Office of Research Oversight (ORO) Comprehensive Program Review (CPR)
Exit Interview
September 27, 2019 9 AM

Attendees:

b6 – GRA/RDC	b6
b6 - SRS	b6
b6 - HRP	b6
b6 – IACUC (Vet)	b6
b6 – IACUC (Vet)	b6
b6 - RIS	b6
b6 - RIS	b6
b6 - SRS	b6
b6 – HRP (Medical Officer)	b6
b6 - HRP	b6
b6 (By phone)	b6
	b6
Note: b6 did not attend Exit Interview – IACUC (Vet)	b6
	b6
	b6
	b6
	b6 (V-tel)

Presenter 1: [redacted] **– General Research Administration and R&D Committee**

- Thanked everyone for making visit so smooth and efficient with wonderful hospitality. Appreciated escorts. Special thanks to [redacted].
- Understand that everyone is anxious to fix things
- Additional guidance will be provided to us as the process continues
- Gave overview of CPR
- Explained process for providing information in the exit interview
- Expect report in approximately 80 days for factual correction review (name spellings, rooms numbers etc.)
- Response cycle is 30, 60 days as needed and will work with each group to get issues resolved
- Will be sending out 2-part survey and request 100% completion by those that receive it
- Members for GRA were [redacted], [redacted] and [redacted]

Findings: None

Observations:

1. Suggest the consolidation of two tracking systems for monitoring training. Suggest use of IRBNet be method for review
2. Suggest the safety training requirements not currently monitored in IRBNet be added

Presenter 2: [redacted] **– HRP**

- Thanked everyone and noted that going forward, the HRP should prepare for expanded responsibilities
- Identified the Research Pharmacy Program and [redacted] and [redacted] as strengths of the HRP program.
- Per regulation, PIs are responsible for maintaining pharmacy binders. ORO suggests that PIs take more direct responsibility, so that Pharmacy staff confirms contents, rather than assembles and maintains them.
- Relayed investigator compliments to Pharmacy staff of "The real deal" etc.
- Members for HRP were [redacted], [redacted] and [redacted].

Findings:

1. IRB did not ensure ICFs included all elements from new 2018 requirements in some cases - Noted that a legally-authorized representative (LAR) consent was also missing the required language which was related to the use of biospecimens (whether or not they would be used in future studies). In one case, an ICF did not clearly delineate what was standard of care from research.
2. IRB did not follow SOPs for initial and continuing review of research and documentation of types of determinations that may be made (e.g., approval with contingencies, with conditions, etc.). The description of available options to be used should be clearer. Suggested that the IRB rely on regulatory guidance to consider using a simpler set of possible determinations.
3. Missing required training for IRB members – Review the VHA directives and local policies and use them for contacting the MCD when suspension of privileges etc. is necessary.

One "Obser-finding": Interpretation of information related to IDEs is inaccurate in SOP II.2.B. 21 CFR 812 should be used to correct information. There is confusion between overall study risk categories (minimal risk/greater than minimal risk) and device significant risk/non-significant risk determinations. Investigational new drug terminology is also confused with IDE terms. ORO will be sending SOP guidance to IRB Coordinator. ORO suggests phasing out the related MCM-12 and including the necessary information in the IRB SOP. Timeline for reporting of related death in MCM-12 is not compliant with regulatory requirements.

Observations:

1. IRB minutes/letters: 5 continuing reviews were issued approved under expedited review category of 5, but should have been under category 8. The IRB should Establish a process for appropriate categorization of expedited reviews.
2. SOPs/ICF Templates updates needed: Discussed with IRB in person prior to meeting. Specifics will be included in the final report.
3. Preparatory to Research process: One PI indicated that they had not used the process because they thought a completed protocol was required. Consider clarifying information about the requirements for use of this process e.g. complete protocol not required.
4. Involve Privacy Officer (PO) in more activities: Consider having the preparatory to research request be reviewed by the PO after providing additional training to her. The PO should provide additional training to investigators related to that review process, as well as other pertinent topics.
5. Meeting minutes should be clarified so that it is obvious what is being voted on. Ensure that PI notification matches what is documented in minutes.
6. The IRB office currently offers a high level, customized "Boutique" service to investigators. This is a great service but may become burdensome as program grows. Consider creation of a more streamlined process that includes buy-in from the investigators in correcting their own issues.

Question from Dr. b6 – What is the best practice for review of protocols that express purpose is for breeding-> Can they be considered holding protocols or do they require a review by IACUC etc.?

Presenter 3: b6 **– RIS**

- The RIS team conducted pre-review of 7-8 protocols before arrival. They met with all PIs.
- Completed lab walkthrough and spoke with staff in labs
- Spoke with b6 - Informed of upcoming changeover to SFFX system (Only 3 levels deep which required extensive revision of research folder level processes currently in use).
- They found no errors in folder permissions/restrictions.
- Members for RIS were b6 and b6

Findings:

1. IT equipment inventory: Non-VA equipment must be on inventory. The facility needs to develop a process that includes Logistics to accomplish this and document ownership of untagged machines.
2. Storage of VA records: Paper and electronic records of animal and bench science protocols are frequently stored in non-VA locations. This is acceptable, but documentation of storage locations is required by records policies. Work with Facility Records Manager to devise a plan for these records to document their locations.
3. Use of non-VA mobile and portable devices is permitted, but terms and conditions must be established (e.g., no sensitive data stored on such devices). Need SOP to cover terms and conditions of use and educate investigators. Look for guidance from OIT coming in about 2 months.

Observations:

1. Unencrypted PHI was being sent to sponsor in one study. RIS offered two options that could be implemented: a) Obtain a statistical determination that confirms the small chance of ability for re-identification of the participant or b) Mailing Exception – Allows for sending of unencrypted PHI when the receiver of the information has no way to unencrypt the data. It must be sent by carrier with tracking. Investigators should work with ISO and PO on such issues.

Presenter 4: b6 **– Safety and Research Security**

- Informed of potential picric acid in GC-147 that will require immediate action. Crystalized picric acid is a shock sensitive explosive. Per policy, picric acid is to be checked monthly. The paperwork on the container listed 2013 as the last date of inspection for wetness. The researchers associated with the laboratory left the VA on

Monday. Future deliveries of picric acid should involve Safety Office for delivery and monitoring. This should be addressed as quickly as possible. Check to see if local expertise is available.

- Members of SRS were b6 and b6

Findings:

1. No SOP for laboratory activation/decommission procedures. At a minimum a 30-day pre-notification by investigators of their intent to leave facility should be required.
2. No SOP for review of safety of research done off-site. Consider developing an MOU with UAMS. Either determine that their inspections are adequate or reach agreement so that we can do our own.
3. Repeat finding - SRS does not ensure review of affiliate inspection reports (SRS could implement a process for the review done by SRS in place of this review).
4. Personal Protective Equipment (PPE) hazard assessments not performed and certified.
5. Emergency showers: No emergency shower available in VMU (Closest is in hallway outside VMU) Needed due to hazardous nature of cage cleaner. All showers are in hallways so lab doors should be left open when working with corrosive agents. Discuss with Facility Safety Officer.
6. Not all researchers have received appropriate/mandatory training (initial and ongoing) e.g. biosafety, chemical hygiene, OSHA, hazardous waste, formaldehyde, formalin etc.
7. Chemical Hygiene Plan (CHP): Missing two elements a) reproductive toxins b) acute toxicities. Being revised now
8. MSDSs: Not readily available in all labs or to all researchers. May use electronic format but hard copies must be provided to those without access to the electronic versions.
9. CHP: Not available to all researchers. Please keep hard copy in all labs.
10. SRS has not reviewed the effectiveness of chemical hygiene plan annually.
11. Repeat finding: Chemical inventories not reviewed semi-annually.
12. Repeat finding: Required drills not completed/tracked/documented. Safety (chemical spill drill), Security (irradiator), Emergency Preparedness (Fire drills).
13. Repeat finding: SRS inspection deficiencies not reviewed through resolution e.g. environmental rounds, Annual Workplace Evaluations, police rounds, lab inspections, etc.
14. Bloodborne Pathogen Training is not adequate: Missing PPE handling information as well as recapping of needles.
15. Formalin: No initial exposure monitoring prior to use. (Have a potential 4-hour exposure in a current project)
16. Staff changes not getting approval of SRS appropriately. When a new investigator/staff member will be added, am amendment needs to be approved through IRBNet prior to implementation of the change.
17. SRS Member appointments: Multiple lapses allowed the approved membership to drop below required level – new members started before MCD signature was obtained.
18. Safety records were not maintained by research.
19. Repeat finding – SOPs for reporting non-compliance and unexpected events are not being followed. Required review, reporting and determinations are not being made or documented.
20. Findings of walkthroughs will be summarized in report – Not provided at this time

Observations:

1. SRS should capture recusals in minutes and verify that members recused are not counted in votes (error noted in 2018)
2. Occupational Health Service: SRS should provide OHS with their requirements for hazardous item use so they are able to incorporate these in their process and prepare for future involvement in process. Notification should also be made when the lab anticipates receipt of new animal species.
3. Research Administration needs to work with the Chemical Hygienist to ensure that exposure monitoring is done. This should include development of an exposure monitoring assessment for hazardous gases (isoflurane or anesthetic gasses) – determine frequency and process for continual monitoring when too high
4. SRS should add a statement indicating that Research will follow the facility's exposure management plan. Need to notify all researchers and provide a hard copy of policy in all labs for WOCs.

5. Freezers contain mold, unidentified samples – abandoned by PI (Does not contain BSL III level samples). Need a plan for their removal from the facility.
6. Chemical fume hoods and biosafety cabinets – Current policy includes semi-annual inspections but only required annually. Need to align policy and practice and establish contract.

Presenter 5: b6 **– IACUC/RSAW**

- Informed that there had already been discussion with the IACUC staff who had shown a great willingness to make changes as needed/suggested
- Informed there were many repeat findings from the 2010 inspection
- Members of IACUC review team were b6, b6 and b6

Findings:

1. Repeat finding – IACUC members had lapsed appointments (same reason as SRS) – Reminded that the committee cannot conduct business without appropriate constitution. IACUC must re-review all business conducted during the time(s) it was not properly constituted. This finding should be addressed immediately.
2. Semiannual review of animal facility was not being done in a compliant manner – not documented in the IACUC minutes and may not have been completed – Last review documented in 2017 – Use the VA Checklist that is online from ORD in the future
3. Repeat finding – Semi-annual review must be presented to the MCD in a face to face meeting within 60 days of completion of the final report. Meeting should include IACUC Chair, Veterinarian, ACOS/R and MCD. Teleconferencing is allowed if necessary. Recommended checklist (#2) includes a place to capture MCD signature.
4. Repeat finding – Overheat test not documented as completed in VMU since 2016 – Must be completed to verify response time of engineering to the deviation in temperature in animal rooms – HVAC may not be configured correctly to alert appropriately. – Dr b6: Consider adding of temptrack to the VMU
5. HVAC re-heat boxes were not designed to fail in off or closed position. Currently fail setting is in an open position. Could lead to loss of animal life very quickly due to overheating.
6. Occupational Health and Safety is not providing initial or annual assessments of animal facilities personnel. Local policy does not meet requirement for assessments. Need to add to or create an SOP regarding allergens (mouse fur, dander, urine).
7. There is no written policy for establishing an Occupational Health and Safety program for animal users.
8. People with intermittent access to animals are not offered the OHS risk assessment – Should be offered to all who enter the VMU (IACUC members, Engineering, EMS, Police, staff, etc.)
9. Repeat finding – IACUC did not document annual review of VMU SOPs.
10. IACUC did not ensure complete and accurate description of research activities – activities differed in some parts of ACORP documents, especially different doses, dose frequency, etc.
11. Several instances of protocol non-compliance – Random selection of surgery records were reviewed which showed that procedures conducted were not those approved by the IACUC (Multiple incidents)
12. The use of non-pharmaceutical grade compounds are not adequately described. A rationale for their use must be documented and reviewed, including specification of safety precautions.
13. Post approval monitoring program not being followed as written in Assurance – It does not catch all that is happening – IACUC should look at that and update requirements with a much more robust process.
14. Designated member reviews are not being completed in a manner compliant with the regulations – Did not meet all regulatory expectations, e.g., did each designated reviewer see and approve the final protocol?
15. Repeat finding – IACUC has no SOP for reporting non-compliance or problems. An SOP was submitted as part of the previous remediation plan but was not being followed and was not provided for this review. A document review noted 16 mice deaths in a 3 month window, July-September , which were not reported. The report should have been made to the IACUC within 5 business days of discovery of the reportable event. IACUC was unaware of the event.
16. VMU Disaster Plan is not incorporated in facility-level disaster plan –

17. Records of veterinary site visits didn't show frequency of visits that matched SOP, AAALAC, or assurance.
18. Walk-through findings – will be in report.

Observations:

1. Should appoint an IACUC Committee Member to serve on the R&DC
2. Whistleblower Poster information needs to be updated with correct contact information and made truly anonymous
3. VMU should consider reversing the air flow in the necropsy room from positive to negative
4. Need a formal arrangement for a back-up Veterinarian
5. Need to fill the requirement for IACUC member on SRS immediately
6. Need to invest in opportunities for continued education for VMU staff, veterinarian, etc.