reportable Events
Section Number: 6.7
Effective Date: January 20, 2020
Last Revision: April 21, 2025
Replaced SOP Revised On:

Federal regulations 45 CFR 46.108(a)(4) and 21 CFR 56.108(b)(1-3) require the IRB to follow written procedures for ensuring the prompt reporting to the IRB, appropriate institutional officials, and governmental departments and/or agency heads of any:

5. unanticipated problems involving risks to subjects or others
6. serious or continuing noncompliance with Federal regulations
7. serious or continuing noncompliance with requirements or determinations of the IRB
8. suspension or termination of IRB approval

This policy outlines the procedures for prompt reporting to the GBMC IRB of adverse events, unanticipated problems and all other reportable events.

All reporting requirements of the external IRB of record and/or the overall principal investigator's participating institution shall also be followed as dictated in all applicable agreements and/or contracts.

Definitions

Adverse Event (AE): An AE is defined as “any untoward or unfavorable medical occurrence in a human subject, including any abnormal sign (for example, abnormal physical exam or laboratory finding), symptom, or disease, temporally associated with the subject’s participation in the research, whether or not considered related to the subject’s participation in the research. Adverse Events encompass both physical and psychological harms. They occur most commonly in the context of biomedical research, although on occasion, they can occur in the context of social and behavioral research.”

Serious Adverse Event (SAE): A SAE is defined as “any adverse event temporally associated with the subject’s participation in research that meets any of the following criteria:

7. results in death;
8. is life-threatening (places the subject at immediate risk of death from the event as it occurred);
9. requires inpatient hospitalization or prolongation of existing hospitalization;
10. results in a persistent or significant disability/incapacity;
11. results in a congenital anomaly/birth defect; or

12. any other adverse event that, based upon appropriate medical judgment, may jeopardize the subject's health and may require medical or surgical intervention to prevent one of the other outcomes listed in this definition”

Unanticipated Problem (UP): An unanticipated problem is defined as “any incident, experience, or outcome that meets all of the following criteria:

4. unexpected (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent document; and (b) the characteristics of the subject population being studied;
5. related or possibly related to participation in the research; and
6. suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.”

Possibly related to the research means that “there is a reasonable possibility that the adverse event, incident, experience or outcome may have been caused by the procedures involved in the research”.

Internal Adverse Event: An adverse event that occurs in study participants who were enrolled through GBMC or a GBMC affiliated study site.

External Adverse Event: An adverse event that occurs in study participants who were not enrolled through GBMC or a GBMC affiliated study site.

Reporting Requirements for Internal Adverse Events

All internal adverse events that meet the above-definition of a serious adverse event or an unanticipated problem shall be reported to the GBMC IRB within 5 business days of the investigator becoming aware of the event.

All internal events that meet the above-definition of an adverse event but do not meet the above-definition of a serious adverse event or unanticipated problem shall be reported to the GBMC IRB within 10 business days of the investigator becoming aware of the event.

All internal adverse events that are reported to an outside entity (e.g. external IRB of record, sponsor, FDA) with study oversight shall be reported to the GBMC IRB within 10 business days of the investigator becoming aware of the event.

All subject deaths that occur while on study shall be reported to the GBMC IRB within 48 hours of the investigator becoming aware of the event unless the event is clearly unrelated to the study procedures or related to natural progression of a disease process.

Reporting Requirements for External Adverse Events

The “OHRP advises that it is neither useful nor necessary under the HHS regulations at 45 CFR part 46 for reports of individual adverse events occurring in subjects in multicenter studies to be distributed routinely to investigators or IRBs at all institutions conducting the research.”

Only external adverse events that meet the following criteria need to be reported to the GBMC IRB:

5. events that are determined by the sponsor to be an unanticipated problem involving risks to subjects or others
6. events that result in a modification to the protocol, informed consent document and/or investigator brochure
7. events that result in suspension of all or parts of the research
8. events that result in early termination of the research

External adverse events shall be reported to the GBMC IRB within 10 business days of the investigator becoming aware of the event.

Other Reportable Events

In addition to the above-mentioned adverse events, serious adverse events, and unanticipated problems, the GBMC IRB considers the following to be reportable events:

9. new or updated safety information relating to the study or study product
10. DSMB/DMC or other independent safety monitoring group report
11. any externally imposed suspension or termination of the research due to new or increased risks
12. a breach of confidentiality or violation of HIPAA
13. unresolved participant complaints
14. adverse external audit results or enforcement actions
15. external audit of research investigator and the outcome
16. any other problem indicating that the research places subjects or others at an increased risk of harm or otherwise adversely affects the rights, welfare or safety of subjects or others

The above mentioned other reportable events shall be reported to the GBMC IRB within 10 business days of the investigator becoming aware of the event.

For reasons of confidentiality, subject names must not be included in any reportable event submission. Subject identifiers such as enrollment numbers should be used instead.

GBMC IRB Review Process for Reported Events

All reported events shall be screened by the GBMC IRB office staff. The IRB office staff shall either place the submitted item on the agenda for the next scheduled meeting of the convened IRB or forward it to the IRB Chairperson or his designee for review.

The following internal events shall be promptly forwarded to the GBMC IRB Chairperson or his designee for immediate review:

7. Death of a subject or life-threatening circumstances
8. Serious adverse events that are unresolved
9. Unanticipated problems resulting in risks to subjects or others
10. Serious or continuing noncompliance with Federal regulations
11. Serious or continuing noncompliance with requirements or determinations of the IRB
12. Any other event involving risks to subjects or others

The IRB Chairperson or designee shall report the review findings back to the convened IRB at the next scheduled meeting. The principal investigator shall be notified of all review findings and if any corrective action is required or additional information is needed.

If the GBMC IRB determines that corrective action is necessary, the required action may include:

10. Frequent progress or status reports to the IRB
11. Suspension of all or parts of the research
12. Termination of the research
13. Other actions as determined by the IRB

If the GBMC IRB determines that the event is of a magnitude that it must be reported to other appropriate authorities, those authorities may include:

5. GBMC institutional officials
6. External IRB of record
7. The Office for Human Research Protection (OHRP)
8. The Food and Drug Administration (FDA)
9. Other governmental departments or agency heads as appropriate

The IRB Coordinator shall be responsible for notifying the following GBMC officials regarding the reportable event within 5 business days of the IRB's determination:

4. Chief Medical Officer
5. Vice President for Legal Affairs and General Counsel
6. Vice President for Quality and Patient Safety

The IRB Chairperson shall be responsible for notifying all appropriate governmental departments and/or agencies within 15 business days of GBMC officials being notified of the reportable event unless otherwise dictated in the IRB reliance agreement. A copy of all correspondence and/or reports shall be forwarded to the above-mentioned GBMC officials.

[All quoted passages within this policy have been taken from the OHRP “Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events” dated 1/15/07]

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Protocol Deviations/Violations
Section Number: 6.8
Effective Date: January 20, 2020
Last Revision:
Replaced SOP Revised On:

As previously stated in Section 6.7—Adverse and Other Reportable Events--Federal regulations 45 CFR 46.108(a)(4) and 21 CFR 56.108(b)(1-3) require the IRB to follow written procedures for ensuring the prompt reporting to the IRB, appropriate institutional officials, and governmental departments and/or agency heads of any:

9. unanticipated problems involving risks to subjects or others
10. serious or continuing noncompliance with Federal regulations
11. serious or continuing noncompliance with requirements or determinations of the IRB
12. suspension or termination of IRB approval

This policy outlines the procedures for prompt reporting to the GBMC IRB.

All reporting requirements of the external IRB of record and/or the overall principal investigator's participating institution shall also be followed as dictated in all applicable agreements and/or contracts.

The term "protocol deviation" is not defined by either OHRP human subjects regulations (45 CFR 46) or FDA human subjects regulations (21 CFR 50). For GBMC IRB purposes, a protocol deviation is any modification or departure from the defined procedures and treatment plans set forth in the IRB-approved protocol.

Protocol deviations/violations range in seriousness according to how the changes may impact subject safety. The GBMC IRB has divided protocol deviations/violations into two categories—major and minor.

A major protocol deviation/violation is defined as any change that may impact subject safety or alter the risk/benefit ratio, compromise the integrity of the study data, and/or affect a subject's willingness to participate in the study. Major protocol deviations/violations include but are not limited to the following:

- Enrollment of a subject before IRB approval of study
- Enrollment of a subject after IRB approval of study has expired
- Enrollment of a subject who did not meet inclusion/exclusion criteria
- Failure to obtain informed consent prior to initiating study procedures
- Inappropriate documentation of informed consent (e.g. missing subject signature)

- Use of a non-IRB approved informed consent
- Use of an invalid informed consent (e.g. outdated version)
- Failure to perform a study specific procedure (impacting subject safety)
- Out of window visit and/or procedure (impacting subject safety)
- Performing study procedures not approved by the IRB
- Drug/study medication dispensing or dosing error
- Incorrect storage/handling of study drug/medication, biological samples, etc.
- Loss or destruction of samples or data
- Failure to follow protocol safety and monitoring requirements
- Any lapse in study approval where there is a continuation of research activities
- Any event requiring prompt reporting according to the protocol or IRB of record
- Any other deviation impacting subject safety

A minor protocol deviation/violation is defined as a one-time change that does not significantly affect the safety of the subject. Minor protocol deviations/violations include but are not limited to the following:

- Use of recruitment method and/or material not approved by the IRB
- Missing original signed and dated informed consent (copy available)
- Copy of signed informed consent not given to subject
- Missing pages of executed informed consent
- Failure to perform a study specific procedure (not impacting subject safety)
- Out of window visit and/or procedure (not impacting subject safety)
- Failure of subject to return unused study drug/medication
- Improper investigational product accountability
- Failure to follow Federal regulations
- Failure to follow requirements or determinations of the GBMC IRB and/or external IRB of record

Minor protocol deviations/violations that occur repetitively may be determined to be a major deviation by the GBMC IRB and require corrective action.

All major protocol deviations/violations shall be reported to the GBMC IRB within 5 business days of the investigator becoming aware of the event.

All major protocol deviations/violations resulting in the death of a subject shall be reported to the GBMC IRB within 48 hours of the investigator becoming aware of the event.

All minor protocol deviations/violations shall be submitted to the GBMC IRB on an individual basis or no less than every quarter (every 90 days) in the form of a summary report.

All emergency situations involving the implementation of a non-IRB approved protocol deviation to eliminate apparent immediate hazards to a subject shall be reported to the GBMC IRB within 48 hours of the event taking place.

Protocol deviations/violations that occur at a non-GBMC affiliated site in a multi-center research study do not need to be reported to the GBMC IRB.

All protocol deviations/violations shall be screened by the GBMC IRB office staff. The IRB office staff shall either place the submitted item on the agenda for the next scheduled meeting of the convened GBMC IRB or forward it to the IRB Chairperson or his designee for review.

The following protocol deviations/violations shall be promptly forwarded to the GBMC IRB Chairperson or his designee for immediate review:

1. All major deviations/violations that could possibly be classed as a:
 - a. serious noncompliance,
 - b. continuing noncompliance, or
 - c. unanticipated problem involving risks to subjects or others
2. All major deviations/violations resulting in the death of a subject
3. All deviations/violations being conducted under an emergency situation

The GBMC IRB Chairperson or his designee shall report the review findings back to the convened IRB at the next scheduled meeting. The principal investigator shall be notified of all review findings and if any corrective action is required or additional information is needed.

If the GBMC IRB determines that corrective action is necessary, the required action may include:

14. Monitoring of the informed consent process
15. Re-consenting of currently enrolled subjects
16. Monitoring of research activities
17. Suspension of all or parts of the research
18. Termination of the research
19. Other actions as determined by the IRB

If the GBMC IRB determines that the event is of a magnitude that it must be reported to other appropriate authorities, those authorities may include:

10. GBMC institutional officials
11. External IRB of record
12. The Office for Human Research Protection (OHRP)
13. The Food and Drug Administration (FDA)
14. Other governmental departments or agency heads as appropriate

The IRB Coordinator shall be responsible for notifying the following GBMC officials regarding the reportable event within 5 business days of the IRB's determination:

7. Chief Medical Officer
8. Vice President for Legal Affairs and General Counsel
9. Vice President for Quality and Patient Safety

The IRB Chairperson shall be responsible for notifying all appropriate governmental departments and/or agencies within 15 business days of GBMC officials being notified of the reportable event unless otherwise dictated in the IRB reliance agreement. A copy of all correspondence and/or reports shall be forwarded to the above-mentioned GBMC officials.

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Post-Approval Monitoring (PAM) Overview
Section Number: 9.1
Effective Date: January 1, 2025
Last Revision:
Replaced SOP Revised On:

An IRB has the authority to “approve, require modifications in (to secure approval), or disapprove all research activities” [45 CFR 46.109(a) and 21 CFR 56.109(a)]. Furthermore, an IRB has the authority to “suspend or terminate approval of research that is not being conducted in accordance with the IRB’s requirements or that has been associated with unexpected serious harm to subjects” [45 CFR 46.113 and 21 CFR 56.113].

When a research project is reviewed and approved by an IRB, it is the responsibility of the principal investigator to comply with the provisions of the IRB-approved protocol and adhere to all federal regulations, state and local laws, GBMC institutional policies, and GBMC IRB specific policies governing human subject research. To ensure that compliance is maintained, GBMC has in place a Post-Approval Monitoring (PAM) Program where internal audits of research projects are conducted.

The purpose of GBMC’s PAM Program is to monitor protocol and regulatory compliance, identify areas for improvement, provide tools for maintaining compliance, and take corrective action when necessary.

The GBMC IRB is responsible for all research that takes place at GBMC and has oversight of GBMC’s PAM Program. Audits are performed by an IRB Office staff member and/or IRB committee member.

GBMC’s PAM Program applies to the following:

- Research projects that are reviewed and approved by the GBMC IRB with the GBMC IRB being the IRB of record
- Research projects that are reviewed and approved by the GBMC IRB but are ceded to an external IRB with the external IRB being the IRB of record

There are two types of PAM audits:

- Not-for-cause
- For-cause

Not-for-cause audits are routine, targeted audits. All currently active research projects have the potential for being audited if certain prioritized criteria are met [See SOP Section 9.2—Post-Approval Monitoring (PAM) Not-for-Cause Audits].

For-cause audits are directed audits that generally take place due to concerns regarding research protocol compliance, and/or research subject rights and welfare. A for-cause audit may also be initiated due to complaints, repeated errors, or a lack of responsiveness by the principal investigator to GBMC IRB requests. GBMC recognizes the following two individuals as having the authority to determine the need and to call for a for-cause audit:

- GBMC IRB Chairperson
- GBMC Chief Medical Officer

Not-for-cause audits are performed on a quarterly basis. For-cause audits can take place at any time.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Post-Approval Monitoring (PAM) Not-for-Cause Audits
Section Number: 9.2
Effective Date: January 1, 2025
Last Revision:
Replaced SOP Revised On:

Introduction

After a research project is reviewed and approved by an IRB, there is the expectation that the principal investigator will comply with the provisions of the IRB-approved protocol and adhere to all federal regulations, state and local laws, GBMC institutional policies, and GBMC IRB specific policies governing human subject research. As a way of monitoring compliance, GBMC has in place a Post-Approval Monitoring (PAM) Program where internal audits of research projects are conducted.

There are two types of audits:

- Not-for-cause
- For-cause

This policy describes the process and outlines the procedures to be followed for conducting not-for-cause audits at GBMC.

Not-for-cause audits are routine, targeted audits.

Not-for-cause audits are conducted on a quarterly basis beginning with January of the calendar year. The goal is to audit a minimum of eight (two per quarter) research projects per calendar year that are currently active with subjects enrolled. A principal investigator shall have no more than one research project audited per calendar year.

Selection Process for Not-for Cause Audits

Research projects to be audited are selected at the discretion of the IRB Coordinator using, but not limited to, any of the following criteria where the project:

- Is IRB-approved (by either the GBMC IRB or an external IRB of record)
- Is active and ongoing
- Is prospective (retrospective projects are excluded from not-for-cause audits)
- Has subjects currently enrolled
- Involves the enrollment of minors
- Involves the enrollment of individuals with impaired decision-making capacity

- Involves the enrollment of vulnerable populations
- Is investigator-initiated
- Has a new and/or inexperienced principal investigator
- Has a new and/or inexperienced project coordinator
- Has had IRB determinations requiring a specific action(s) in response
- Has been audited before with recommendations for improvement

Not all criteria must be met to be selected for a not-for-cause audit.

Not-for-cause audits are not conducted on projects that have been exempted from IRB oversight or determined to be not human subject research.

Notification of and Preparation for a Not-for-Cause Audit

Once a research project has been selected to undergo a not-for-cause audit, the IRB Coordinator shall notify the principal investigator and project coordinator of the impending audit in writing. The notifying correspondence shall identify the research project that has been selected for auditing and include a request to schedule the audit at a mutually agreeable time. The audit shall take place within 30 days from the date of the initial notification correspondence, unless a delay is requested.

If the principal investigator would like to request a delay, the principal investigator shall have five (5) business days (after receipt of initial notification correspondence) to request a delay in writing.

Requests for delay shall be reviewed by the IRB Chairperson and a final decision made within five (5) business days. The IRB Coordinator shall notify the principal investigator in writing, as soon as possible, after the decision is made.

If the IRB Chairperson has a conflict of interest with the research project to be audited, the request for delay shall be given to the IRB Vice Chairperson.

The IRB Coordinator shall supply the principal investigator and project coordinator with a copy of the “Post-Approval Monitoring Audit Checklist” that will be used as a guide for conducting the audit. The checklist shall be supplied as an attachment to the initial correspondence notifying the principal investigator and project coordinator of the impending audit. The checklist may be used by the principal investigator as a means of preparing for the audit.

It is the responsibility of the principal investigator (or designee) to ensure that the individual conducting the audit has access to all relevant information (e.g. study files, regulatory documentation) pertaining to the research project at time of audit. This may include, but is not limited, to the following:

- Project contracts and/or other applicable agreements
- Documentation of a Site Initiation Visit

- Proof that subjects have met eligibility requirements
- Screening and enrollment log
- Subject (signed) informed consent forms
- Subject (signed) HIPAA research authorization forms (if standalone)
- Sponsor correspondence relating to amendments and revisions
- Adverse event reports submitted to the sponsor
- Protocol deviation reports submitted to the sponsor
- Investigational product (drug or device) administration and accountability records
- Subject withdrawal or drop out documentation
- Subject payment/compensation accounting documentation
- Delegation of Authority Log
- FDA Form 1572 – Statement of Investigator
- Project team personnel curriculum vitae
- Project team personnel evidence of project specific training
- Project team personnel evidence of Good Clinical Practice training
- Project team personnel evidence of licensure
- Computer files pertaining to the research project being audited

On the day of the audit, the principal investigator (or designee) shall make available to the auditor a conference room or quiet area for use while conducting the audit. The principal investigator shall appoint a designated individual to be available to the auditor to assist with documentation retrieval, answer any questions or provide clarification as needed throughout the course of the audit.

Prior to the day of the audit, the IRB Coordinator shall make known to the principal investigator and study coordinator who the auditor will be. Not-for-cause audits are performed by an IRB Office staff member and/or IRB committee member.

Not-for-Cause Audit Completion and Distribution of Final Report

Once a not-for-cause audit has been conducted and completed, the IRB Coordinator shall review the audit findings and prepare a summary report to include, as needed, recommendations for improvement and/or the identification of deficiencies requiring corrective action. The report shall be given to the IRB Chairperson for review within five (5) business days of audit completion. If the IRB Chairperson has a conflict of interest with the research project being audited, the report shall be given to the IRB Vice Chairperson.

The IRB Chairperson shall have five (5) business days to review the report. The IRB Chairperson can either approve the report as written or request revisions be made to the document. The IRB Coordinator shall make any requested revisions to the report within five (5) business days. Once the report has received final approval from the IRB Chairperson, the IRB Coordinator shall send the finalized report to the principal investigator and project coordinator.

The final report shall be distributed to the convened IRB at the next scheduled meeting.

Post-Audit Findings and Results

If no deficiencies are identified in the final audit report, no response is required by the principal investigator.

If recommendations for improvement are made in the final report, the principal investigator is not obligated to formally respond to the recommendations.

If deficiencies are identified in the final report requiring responsive action, the principal investigator shall have ten (10) business days (after receipt of the final report) to respond in writing with a corrective action plan for resolving the identified deficiencies.

If the principal investigator disagrees with the audit findings as presented in the final report, the principal investigator shall have five (5) business days (after receipt of the final report) to make an appeal in writing.

Appeals shall be reviewed by the IRB Chairperson and a final decision made within five (5) business days. The IRB Coordinator shall notify the principal investigator in writing, as soon as possible, after the decision is made.

If the IRB Chairperson has a conflict of interest with the research project being audited, the appeal request shall be given to the IRB Vice Chairperson for review and determination.

If the audit identifies a matter of serious or continuing protocol noncompliance and/or a serious concern relating to a research subject's rights and welfare, the research project may be suspended in whole or in part until the identified issue(s) can be resolved.

Audit Completion and Close-Out

An audit shall be considered complete and closed-out once all deficiencies identified in the final report are addressed and resolved and no further audit-related activities are necessary. The IRB Coordinator shall notify the principal investigator in writing when it has been determined that the audit is complete.

If no deficiencies are identified in the final audit report, the principal investigator shall be informed in the initial post-audit correspondence that the audit is complete with no further action being necessary.

Research projects that have undergone an audit with deficiencies identified may be subject to future targeted audits to further monitor compliance.

Filing and Storage of Audit Results and Documentation

The IRB Office shall keep on file indefinitely (or until the research project's file is purged) all documentation relating to the audit to include but not be limited to:

- Pre-audit notification correspondence
- Audit checklist
- Final audit report
- Post-audit correspondence
- Corrective action plans, if required

In addition to the hard-copy audit file maintained in the IRB Office, the IRB Coordinator shall create a special event package in the research project's electronic file in IRBNet. At a minimum, the following documents will be uploaded into the special event package:

- Post-audit correspondence
- Final audit report

The principal investigator is responsible for keeping their own documentation of the audit in their research project records.

Failure to Cooperate with the Performance of an Audit

Principal investigators and research project team members are expected to fully cooperate with a Post-Approval Monitoring (PAM) audit. Failure to cooperate with an audit shall be considered a serious non-compliance with GBMC IRB policy.

Failure to cooperate may include but not be limited to:

- Refusal and/or failure to respond to initial notifications and communications requesting that an audit be scheduled
- Refusal and/or failure to make all necessary and/or requested documents and records available for review and use during an audit
- Denying access to areas where project procedures and activities are conducted
- Refusal and/or failure to respond to post-audit communications
- Refusal and/or failure to submit corrective action plans, if required
- Other actions that delay or prevent an audit from taking place or being conducted

Failure to cooperate may result in disciplinary action and/or suspension or termination of the research project being audited.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Post-Approval Monitoring (PAM) For-Cause Audits
Section Number: 9.3
Effective Date: January 1, 2025
Last Revision:
Replaced SOP Revised On:

Introduction

After a research project is reviewed and approved by an IRB, there is the expectation that the principal investigator will comply with the provisions of the IRB-approved protocol and adhere to all federal regulations, state and local laws, GBMC institutional policies, and GBMC IRB specific policies governing human subject research. As a way of monitoring compliance, GBMC has in place a Post-Approval Monitoring (PAM) Program where internal audits are conducted.

There are two types of audits:

- Not-for-cause
- For-cause

This policy describes the process and outlines the procedures to be followed for conducting for-cause audits at GBMC.

For-cause audits are directed audits that generally take place due to concerns regarding identified or suspected serious protocol non-compliance and/or research subject rights and welfare. A for-cause audit may also be initiated in cases where there are unresolved complaints, continuing non-compliance with GBMC IRB policies and procedures, or a lack of compliance with GBMC IRB determinations.

For-cause audits may be conducted at any time, with little notice to the principal investigator.

Selection Process for For-Cause Audits

GBMC recognizes the following two individuals as having the authority to request a for-cause audit:

- GBMC IRB Chairperson
- GBMC Chief Medical Officer

Indications for a for-cause audit include, but are not limited to:

- Serious and/or continuing non-compliance with the IRB-approved protocol

- Serious and/or continuing non-compliance with GBMC IRB policies
- Serious and/or continuing non-compliance with GBMC IRB determinations
- Serious and/or continuing unanticipated problems involving risk to subjects or others
- Unresolved subject complaints
- Whistleblower complaints that require investigation

All research conducted at GBMC can be subject to a for-cause audit. This includes:

- Active research projects under the oversight of the GBMC IRB
- Active research projects under the oversight of an external IRB
- Research projects that have been permanently closed
- Both prospective and retrospective research projects
- Research projects determined to be exempt from IRB oversight

For-cause audits are not conducted on projects that have been determined to be not human subject research.

Notification of and Preparation for a For-Cause Audit

Once a for-cause audit has been formally requested, the IRB Coordinator shall notify the principal investigator and project coordinator of the impending audit in writing. The correspondence shall identify the research project that is under investigation and the reason(s) for the audit. The audit shall take place within three business days from the date of the notifying correspondence. It is not acceptable to request a delay for a for-cause audit.

The IRB Coordinator shall supply the principal investigator with a list of relevant information (e.g. study files, regulatory documentation) pertaining to the research project in question to be supplied at time of audit. It is the responsibility of the principal investigator to make certain that the requested information is available at time of audit.

On the day of the audit, the principal investigator (or designee) shall make available to the auditor a conference room or quiet area for use while conducting the audit. The principal investigator shall appoint a designated individual to be available to the auditor to assist with documentation retrieval, answer any questions or provide clarification as needed throughout the course of the audit.

For-cause audits are conducted by the IRB Coordinator and/or IRB committee member.

For-Cause Audit Completion and Distribution of Final Report

Once a for-cause audit has been conducted and completed, the IRB Coordinator shall review the audit findings and prepare a summary report to include, as needed, recommendations for improvement and/or the identification of deficiencies requiring corrective action. The report shall be given to the IRB Chairperson for review within five (5) business days of audit completion with a copy given to GBMC's Chief Medical Officer. If the IRB Chairperson has a

conflict of interest with the research project being audited, the report shall be given to the IRB Vice Chairperson.

The IRB Chairperson shall have five (5) business days to review the report. The IRB Chairperson can either approve the report as written or request revisions be made to the document. The IRB Coordinator shall make any requested revisions to the report within five (5) business days. Once the report has received final approval from the IRB Chairperson, the IRB Coordinator shall send the finalized report to the principal investigator and project coordinator.

The final report shall be distributed to the convened IRB at the next scheduled meeting.

Post-Audit Findings and Results

If the final audit report does not identify any deficiencies or other matters relating to the reason(s) for the for-cause audit, no response is required by the principal investigator.

If the final audit report identifies deficiencies or other matters relating to the reason(s) for the for-cause audit and the identified issues involve serious or continuing non-compliance and/or serious concerns relating to a research subject's rights and welfare, the research project may be suspended in whole or in part until the identified issue(s) can be resolved

The principal investigator shall have ten (10) business days (after receipt of the final report) to respond in writing with a corrective action plan for resolving the identified deficiencies.

If the principal investigator disagrees with the audit findings as presented in the final report, the principal investigator shall have ten (10) business days (after receipt of the final report) to make an appeal in writing.

Appeals shall be reviewed by the IRB Chairperson and a final decision made within five (5) business days. The IRB Coordinator shall notify the principal investigator in writing, as soon as possible, after the decision is made.

If the IRB Chairperson has a conflict of interest with the research project being audited, the appeal request shall be given to the IRB Vice Chairperson for review and determination.

Audit Completion and Close-Out

An audit shall be considered complete and closed-out once all deficiencies identified in the final report are addressed and resolved and no further audit-related activities are necessary. The IRB Coordinator shall notify the principal investigator in writing when it has been determined that the audit is complete.

If no deficiencies are identified in the final audit report, the principal investigator shall be informed in the initial post-audit correspondence that the audit is complete with no further action being necessary.

Research projects that have undergone an audit with deficiencies identified may be subject to future targeted audits to further monitor compliance.

Filing and Storage of Audit Results and Documentation

The IRB Office shall keep on file indefinitely (or until the research project's file is purged) all documentation relating to the audit to include but not be limited to:

- Pre-audit notification correspondence
- Audit checklist
- Final audit report
- Post-audit correspondence
- Corrective action plans, if required

In addition to the hard-copy audit file maintained in the IRB Office, the IRB Coordinator shall create a special event package in the research project's electronic file in IRBNet. At a minimum, the following documents will be uploaded into the special event package:

- Post-audit correspondence
- Final audit report

The principal investigator is responsible for keeping their own documentation of the audit in their research project records.

Failure to Cooperate with the Performance of an Audit

Principal investigators and research project team members are expected to fully cooperate with a Post-Approval Monitoring (PAM) audit. Failure to cooperate with an audit shall be considered a serious non-compliance with GBMC IRB policy.

Failure to cooperate may include but not be limited to:

- Refusal and/or failure to respond to initial notifications and communications requesting that an audit be scheduled
- Refusal and/or failure to make all necessary and/or requested documents and records available for review and use during an audit
- Denying access to areas where project procedures and activities are conducted
- Refusal and/or failure to respond to post-audit communications
- Refusal and/or failure to submit corrective action plans, if required
- Other actions that delay or prevent an audit from taking place or being conducted

Failure to cooperate may result in disciplinary action and/or suspension or termination of the research project being audited.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: Grounds for Suspension or Termination of Research
Section Number: 10.1
Effective Date: January 1, 2005
Last Revision: May 19, 2025
Replaced SOP Revised On:

The GBMC IRB has the authority to “suspend or terminate approval of research that is not being conducted in accordance with the IRB’s requirements or that has been associated with unexpected serious harm to subjects” as stated in 45 CFR 46.113 and 21 CFR 56.113.

Research that has been reviewed and approved by the IRB may be subject to further review and approval or disapproval by GBMC officials. However, those officials may not approve research if it has been disapproved by the IRB (45 CFR 46.112 and 21 CFR 56.112).

This policy outlines the procedures to be followed to suspend or terminate some or all of an IRB-approved research project.

This policy applies to the following:

- Research projects that are reviewed and approved by the GBMC IRB with the GBMC IRB being the IRB of record
- Research projects that are reviewed and approved by the GBMC IRB but are ceded to an external IRB with the external IRB being the IRB of record

Definitions

Suspension: Suspension means that a temporary halt has been placed on some or all activities relating to a research project until a determination is made that the research may recommence or be terminated. Suspended research projects remain open/active and are subject to continuing or independent annual reviews.

Termination: Termination means that approval for a research project has been withdrawn with the research project being administratively closed out by the IRB. All research activities must cease, except for any follow-up activities necessary for subject safety. Terminated research projects are no longer subject to continuing or independent annual reviews.

Research projects may be suspended in whole or in part or terminated based on but not limited to the following:

- Serious and/or continuing non-compliance with the IRB-approved protocol
- Serious and/or continuing non-compliance with GBMC IRB policies
- Serious and/or continuing non-compliance with GBMC IRB determinations
- Serious events involving risk to or leading to the death of a subject
- Unresolved complaints made by a subject or others
- Adverse GBMC internal not-for-cause or for-cause audit findings

All decisions to suspend a research project, in whole or in part, shall be made by:

- The fully convened GBMC IRB, after a full investigation and review of the circumstances warranting the suspension, or
- The GBMC IRB Chairperson or Vice Chairperson, in an emergency situation.

Any suspensions of research made by the GBMC IRB Chairperson or Vice Chairperson, in an emergency situation, shall be reported back to the convened IRB at the next scheduled meeting. The convened IRB shall review the circumstances warranting the suspension and make one of the following three decisions:

1. Lift the suspension and reinstate full approval to the research project
2. Continue the suspension, pending specific corrective actions
3. Terminate the research project

All decisions to terminate a research project shall be made by the GBMC IRB at a convened meeting.

All decisions made by the convened IRB shall be made by a majority vote of the members present. If a member of the convened IRB has a conflict of interest with the research project being reviewed, they shall abstain from participating in the review and voting processes.

GBMC's Executive Vice President and Chief Medical Officer who serves as the GBMC IRB Signatory and Institutional Official has the authority to terminate a research project for institutional reasons in consultation with the GBMC IRB Chairperson. Any termination decisions made by the GBMC Chief Medical Officer shall be reported back to the convened IRB at the next scheduled meeting,

Terminated research projects shall be administratively closed by the GBMC IRB at a convened meeting. Projects that are administratively closed by the IRB cannot be reopened. To resume research activities, the project must be resubmitted in its entirety.

All determinations and actions shall be documented in the IRB meeting minutes as described in SOP Section 3.5—Minutes of the Meeting.

GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)

Name of SOP: Notification of Suspension or Termination of Research
Section Number: 10.2
Effective Date: January 1, 2005
Last Revision: June 16, 2025
Replaced SOP Revised On:

The GBMC IRB has the authority to “suspend or terminate approval of research that is not being conducted in accordance with the IRB’s requirements or that has been associated with unexpected serious harm to subjects” as stated in 45 CFR 46.113 and 21 CFR 56.113.

This policy outlines the procedures to be followed once a decision has been made to suspend or terminate a currently active research project as described in SOP Section 10.1—Grounds for Suspension or Termination of Research.

Once a decision has been made by the GBMC IRB to suspend or terminate a currently active research project, the IRB Coordinator shall notify the principal investigator within 24 hours.

The notification for a suspension shall include but not be limited to:

- A statement explaining the basis for the suspension
- What, if any, research project activities may continue
- The actions to be taken to have full approval reinstated
- Instructions on how to appeal the decision, if in disagreement

The notification for a termination shall include but not be limited to:

- A statement explaining the basis for the termination
- Instructions on how to appeal the decision, if in disagreement

When a currently active research project is suspended or terminated by the convened GBMC IRB, in addition to the stopping of some or all research activities, it shall be required that currently enrolled subjects be notified that the project has been suspended or terminated. The principal investigator shall prepare and submit to the IRB for review a proposed letter or telephone script notifying currently enrolled subjects of the suspension or termination of the research project and any subsequent procedures to be followed. The proposed letter or telephone script must be submitted within 10 days from the date of the IRB’s decision notification letter to suspend or terminate the research project.

If the principal investigator disagrees with the suspension or termination decision made by the GBMC IRB, he/she may make an appeal to the IRB. The appeal must be submitted within 10 days from the date of the decision notification letter. The appeal correspondence must contain the rationale for the appeal and include any supporting information and/or documentation. The IRB office staff shall place the appeal request on the agenda for the next scheduled meeting of the convened IRB. The principal investigator may be required to attend the meeting to present his/her appeal to the IRB and be available to answer questions.

The IRB shall take one of the following three actions after considering the appeal:

4. Approve the appeal as presented
5. Approve the appeal as presented with conditions
6. Disapprove/not approve the appeal

The IRB's action in response to the appeal shall be conveyed by the IRB office staff to the principal investigator as soon as possible after the convened meeting of the IRB.

If the IRB determines that the events surrounding the suspension or termination of a research project are of a magnitude that they must be reported to other appropriate authorities, those authorities may include:

15. GBMC institutional officials
16. The Office for Human Research Protection (OHRP)
17. The Food and Drug Administration (FDA)
18. Other governmental departments or agency heads as appropriate

[Numbers 2, 3 and 4 above shall not be applied to non-Federally funded, non-FDA regulated research initially approved by the GBMC IRB on or after January 21, 2019]

The IRB Coordinator shall be responsible for notifying the following GBMC officials regarding the reportable event within 5 business days of the IRB's determination:

10. Chief Medical Officer
11. Vice President for Legal Affairs and General Counsel
12. Vice President for Quality and Patient Safety

The IRB Chairperson shall be responsible for notifying all appropriate governmental departments and/or agencies within 15 business days of GBMC officials being notified of the reportable event. A copy of all correspondence and/or reports shall be forwarded to the above-mentioned GBMC officials.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: IRB Records Retention Overview
Section Number: 11.1
Effective Date: January 1, 2005
Last Revision: August 18, 2025
Replaced SOP Revised On:

The GBMC IRB prepares and maintains records in accordance with 45 CFR 46.115 and 21 CFR 56.115.

The records that the GBMC IRB prepares and maintains include but are not limited to:

- Files of projects under the oversight of the GBMC IRB
- Files of projects under the oversight of an external IRB
- Documentation of expedited reviews performed by the GBMC IRB
- Files of projects determined to be exempt from IRB oversight
- Files of projects determined to be not human subjects research
- Documentation of continuing and independent annual reviews
- Principal investigator curricula vitae
- Minutes of IRB meetings
- IRB meeting agendas
- Rosters of IRB members
- IRB member annual conflict of interest statements
- FCOI—CFR Title 42, Part 50, Subpart F—documentation and tracking records
- GBMC IRB standard operating policies and procedures (SOPs)
- Documentation of internal post-approval monitoring (PAM) audits
- Documentation of external FDA audits of GBMC IRB
- Documentation of reliance with external IRBs
- SMART IRB documentation
- CIRB Annual Signatory Institution Worksheets
- Darwin and Lloyd & Partners annual insurance reports
- Review fee schedules and payment records
- Project tracking lists containing current and historical data
- IRBNet administrative documents
- IRBNet monthly reports
- IRBNet submission form templates

- IRBNet letter templates

The GBMC IRB maintains records in both printed and electronic formats and can be made “accessible for inspection and copying by authorized representatives” of the federal government (e.g. OHRP, FDA) at “reasonable times and in a reasonable manner” [45 CFR 46.115(b) and 21 CFR 56.115(b)].

In addition to representatives of the federal government, the GBMC IRB records are accessible to the IRB Office staff, members of the GBMC IRB, GBMC’s Executive Vice President/Chief Medical Officer, and other institutional officials as appropriate. All other individuals and requests to access IRB records, shall be screened by the IRB Coordinator on a case-by-case basis.

This policy (Section 11.1—IRB Records Retention Overview) and the three other policies in this SOP section (Section 11) listed below do not address the recordkeeping responsibilities of the individual principal investigators:

- Section 11.2—IRB Office Files
- Section 11.3—IRBNet and the Storage of Research Project Files
- Section 11.4—IRB Standard Operating Policies and Procedures (SOPs)

It is the principal investigator’s responsibility to maintain adequate records in accordance with Federal regulations and guidance and sponsor requirements.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: IRB Office Files
Section Number: 11.2
Effective Date: August 18, 2025
Last Revision:
Replaced SOP Revised On:

IRB Office files are defined as files that are necessary for maintaining the daily operations of the IRB Office and Institutional Review Board. IRB Office files consist of both current and historical documents and records.

The IRB Office files are maintained by the IRB Office staff in both electronic and hard copy formats:

- Electronic files are stored on the dedicated IRB Office I drive.
- Hard copy files are stored in file cabinets located in the IRB Office

The following table lists the primary records that are maintained by the IRB Office staff:

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Record Type	Format	Retention Period
Research project files dated 3/11/13 or older (IRBNet go live date)	Hard copy	Minimum of six years after project has been permanently closed
Principal investigator curricula vitae	Electronic	Indefinitely
Minutes of IRB meetings	Electronic and hard copy	Indefinitely
IRB meeting attendance sheets	Hard copy	Indefinitely
Rosters of IRB members	Electronic	Indefinitely
IRB member conflict of interest statements	Hard copy	Indefinitely
Individual IRB member files	Hard copy	Indefinitely
FCOI—CFR Title 42, Part 50, Subpart F—documentation and tracking records	Electronic and hard copy	Indefinitely
GBMC IRB standard operating policies and procedures (SOPs)	Electronic and hard copy	Indefinitely
Documentation of internal post-approval monitoring (PAM) audits	Electronic and hard copy	Minimum of six years after project has been permanently closed
Documentation of external FDA audits of GBMC IRB	Electronic and hard copy	Indefinitely
Documentation of reliance with external IRBs	Electronic and hard copy	Minimum of six years after project has been permanently closed
SMART IRB documentation	Electronic and hard copy	Indefinitely
CIRB Annual Signatory Institution Worksheets	Electronic and hard copy	Indefinitely
Darwin and Lloyd & Partners annual insurance reports	Electronic	Indefinitely
Review fee schedules and payment records	Electronic and hard copy	Indefinitely
Project tracking lists containing current and historical data	Electronic	Indefinitely
IRBNet administrative documents	Electronic and hard copy	Indefinitely
IRBNet submission form templates	Electronic	Indefinitely
IRBNet letter templates	Electronic	Indefinitely

This policy does not address the maintenance and retention of project files in IRBNet (See SOP Section 11.3—IRBNet and the Storage of Research Project Files).

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: IRBNet and the Storage of Research Project Files
Section Number: 11.3
Effective Date: August 18, 2025
Last Revision:
Replaced SOP Revised On:

GBMC uses IRBNet for the electronic administration and management of its IRB. All submissions for review by the IRB must be sent electronically via IRBNet. Paper submissions are not accepted. (See SOP Section 4.2—Submission Deadlines and Requirements).

GBMC went live with IRBNet on March 3, 2013. Prior to that date, all research project files were maintained in hard copy. All research projects active at time of going live were transitioned to IRBNet.

All research project files dating after March 3, 2013 are stored electronically in IRBNet.

IRBNet is used to store multiple files and documents in addition to research project files. The documents housed in IRBNet include but are not limited to:

- Files of projects under the oversight of the GBMC IRB
- Files of projects under the oversight of an external IRB
- Documentation of expedited reviews performed by the GBMC IRB
- Files of projects determined to be exempt from IRB oversight
- Files of projects determined to be not human subjects research
- Documentation of continuing and independent annual reviews
- Minutes of IRB meetings
- IRB meeting agendas
- Documentation of internal post-approval monitoring (PAM) audits
- Documentation of reliance with external IRBs
- Current IRBNet submission forms and other templates

The above-listed files and documents shall be stored in IRBNet indefinitely. All corresponding hard copy files of projects that were transitioned to IRBNet after March 11, 2013 shall be retained indefinitely.

The IRB Coordinator is the IRBNet Administrator and point-of-contact for all issues pertaining to the maintenance and use of IRBNet.

**GREATER BALTIMORE MEDICAL CENTER
Institutional Review Board
Standard Operating Policies and Procedures (SOP)**

Name of SOP: IRB Standard Operating Policies and Procedures (SOPs)
Section Number: 11.4
Effective Date: January 1, 2005
Last Revision: August 18, 2025
Replaced SOP Revised On:

The Department of Health and Human Services (HHS) Office for Human Research Protections (OHRP) and the Food and Drug Administration (FDA) has a jointly prepared guidance--*Institutional Review Board (IRB) Written Procedures: Guidance for Institutions and IRBs dated February 2025*--with the purpose of assisting institutions and institutional review boards (IRBs) in the preparation and maintenance of written procedures that align with regulatory requirements, ensure compliance, enhance human subject protection, and improve the overall effectiveness of research oversight.

The above-referenced OHRP/FDA guidance states that the “OHRP and FDA believe that when institutions and IRBs develop and follow clear written procedures, there is an increased likelihood that the rights and welfare of human subjects will be protected.”

IRBs must comply with Federal regulations in 45 CFR 46 (HHS) and 21 CFR 50 and 56 (FDA) when reviewing research subject to those regulations and, at a minimum, IRBs are required [45 CFR 46.103(4) and (5) (HHS) and 21 CFR 56.108(a) and (b) (FDA)] to have written procedures for:

1. “Conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and the institution.”
2. “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.”
3. “Ensuring prompt reporting to the IRB of proposed changes in a research activity, and for ensuring that investigators will conduct the research activity in accordance with the terms of the IRB approval until any proposed changes have been reviewed and approved by the IRB, except when necessary to eliminate apparent immediate hazards to the subject.”
4. Prompt reporting of “any unanticipated problems involving risks to subjects or others” to the IRB, appropriate institutional officials, the OHRP, and the FDA.
5. Prompt reporting of “any serious or continuing noncompliance with regulations or the requirements or determinations of the IRB” to the IRB, appropriate institutional officials, the OHRP, and the FDA.
6. Prompt reporting of any “suspension or termination of IRB approval” to the IRB, appropriate institutional officials, the OHRP, and the FDA.

It is noted that, in addition to the above-listed functions and operations requiring written procedures, there are other HHS and FDA regulations and institution-specific IRB activities that are not required to be in written procedural form and, as stated in the above-referenced OHRP/FDA guidance, “regulations allow flexibility in both form and content of written procedures, which give IRBs the ability to establish procedures best suited to their own operations.” “Institutions/IRBs may choose to create written procedures that focus solely on the regulatory responsibilities of the IRB, or they may choose to also incorporate institutional policies and procedures that are a function of the institution’s Human Research Protections Program (HRPP).”

GBMC has chosen to create and maintain an IRB Standard Operating Policies and Procedures (SOP) manual that incorporates both regulatory requirements and GBMC institution/GBMC IRB specific policies and procedures.

The GBMC IRB maintains two separate Standard Operating Policies and Procedures manuals:

1. Pre-2018 Requirements Manual
2. 2018 Requirements Manual

The Pre-2018 Requirements Manual applies to all research projects initially approved or determined to be exempt by the GBMC IRB prior to January 21, 2019.

The 2018 Requirements Manual applies to all research projects initially approved or determined to be exempt on or after January 21, 2019.

The above-referenced OHRP/FDA guidance states that “Written procedures may be maintained electronically or may be paper-based.” Both the Pre-2018 Requirements Manual and the 2018 Requirements Manual are kept in a paper-based format (in separate binders with live approval signatures) and electronically on the dedicated IRB Office I Drive. Both manuals are posted on the GBMC IRB website for ready access by both hospital personnel and the general public.

It is the responsibility of the IRB Coordinator to write, revise and maintain both GBMC IRB Standard Operating Policies and Procedures manuals. These activities shall be done on an ongoing basis.

All newly written and/or revised policies and procedures shall be reviewed and approved by the IRB and GBMC’s Executive Vice President/Chief Medical Officer prior to wide-spread distribution.

The IRB Coordinator shall present all newly written and/or revised policies and procedures to the convened IRB at a regularly scheduled meeting. Newly written and/or revised policies and procedures shall be presented to GBMC’s Executive Vice President/Chief Medical Officer for review via email prior to the scheduled convened IRB meeting.

All newly written and/or revised policies and procedures must be approved by a majority of the IRB members present at the convened meeting. Majority is defined as being fifty percent of the members present plus one.

A newly written and/or revised policy is considered approved by GBMC's Executive Vice President/Chief Medical Officer once the paper-based document has been hand-signed.

After being hand-signed by GBMC's Executive Vice President/Chief Medical Officer, all paper-based versions of the newly approved policies and procedures (new or revised) shall be placed in the appropriate paper-based binder. Previous versions of all policies and procedures are kept on file indefinitely in both paper-based and electronic formats.