St George's University of London

St George's University Hospitals NHS
NHS Foundation Trust

Standard Operating Procedure (SOP)

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Signature of Authorisor			

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Standard Operating Procedure (SOP)
Auditing

SOP Chronology

SOP Version Number:	Reason for Change:	Author:
V1.0	Original Version	Lucy H H Parker
V2.0	Updated Logo and Trust Name	Fran Mautadin
V3.0	CORRECTED Audit finding definitions in line with RQA and MHRA finding definitions	Debbie Rolfe

1. Background

As both a representative of a Sponsor organisation (an institution that takes responsibility for initiation, management and/or financing of a clinical trial) and an NHS organisation (host site), the JREO is responsible for auditing research practice and assuring adherence to current legislation and guidelines. As such, it is necessary to audit research against the standards of the Research Governance Framework 2005 (2nd Edition) and the Medicines for Human Use (Clinical Trials) Regulations 2004 where applicable, incorporating Good Clinical Practice.

This Standard Operating Procedure (SOP) is to assist researchers in understanding the audit process, so that they are prepared should they volunteer or be selected for audit.

The purpose of a research audit is to:

- Ensure participant and staff safety
- Assist researchers with compliance to regulatory requirements and Trust and University policy
- Improve research systems and data quality
- Prepare researchers for external audit processes
- Demonstrate robust research processes to external funders and industry

1.1 Audit requirement

Under the Research Governance Framework, the Sponsor is responsible for the management and monitoring of a study. The JREO is responsible for auditing research on behalf of St George's University Hospitals NHS Foundation Trust as a host NHS organisation and St George's University of London, both as a host non-NHS site and as a Sponsor organisation. Projects will be audited:

- When the PI requests an audit of their study
- As part of the JREO Audit Programme
- If there is suspicion of non-compliance to regulation

1.2 Role of the auditor

It is the auditor's primary role to collect evidence of research practice and compare it against the requirements of Good Clinical Practice, Research Governance and applicable UK regulations and guidance. The auditor is responsible for documenting observations and conclusions, safeguarding audit documentation, records and reports, assessing whether requirements are being met, and developing reports incorporating recommendations for change or adherence.

2. Joint Research and Enterprise Office (JREO) Policy

All JREO SOPs will be produced and approved in accordance with the JREO SOP on SOPs and must be used in conjunction with local NHS Trust and St George's policies and procedures.

The JREO acts as the representative of both St George's University of London (SGUL) and St George's University Hospitals NHS Foundation Trust (SGHT)). St George's will be the official name used on all SOPs to represent both institutions acting as Sponsor.

3. Scope

This SOP describes the audit procedures of the Joint Research and Enterprise Office (JREO), acting on behalf of St George's, University of London and St George's University Hospitals NHS Foundation Trust. This SOP describes the processes for selecting those studies for audit that fall under the Department of Health Research Governance Framework for Health and Social Care 2005 (2nd Edition) and/or the Medicines for Human Use (Clinical Trials) Regulations 2004 and subsequent amendments and reporting audit results to Investigators. This SOP also describes the requirements for Investigators to respond to JREO audit reports and implement corrective actions.

This SOP does not cover the actual process of auditing or the associated documents. This is covered in the internal JREO working practice document (WPD) JREOWPD0006.

4 Definitions

4.1 CAPA

A formal plan of corrective and preventative action (also known as a CAPA) JREODOC0107

5 Responsibilities

This SOP is to be followed by the JREO governance section and the Chief Investigator (CI) and Principal Investigator (PI) of the study.

6. Procedure

6.1 Audit Programme

The JREO has devised an Audit Programme. The Programme randomly selects approximately 10% of active research studies that have St George's named as an active research site. Half of studies selected will be Clinical Trials of an Investigational Medicinal Product (CTIMP). Studies that are also monitored by the JREO will be included in the list for possible selection. No study will be audited more than once in a rolling year. The list of studies to be audited is chosen randomly on a rolling quarterly basis.

6.2 Auditor Qualifications

The auditor should be independent to the research team/research systems to conduct audits appropriately. An auditor should be qualified by training and experience to conduct audits properly. An auditor's qualifications should be documented (ICH GCP 5.19.2). For the purpose of this SOP, the JREO Governance team member assigned to audit the study will be referred to as the Lead Auditor

6.3 Audit Plan

An audit plan will be developed by the Lead Auditor and agreed with the researcher involved prior to beginning the audit.

The formal plan should:

- Define scope and objectives for audit
- Provide timelines for audit conduct
- Identify where and when the audit will take place
- Identify requirements to be audited against
- Identify groups and areas to be audited
- List documents and records to be studied
- List responsible people whose functions will be audited
- Clarify who will get the final report and when it will be ready

6.4 Audit Process

This is the most intensive part of any audit process as it is the period where information is assessed and recorded. The process will start with the Lead Auditor explaining the scope and objectives of the audit, and how it will be carried out. Examples of audit techniques include:

- Interviewing researchers
- Reading documents
- Reviewing manuals
- Studying records
- Reading reports
- Analysing data
- Observing activity
- Examining conditions
- Confirming interview evidence
- Documenting observations

6.5 Audit Findings

Once the practical audit has been completed the Lead Auditor will write up a report with the audit findings and recommendations to correct the findings.

The Lead Auditor will:

- List any gaps in compliance with any supporting evidence
- Cross-reference with regulatory requirements

For the purposes of the report, there will be three categories of findings. These are Critical, Major and other.

Critical weakness of, or non-compliance with, a control process which, if not resolved **will cause harm** to patients or data integrity and/or company reputation that requires the immediate notification and attention of senior management and clear timelines for resolution For example:

- Where evidence exists that the safety, wellbeing, rights or confidentiality of study subjects has been (or has had significant potential to be) jeopardised.
- Where reason has been found to cast serious doubt upon the accuracy and/or credibility of study data.
- Where approval for the study has not been sought from one or more regulatory agency/body or granted from one or more regulatory agency/body (e.g. Ethics committee, MHRA) but the study has commenced regardless.
- Where following study approval, significant amendments have been made to the study protocol or documentation but no new request for approval has been submitted.

Major: weakness of or non-compliance with a control process which, if not resolved **has the potential to cause harm** to patients or data integrity and/or company reputation that requires the immediate notification and attention of senior management and clear timelines for resolution:

- Where there has been a significant unjustified departure from GCP e.g. failure to provide participants with a copy of their Informed Consent Form or Participant Information Sheet.
- Where procedures not covered/included on the consent form are being performed or where new procedures have been introduced into the study protocol but where participants who had consented prior to their introduction have not been asked to re-consent.

Other: weakness of, or non-compliance with, a control process that currently **causes no harm** to patients or data integrity and/or company reputation that requires resolution. For example:

- Which demonstrate that no definite document management/organisation processes are in place at site / no investigator site file exists.
- Where there has been failure by study staff to inform the relevant authorities of amendments to start and stop dates or study specific documents.

6.6 Audit Results

If the audit reveals a number of areas that need improvement, the Lead Auditor will arrange a meeting with relevant research staff to discuss the recommendations or gaps in compliance. If an audit reveals critical findings or significant major findings the auditor should escalate to the HRG/RAM who in turn may determine that a Serious Breach should be reported to the MHRA and Sponsor JREOSOP0032.

6.7 Final Audit Report

Over the following two weeks from initial audit, the Lead Auditor will review the gathered information and compile a final report, which will be disseminated to the Principal Investigator. If the study is sponsored by an organisation other than St George's, the Sponsor will be offered a copy of the audit report.

The report will include:

- A review of the evidence collected
- A discussion of any conclusions drawn from the audit
- A list of identified gaps in compliance
- An assessment of how well regulatory requirements have been met
- Recommendations for change in practice to conform to regulation

6.8 Follow-up actions

It is the Chief Investigator's responsibility to ensure action is taken to correct any identified gaps in regulation compliance. If any advice or assistance is required, the

investigator should contact the Lead Auditor, who will be able to help with this. The Chief Investigator of the study is expected to respond to the audit report within 1 calendar month and corrective actions made in a timely manner.

6.9 Research Governance Committee (RGC)

The RGC of St George's will be informed of the results of the audits undertaken since the last RGC meeting. If multiple audits have revealed similar findings, the RGC will be informed as to what corrective and preventative plans have been made and implemented.

7. References

Department of Health Research Governance Framework for Health and Social Care 2005 (2nd Edition).

UK Clinical Trials (Medicines for Human Use) Regulations 2004;

ICH, GCP Guidelines 1996

JREOSOP0032 Serious Breach Reporting

8. Appendices

Appendix 8.1: JREO Audit Plan

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Title of Study:	
JREO Ref:	
Ethics Ref:	
CTA Ref (if applicable):	
Type Of Study:	
Chief Investigator:	
Principal Investigator at SGHT:	
Sponsor:	
Date of Audit:	

Essential documents to be available during the audit

• Protocol
• Consent form and Participant Information Sheets
• Ethics approvals and correspondence
• JREO approval and correspondence
• Regulatory approvals and correspondence (e.g. MHRA, GTAC etc.) (IMP study only)
• General Study Correspondence (except Trust, Ethics and Regulatory)
• Training documents
• SOPs
• Data management
• Serious Adverse Events
• Pharmacy/Product-Related (IMP study only)
• Monitoring and Audit documentation
• Source data (i.e. patient notes)

The objective of this audit is to ensure compliance with <if IMP study> Medicines for Human Use (Clinical Trials) Directive 2004, incorporating amendments (2006) from the EU Directive 2005/28/EC on GCP <if non-IMP study> Research Governance Framework for Health and Social Care, 2nd edition. For all studies, we will be looking for adherence to Good Clinical

Practice as outlined in the ICH Harmonised Tripartite Guideline for Good Clinical Practice (1996). The final audit report will document findings against these guidelines.

Audit Timeline

On the day, the auditor(s) will introduce themselves and explain the planned procedure for the day. It would be useful if a separate room could be organised for the auditors to review the documents. At a minimum, there should be a desk per auditor. For studies that have started recruiting participants, a selection of patient notes should be made available for source data verification. The selection of patient notes will be discussed and decided on in advance with the JREO Lead Auditor although further notes may be requested on the day.

Once the audit is complete, the auditor(s) will briefly go through the findings with the study personnel, and PI if present. A formal report will be provided within two weeks of the audit. If the study is sponsored by a different organisation, the Sponsor will be contacted to see if they would like a copy of the audit for their records.

A response from the PI to the audit findings should be provided within 1 calendar month of receipt of the audit report. Failure to respond to the audit report may result in the study having its approval to be conducted at St George's University Hospitals NHS Foundation Trust revoked.