



ETCTN

Experimental Therapeutics Clinical Trials Network

Team Driven. Cancer Therapy Focused.

National Cancer Institute at the National Institutes of Health

NCI GUIDELINES FOR MONITORING THE EXPERIMENTAL THERAPEUTICS CLINICAL TRIALS NETWORK (ETCTN) AND OTHER EARLY PHASE CTMS-MONITORED STUDIES

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LIST OF ACRONYMS

AO	Affiliated Organization
AP	Associate Plus
CAPA	Corrective and Preventative Action
CDUS	Clinical Data Update System
CIRB	Central Institutional Review Board
CRA	Clinical Research Associate
CRF	Case Report Form
CTEP	Cancer Therapy Evaluation Program
CTMB	Clinical Trials Monitoring Branch
CTMB-AIS	Clinical Trials Monitoring Branch - Automated Information System
CTMS	Clinical Trials Monitoring Service
CTSU	Cancer Trials Support Unit
DARF	Drug Accountability Record Form
DCTD	Division of Cancer Treatment and Diagnosis
DSMB	Data Safety Monitoring Board
DTL	Delegation of Tasks Log
EDDOP	Early Drug Development Opportunity Program
ETCTN	Experimental Therapeutics Clinical Trials Network
GCP	Good Clinical Practice
ICC	Informed Consent Content
ICH	International Council for Harmonisation
IDB	Investigational Drug Branch
IDSC	Investigational Drug Steering Committee
IND	Investigational New Drug
FDA	Food and Drug Administration
IRB	Institutional Review Board
IVR	Physician Investigator (as designated in RCR)
LAO	Lead Academic Organization
NCI	National Cancer Institute
NCTN	National Clinical Trials Network
NIH	National Institutes of Health
NPIVR	Non-Physician Investigator (as designated in RCR)
OHRP	Office of Human Research Protections
PMB	Pharmaceutical Management Branch
PRC	Protocol Review Committee
QA	Quality Assurance
QC	Quality Control
RCR	Registration and Credential Repository
TSDV	Target Source Data Verification

DEFINITIONS

Annual Site Visit is conducted by CTMS approximately one year subsequent to the Initial Site Visit and annual thereafter, as long as pertinent Phase 1, selected Phase 1/2 and Phase 2 studies are ongoing. The purpose is to review regulatory documentation; pharmacy operations, drug accountability, storage and security procedures; and review and verify source documentation of patient case data (Data Review) of the study participants enrolled onto CTMS monitored clinical studies.

Comprehensive Monitoring is conducted of Phase 1 and some early Phase 2 studies assigned for CTMS Comprehensive Monitoring. Review of source documentation and procedures are conducted via an Annual Site Visit and two Data Review (Data Visits) within the same year depending on patient enrollment.

Data Review is conducted twice a year (in addition to the Annual Site Visit) to assess the availability and organization of source documentation, to verify submitted data and check for accuracy, to review the informed consent forms and to review adverse events to ensure Expedited Adverse Event Report Requirements are being met. In addition, copies of the Drug Accountability Records and patient registration lists will be retrieved and reviewed for deficiencies.

Re-visit/Re-audit (CDUS-monitored study) is conducted for any component rated as Unacceptable. A re-visit should be done no later than a year after an Unacceptable rating.

Off-Cycle Visit is a special audit used for circumstances such as 'for cause'. These types of audits may be warranted when there are significant irregularities found through quality control procedures or when allegations of possible scientific misconduct are made. It is the responsibility of the organization or Clinical Investigator to immediately notify CTMB upon learning of any significant irregularities or allegations related to scientific misconduct by a staff member or site participating in their research program.

Off-site Review under certain circumstances there may be a limited review of data/source documentation at an affiliated site or at CTMS location.

Response Audit is a special audit that may be may be conducted when there are initial promising findings. These types of audits may include independent radiologic review for confirmation of disease response. CTEP or a sponsor may request a 'response audit' and CTEP determines if this type of audit is warranted.

Routine Monitoring is conducted for Phase 2 studies usually assigned for CTMS Routine Monitoring. A review of all components (Regulatory Documentation, Pharmacy and Patient Cases) is performed. Reviews are conducted on a 18 to 36 month basis. More frequent visits may be conducted if warranted by accrual, due to safety concerns or concerns related to data quality or timely submission.

Web Reporting can be done at any time during the study to perform aggregated adverse event evaluations to assist with detecting patterns or other early signs of toxicity that may be of concern. It is a tool used by the Medical Officers in CTEP and clinical investigators participating on NCI-sponsored ETCTN clinical trials.

SECTION 1 BACKGROUND AND PURPOSE OF THE EXPERIMENTAL THERAPEUTICS CLINICAL TRIALS NETWORK AND OTHER EARLY PHASE CTMS-MONITORED STUDIES

1.1 Introduction

The National Cancer Institute (NCI) has formed partnerships in the pharmaceutical industry, academic institutions, and individual investigators for the early clinical evaluation of innovative cancer therapies. The Experimental Therapeutics Clinical Trials Network (ETCTN) was created to evaluate these therapies using a coordinated, collaborative, and inclusive team-based approach to early phase experimental therapeutic clinical trials.

Two programs run in sequence to manage a portfolio of partnerships between NCI and pharmaceutical collaborators:

- NExT is the program in the NCI Developmental Therapeutics Program that selects agents for NCI-sponsored pre-clinical and clinical development. NCI negotiates collaborative research agreements (CRADAs) with the pharma partners supplying the selected agents for CTEP-sponsored development.
- The ETCTN is the clinical trials network administered through the Investigational Drug Branch (IDB) that performs early phase clinical studies of these agents (NCI - Investigational New Drug [IND] agents).

The ETCTN is complementary to the National Clinical Trials Network (NCTN) which focuses on late phase development with an emphasis on Phase 3, disease-specific studies.

The ETCTN is funded through a UM1 cooperative agreement mechanism. NCI staff collaborate with pharma partners under terms set out in the CRADAs, and ETCTN investigators under the terms set out in their research awards, to achieve the ETCTN objectives of advancing the early clinical development of NCI IND agents. NCI provides centralized support, data management, trial registration and regulatory support activities for approved, early phase clinical trials. As a clinical trials network, ETCTN awardees could have the opportunity to enroll patients on to ETCTN studies, irrespective of the specific site leading the trial. ETCTN sites are responsible for monitoring and reporting safety information throughout the conduct of all ETCTN trials.

ETCTN participation has also been extended to NCI-designated Cancer Centers not affiliated with the ETCTN that successfully competed for Early Drug Development Opportunity Program (EDDOP) Cancer Center Support Grant (P30) supplements. In addition, the CATCH-UP (Create Access to Targeted Cancer Therapy or Underserved Populations) program provides access to ETCTN studies for other selected NCI cancer centers to accrue minority/underserved populations to the ETCTN precision medicine cancer trials.

The objectives of the ETCTN are to:

- Conduct early clinical trials of NCI-IND agents in high priority areas of unmet medical needs
- Ensure efficient and timely activation and conduct of these clinical trials
- Integrate preclinical findings using clinical samples for biomarker analysis

- Promote collaboration among institutions and investigators
- Integrate molecular characterization, pharmacology, cancer biology, and imaging into clinical trials

Early phase clinical trials by nature involve agents where the toxicity profile may not be well defined. As a result, the NCI's approach to monitoring is a risk-based approach. Sites involved in the conduct of early phase clinical trials are academic medical centers with documented expertise in early therapeutics drug development. These institutions conducting the clinical trials are referred to as Lead Academic Organizations (LAOs), integrated components (ICs) and affiliated organizations (AOs). Additionally, these sites are visited/monitored more frequently than later phase clinical trials.

1.2 Other Early Phase CTMS-Monitored Studies

NCI supports several additional clinical trial networks and programs that conduct studies involving Cancer Therapy Evaluation Program (CTEP) sponsored investigational agents. For early phase studies, the appropriate monitoring method is determined at the CTEP Protocol Review Committee (PRC) meetings. The decision is based on the known side effects, risk profile of the investigational agent, study population, and whether the investigational agent is used alone or in combination with other agents; or novel approaches. The PRC may decide to assign such studies for CTMS (Clinical Trials Monitoring Service) monitoring. This includes oversight of sites participating in the Pediatric Early Phase - Clinical Trials Network (PEP-CTN) monitored by the CTMS which also follows guidelines outlined in this document.

1.3 Overview of the Quality Assurance Program

Practitioners of clinical trials have an obligation to take appropriate steps to protect both the integrity of science and the human study participants in research studies. The integrity of a data set is a function of the entire process of data recording, collection, analysis and reporting. Detailed plans and systems are needed to assure protocol adherence for the uniform collection of data. Vigilance to detect honest errors, systematic or random, as well as data falsification, is especially important when conducting clinical trials since independent replication of most trials is not feasible.

One goal of a quality assurance program is to prevent potential concerns. One of the foremost means of protection against poor adherence to protocol or poor data quality is the selection of qualified investigators and research staff. Another goal of a quality assurance program is to detect concerns by implementing routine monitoring procedures. The system should make detection of both random errors and systematic errors feasible during the course of data collection. Procedures for data review and statistical methods should be implemented to detect certain types of issues, but purposeful fraud may be very difficult to detect. A third goal is to take appropriate action in a timely and effective manner. It should be recognized that some errors will remain undetected and uncorrected regardless of the quality control, editing, and monitoring procedures in place. Finally, a well designed and implemented quality assurance program should serve as a valuable educational vehicle. The monitoring team should use the opportunity to share with the local staff Good Clinical Practice (GCP) techniques, data management and quality control systems that have been successfully implemented at other institutions. The local staff should use the results of the monitoring visit/review to identify operational areas where improvements can be made.

As one of the world's largest publicly-funded sponsors of clinical trials of investigational antineoplastic agents and cancer clinical trials, the NCI must ensure that research data generated under its sponsorship are of high quality, reliable and verifiable. The NCI's quality assurance and monitoring policies for clinical trials have been in evolution since the start of the initial Cooperative Group Program in 1955. As the NCI's clinical research program has increased in size and complexity, the systems for quality assurance and monitoring have become more formal and systematic.

In 1963, Congress passed the Harris-Kefauver amendments to the Food, Drug, and Cosmetic Act requiring the Food and Drug Administration (FDA) to oversee Investigational New Drug (IND) testing in human study participants. In 1977, the FDA published proposed regulations on the responsibilities of sponsors and monitors of clinical trials. In March 2018, FDA announced the adoption of "E6(R2) Good Clinical Practice: Integrated Addendum to E6(R1)." The guidance was prepared under the auspices of the International Council for Harmonisation (ICH), formerly the International Conference on Harmonisation. The document was intended to improve clinical trial quality and efficiency, while maintaining human subject protection and reliability of trial results. With new and updated regulations and guidances such as these, sponsors can improve and create more efficient approaches to clinical trial design, including conduct and oversight of their clinical trials.

To assist CTEP in fulfilling its regulatory responsibilities as an IND sponsor and to assure protocol compliance and source data verification, resources for data management and monitoring will be provided under an NCI contract through the CTMS. The benefits of centralized data management includes increased efficiency by having a single entity responsible for study build using a core set of common electronic Case Report Forms (eCRFs) to be utilized via Medidata Rave, data management, quality assurance, adverse event analysis, and study report generation.

1.4 Purpose and Objectives

As a sponsor and funding agency for cancer clinical trials, FDA regulations require the Division of Cancer Treatment and Diagnosis (DCTD) to maintain a monitoring program. The Clinical Trials Monitoring Branch (CTMB) of the Cancer Therapy Evaluation Program (CTEP) in the DCTD, provides direct oversight of the Quality Assurance program which includes monitoring and auditing.

The major objective of the monitoring program is to verify study data that could affect the interpretation of primary study endpoints. This is done through independent verification of study data with source documents. The purpose of the monitoring program is to:

- Document the accuracy of data submitted to CTMS and CTEP via the remote data capture system (Medidata Rave) or in some circumstances, summary of the clinical data is submitted to CTEP via the CDUS (see http://ctep.cancer.gov/protocolDevelopment/electronic_applications/cdus.htm)
- Verify investigator compliance with protocol and regulatory requirements
- Provide an opportunity for the monitoring team to share with the institution staff, information concerning data quality, data management, and other aspects of quality assurance

For sites participating under the ETCTN program or when CTEP is supplying study drug for an early phase study, there are various methods of oversight that may be conducted

depending on the phase of the study or when toxicities may be of concern. One or more types of visits may be conducted for oversight purposes to abide by the regulatory requirements, Good Clinical Practices (GCPs) and applicable Standard Operating Procedures (SOPs) generated by the CTMS and/or CTEP. The types of monitoring methods are listed under [Section 3.0](#).

SECTION 2 ROLES AND RESPONSIBILITIES FOR THE CONDUCT OF THE QUALITY CONTROL AND QUALITY ASSURANCE PROGRAMS

The Clinical Trials Monitoring Branch (CTMB) within CTEP has direct oversight responsibilities for the quality assurance and monitoring programs used by the ETCTN, as well as, the NCI NCTN. CTEP staff work closely with CTMS and the ETCTN to ensure the integrity of data and the protection of patient/study participants participating in NCI-sponsored clinical trials.

2.1 Clinical Trials Monitoring Branch (CTMB)

The CTMB is responsible for establishing guidance for the conduct of quality assurance monitoring activities. CTMS under the direction and oversight of the CTMB is tasked with data management, study monitoring and auditing of the ETCTN and other early phase CTMS-monitored sites. These activities allow the CTMS to ensure the sites are complying with protocol and regulatory requirements.

The CTMB staff serves as an educational resource to the cancer research community on issues related to monitoring and regulatory requirements for conducting clinical trials. CTMB staff is responsible for overseeing the scheduling of all monitoring visits, for reviewing monitoring reports and findings, and for reviewing and assessing the adequacy and acceptability of Corrective and Preventative Action (CAPA) plans.

Any data irregularities identified through quality control procedures or through the monitoring program that raise any suspicion of intentional misrepresentation of data must be immediately reported to CTMB. The CTMB must be notified immediately by telephone (240) 276-6545 of any findings suspicious and/or suggestive of intentional misrepresentation of data and/or disregard for regulatory safeguards for any component (Regulatory Documentation Review, Pharmacy Review and Patient Case Review) of a monitoring visit. Similarly, any data irregularities identified through other quality control procedures suspicious and/or suggestive of intentional misrepresentation of data must be immediately reported to CTMB. It is the responsibility of the ETCTN Lead Academic Organization (LAO) or Lead Site of the study to immediately notify CTMB when they learn of any significant irregularities or allegations related to scientific misconduct by a staff member or institution participating in their research program. It should be emphasized the irregularity/misrepresentation of data does not need to be proven. A reasonable level of suspicion suffices for CTMB notification. It is essential that involved individual(s) and/or institution(s) follow their own institution's misconduct procedures in these matters.

For reporting any allegation of research misconduct that is detected by site staff, LAO, and/or CTMS outside of a monitoring visit (i.e., through internal QA review procedures), the CTMB must be notified immediately by telephone (240) 276-6545 or by email (NCICTMBResearchMisconductConcerns@mail.nih.gov). See 'Guidance for Allegations of Research Misconduct' under Appendix 1.

2.2 Quality Control

Quality control is a complex topic spanning the entire range of diagnostic and therapeutic modalities. Generalization concerning optimal quality control is not possible. Cost and benefit are important factors in this assessment. The CTMS utilizes a variety of quality

control procedures:

- Built-in edit checks within the Electronic Data Capture System
- Cross check of data between various electronic reporting systems
- Institution performance evaluations
- Special Response reviews to verify outcome data
- Committees for central review of major elements that impact on the outcome of clinical trials, (e.g., pathology, radiotherapy, surgery, and administration of study agents)
- Educational functions which address data collection, data management, and overall data quality

2.3 Quality Assurance

Quality assurance is the mechanism in which research clinical trials are conducted, recorded, and reported in accordance with the protocol, Standard Operating Procedures (SOPs), GCPs, and applicable regulatory requirements. It is a continuous process that can be conducted on-site or off-site, and involves oversight of all patients/study participants on a trial.

2.3.1 Monitoring Program

Monitoring is the act of overseeing the progress of a clinical trial. All clinical research carries with it the obligation to ensure optimal therapy for patients/study participants and optimal conduct of the research such that the patients' participation is meaningful. Accurate and timely knowledge of the progress of each study is critical to ensure oversight and appropriate monitoring of the clinical trials. This responsibility includes the following elements:

- Precise tracking of patient/study participant accrual
- Ongoing assessment of patient/study participant eligibility and evaluability
- Adequate measures to ensure timely submission of study data
- Adequate measures to ensure timely medical review and assessment of data for each patient/study participant
- Rapid reporting of adverse events and treatment-related morbidity information
- Periodic evaluation of outcome measures and patient safety information

Failure to comply with timely submission and query resolution may result in temporary suspension of site accrual and require submission of a CAPA plan.

2.3.2 Data Safety Monitoring Board (DSMB)

A Data Safety Monitoring Board (DSMB) has been established for the Cancer Therapy Evaluation Program (CTEP), ETCTN for review of data for randomized Phase 2 studies activated on and after October 1, 2019.

The DSMB's role is to assist the NCI maintain the integrity of randomized phase 2 clinical trials by providing independent supervision of the efficacy and safety outcomes of the trial while blinding the study team and CTEP staff to efficacy data

during the course of the trial. Specifically, trials placed under the DSMB are phase 2 trials where the comparison of clinical outcome of two or more treatment arms will be determined. The DSMB will review and evaluate the safety and efficacy data for patients treated in the randomized phase II portion of the studies at protocol-specified time/data points, make recommendations on possible protocol modifications and other pertinent recommendations for the conduct of the studies and oversee the conduct of the trial's interim analyses to ensure the pre-specified trial algorithm (where applicable) is being implemented as designed.

For the early phase clinical trials funded by the NCI, in absence of requiring a formal DSMB, a data and safety monitoring plan is still required in accordance with NIH policy (<http://grants.nih.gov/grants/guide/notice-files/NOT-OD-00-038.html>).

2.3.3 Auditing Program

Auditing is a systematic and independent examination of trial related activities and documents to determine whether the evaluated trial related activities were conducted, dates recorded, analyzed and accurately reported according to the protocol, sponsor's SOPs, GCP, and the applicable regulatory requirements. It is a snapshot in time, commonly an on-site process, and consists of reviewing a subset of patient/study participants on a trial.

The purpose of the auditing program is to document the accuracy of data submitted to CTMS and NCI/CTEP, to verify investigator compliance with the protocol and applicable regulatory requirements and guidelines. If necessary, provide institution staff with resources for a more thorough understanding of the regulatory requirements, good clinical practices (GCPs), data collection and data management practices.

2.3.4 CTMB – Audit Information System (AIS)

The CTMB has designed an information system which permits the on-line submission and collection of all data/findings from monitoring visit and audits. This includes scheduling and tracking monitoring visits and audits, transmission of final reports for monitoring and auditing, collection and tracking of follow-up responses to findings, and capturing documentation for the review of preliminary reports, final reports and follow-up responses. The system allows restricted access to the stored data and will keep a record of any data changes. The CTMB-AIS can be accessed after obtaining: an Identity and Access Management (IAM) account, appropriate documented training, and providing a username and password at:

<https://ctepcore.nci.nih.gov/CTMBWeb/>

SECTION 3 Oversight of Early Phase Clinical Trials

3.1 Types of Monitoring Methods

Prior to its activation, an early phase clinical trial is assigned one of following types of monitoring methods:

3.1.1 Comprehensive Monitoring (CTMS-Monitored Trials)

For protocols assigned for CTMS Comprehensive Monitoring (Phase 1 and early Phase 2, or trials where toxicities may be of concern), data is to be submitted to CTMS at least once every two weeks via Medidata Rave (or other modality if approved by CTEP). Monitoring visits will be conducted three times annually (one annual site visit and two data reviews). Information on CTMS reporting is available at: <http://theradex.com/clinicalTechnologies/?National-Cancer-Institute-NCI-11>.

3.1.2 Routine Monitoring (CTMS-Monitored Trials)

For protocols assigned for CTMS Routine Monitoring, data is to be submitted to CTMS at least once every two weeks via Medidata Rave (or other modality if approved by CTEP). Monitoring visits will be conducted on an 18-36 month basis. More frequent reviews may be conducted if warranted by accrual or due to concerns regarding data quality or timely submission. Information on CTMS reporting is available at: <http://theradex.com/clinicalTechnologies/?National-Cancer-Institute-NCI-11>.

3.2 Types of Visits and Frequency

3.2.1 Clinical Trials Designated for Comprehensive Monitoring

- Data Review - review of selected patient cases (based on enrollment)
- Annual Site Visit - review of all components (Regulatory Documentation, Pharmacy, and Patient Cases)

Generally, there are two Data Reviews and one Annual Site Visit per year, per institution. Additional Data Reviews may be mandated based on the protocol. Due to frequency of visits, re-visits/re-audits are not designated as a type of visit for the CTMS Comprehensive monitored studies.

3.2.2 Clinical Trials Designated for Routine Monitoring

Review of these clinical trials usually occur less often but on a regular basis.

- Routine Visit – review of all components (Regulatory Documentation, Pharmacy and Patient Cases). Depending on the extent or circumstances of the monitoring, the review may be conducted on-site or off-site.
- Frequency – reviews are conducted on a 18 to 36 month basis. More frequent visits may be conducted to consolidate CTMS routine visits with CTMS

comprehensive visits, if warranted by accrual. Due to frequency of visits, re-visits/re-audits are not designated as a type of visit for the CTMS comprehensive monitored trials. Additional visits may occur if there are patient safety concerns, or concerns related to data quality or timely submission.

3.3 Clinical Trials Designated for CDUS Monitoring (Legacy Studies)

Protocols (including PEP-CTN studies) assigned to be Clinical Data Update System (CDUS) monitored consist of cumulative protocol and patient data collections. These data are submitted by the sites electronically to CTEP on a quarterly basis. Limited data is made available for viewing via internal systems. However, for reviewing a more complete dataset, the CDUS data is uploaded into Web Reporting (see Section 3.4 for more information on Web Reporting).

Note: CDUS monitoring method does not apply to trials in Rave or using TSDV (Targeted Source Data Verification).

When a site undergoes a CTMS monitoring visit for a routine visit as described under Section 3.2, that also has CDUS-monitored studies, patient cases from these CDUS monitored studies may be selected for review during the same visit. Review of these patient cases are conducted in the same manner as the patient cases selected for review for the CTMS monitored studies. A re-visit/re-audit may be assigned for a CDUS-monitoring visit, if warranted, because of an Unacceptable rating for one or more of the components reviewed.

During routine and comprehensive monitoring annual visits, the CTMS monitor meets with the lead Clinical Investigator to review their responsibilities and obtain an update on the progress of the clinical trial. The CTMS monitor determines whether the clinical trial-related activities were conducted according to the protocol, GCPs, and applicable regulatory requirements.

If an institution is withdrawn, continued collection of follow-up data of enrolled patient/study participants according to the study schedule is required. Therefore, these sites remain eligible for a monitoring visit. The selection of a withdrawn site for monitoring is at the discretion of the CTMB.

3.4 CTEP Web Reporting

WebReporting is a web-based tool to perform aggregated adverse event evaluations at any time during the conduct of a clinical investigation. The tool provides cumulative safety data on adverse events by grade and attribution. WebReporting provides information on accrual by site and treatment assignment as well as AEs occurring by treatment assignment. Investigational agent activity and overall study compliance by the institution are accessible. This tool is used by the Medical Officers in CTEP's Investigational Drug Branch and all clinical investigators on NCI-sponsored ETCTN clinical trials and other early phase CTMS-monitored trials. Monthly attestation of review and monitoring is captured for review.

3.5 Special Audits and Off-Cycle Visits

A special audit can be a response audit or an off-cycle visit.

A Response Audit may be conducted when there are initial promising findings. Such audits may include independent radiologic review for confirmation of disease response. CTEP or

a sponsor may request a 'response audit' and CTEP determines if this type of audit is warranted.

An Off-cycle/For Cause visit may be warranted when there are significant irregularities found through quality control procedures or when allegations of possible scientific misconduct are communicated. It is the responsibility of the organization or Clinical Investigator to immediately notify CTMB upon learning of any significant irregularities or allegations related to scientific misconduct by a staff member or site participating in their research program.

CTMB may coordinate or request that the CTMS coordinate a special audit. Selection of auditors to conduct these types of audits will be made by the NCI. Other federal agencies or offices may be invited to participate in a special audit at the discretion of the NCI.

3.6 Monitoring Withdrawn Institutions

If an institution is withdrawn, continued collection of follow-up data of enrolled patient/study participants according to the study schedule is required. Therefore, these sites remain eligible for a monitoring visit. The selection of a withdrawn site for monitoring is at the discretion of the CTMB.

SECTION 4 PREPARING FOR THE MONITORING VISIT

This section discusses the timing of notifying a site of a monitoring visit, selecting the monitoring team, and selecting the protocols and patient cases for review.

4.1 Arranging the Monitoring Visit

A planned on-site or off-site visit is entered into the Clinical Trials Monitoring Branch-Audit Information System (CTMB-AIS) by CTMS when the previous visit for the same institution is considered complete (i.e., monitoring report and CAPA plan are reviewed and acknowledged by CTMB). The site to be monitored is usually contacted two months in advance of the visit to ensure sufficient notification for the site to prepare for the visit.

The site is provided with a list of protocols and patient cases selected for review one month in advance of the visit to allow the institution staff sufficient time to prepare, assemble and label the required materials. In the event of a 'for cause' visit, advance notice for conducting an on-site visit and the selection of protocols and/or patient cases to be reviewed may be limited due to the nature of the visit.

4.2 Location of Monitoring Visit

For continued oversight of patient safety, there may be circumstances when remote monitoring/auditing is necessary. To the extent possible, this approach should include remote access to the site's Electronic Medical Records (EMRs) system. Due to logistical issues and unfamiliarity with the site's EMR system related to conducting remote monitoring, it may require extending the duration of the review (i.e., # of days).

When scheduling the monitoring visit, below are the options to select from in the CTMB-AIS database:

- On-Site Review: conducted at the institution being monitored
- Off-Site/Remote Review:
 - Review conducted at parent/affiliated site
 - Review conducted remotely at CTMS location
- Hybrid Review: combination of off-site and on-site review

The use of the above approaches is at the discretion of the CTMS with consultation with CTMB. The address to enter in the AIS database when scheduling an Off-site or Hybrid review is as follows:

- Off-site/Remote Review – enter address of CTMS or Parent Institution
- Hybrid Review – enter address of the where the component(s) being reviewed off-site is taking place. For example, if regulatory documents are reviewed at CTMS and patient cases are reviewed on-site at the institution, enter the 'off-site' address for the review of the regulatory documents. Note: Location of review by component must be identified under the Review Procedures section of the monitoring report.

For on-site visits, institutions may require all entrants (including monitors) to display a government issued ID.

For off-site/remote visits, institutions may require the monitor to display a government issued ID. However, Personally Identifiable Information (PII) should not be requested of the monitor. Examples of what should not be provided are birthdate, copy of monitor's driver's license, social security number, etc. Their IAM account number may be used in lieu of these identifiers. Furthermore, monitors are not Business Associates as defined in the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule.

4.3 Selection of Protocols and Patient Cases for On-Site or Off-Site Monitoring

The CTMS selects the protocols and patient cases for review. While most cases will be selected from patients/study participants accrued since the previous visit, any patient case can be reviewed, at any time.

In the event of a patient case transfer, the receiving/accepting institution should ensure that complete documentation is provided as part of the transfer process. Any monitoring visit/review taking place after the date of transfer will occur at the receiving/accepting institution. This is because only the accepting institution will have access to the subject's information after the transfer takes place.

4.4 Selection of the Monitor or Monitoring Team

The monitor or monitoring team is composed of staff from the CTMS which may include Clinical Research Associates (CRAs), nurses, pharmacists and physicians. On occasion, the monitoring team may be augmented with staff from the NCI or extramural physicians who serve as volunteer monitors.

Monitors are selected based on monitoring experience, knowledge of the federal regulations, GCPs, NCI guidelines and other procedural documents. All monitors must be registered minimally as an Associate Plus (AP) level in the Registration and Credential Repository (RCR).

It is the responsibility of the CTMS staff when scheduling a monitoring visit to ensure there is no 'Conflict of Interest (COI)', or potential COI, between the monitor(s) and the institution being visited.

4.5 Institution Responsibilities

The Lead Academic Organization (LAO) or Lead Institution is responsible for ensuring that all relevant materials are available for review at the time of the visit. In most cases, monitoring visits will be conducted on-site. However, in some circumstances (low accrual, geographical proximity) institutions may be requested to send records to the LAO or Lead Institution for review. In this case, the LAO or Lead Site of the study must ensure institutions provide either the original patient/study participant source documents or copies of the complete record. Alternatively, if reviews take place entirely off-site/remotely, records will need to be provided via an agreed upon mechanism(s).

The following records must be available the day of the visit or sooner, if requested:

- IRB documents, copies of the locally utilized informed consent documents, Delegation of Tasks Logs (DTLs) and other regulatory documentation, if applicable

- NCI Drug Accountability Record Forms (DARFs) for control and satellite pharmacies, shipping receipts, etc. and/or log for imaging/radiopharmaceutical agents
- Complete medical records (or copies) of patient cases selected for review
- Dictated report of all imaging studies (X-rays, scans, MRIs, PET, etc.)
- For imaging studies: source documents/worksheets used for imaging acquisition, processing, quality assurance documentation, reader's interpretation, record of imaging administration, patient/study participant monitoring (vital signs, monitoring of contrast reactions, etc.), and log of staff signatures and imaging responsibilities
- Other relevant source documents or information

To facilitate the review process, it is advisable that institution staff label all documents such as hospital/clinic records, research notes, on-study labs, scans and imaging reports, informed consent documents, etc. If the institution utilizes electronic medical records (EMRs) and/or scans, the records may be printed for viewing by the monitors, or computers with EMR access must be provided. A site staff member must be available to assist with navigating through the EMR system.

For reviews conducted off-site/remotely, the circumstances vary depending on the approach used to review the documentation. A site staff member must also be available to contact and assist with questions.

SECTION 5 CONDUCTING THE VISIT

During the visit, the monitors review specific data related to research and regulatory requirements as described in this section. Source documents must be used to independently verify submitted study data and for protocol compliance. Source documents may include but are not limited to the following:

- Regulatory Documentation (IRB of record documents, informed consent forms, and Delegation of Tasks Logs, if applicable)
- NCI Drug Accountability Record Forms (DARFs) and/or log for imaging/radiopharmaceutical agents, records of shipments/transfers/returns, stock recovery notices, etc.
- Inpatient and outpatient medical records
- Progress notes
- Dictated report of all imaging studies (X-rays, scans, MRIs, PET, etc.)
- Laboratory data
- Admission and discharge summaries
- Study flow sheets and other research records that are signed and dated on a real-time basis by the health care practitioner evaluating the patient/study participant
- For advanced imaging studies, source documentation worksheets would include the acquisition, processing, quality assurance documentation, reader's interpretation, record of imaging administration, patient/study participant monitoring (vital signs, monitoring of contrast reactions, etc.), and log of staff signatures and imaging responsibilities
- Protocol or study roadmaps
- Registration/enrollment tracking sheets
- Patient diaries/calendars/adverse event logs

In preparation for the monitoring visit, certain documents such as regulatory documents, informed consent forms, delegation of tasks logs (DTLs) and DARFs may be reviewed prior to the visit.

5.1 Assessing Findings from the Monitoring Visit

A visit consists of reviewing and evaluating the following components: (1) Regulatory Documentation which includes conformance with IRB regulations and guidelines, informed consent form requirements, and maintenance of delegation of tasks logs (if applicable) (2) Pharmacy operations and record-keeping (use of NCI DARFs or NCI approved drug accountability logs, etc.) and (3) individual Patient Cases. A Review Worksheet for each of these components can be found under Appendices 2, 3, and 4.

During the visit, each of the three components will independently be assigned an assessment of either Acceptable; Acceptable Needs Follow-up, or Unacceptable; based on findings at the time of the visit. An inclusive and precise definition of what constitutes an 'unacceptable' finding is difficult to construct. Rather than developing an inclusive quantitative definition, the CTMS will use a common set of terms or examples of Critical,

Major and Lesser deficiencies. A common system is utilized for assessing each component of the visit, resulting in a standard format for monitoring reports generated in the CTMB-AIS. See definitions below:

Critical Deficiency

Any condition, practice, process or pattern that adversely affect the rights, safety or well-being of the patient/study participant and/or the quality and integrity of the data; includes serious violation of safeguards in place to ensure safety of a patient/study participant and/or manipulation and intentional misrepresentation of data (see: www.ema.europa.eu/docs/en_GB/document_library/other/2014/12/WC500178525.pdf).

NOTE: See 'Guidance for Allegations of Research Misconduct' (Appendix 1) for reporting any allegation of research misconduct that is detected by site staff, Lead Academic Organization (LAO), and/or CTMS outside of a monitoring visit (i.e., through internal Quality Assurance review procedures).

Major Deficiency

A variance from protocol-specified procedures or practices that makes the resulting data questionable.

Lesser Deficiency

Finding does not have significant impact on the outcome or interpretation of the study and is not described above as a major deficiency. An unacceptable frequency/quantity of lesser deficiencies should be assigned as a major deficiency when determining the final assessment of a review component.

5.2 Review of the Regulatory Documentation

Protocols with no patient enrollment are not required to be selected for review.

5.2.1 Review of the NCI Central Institutional Review Board (CIRB) - IRB of Record

For each protocol selected for an review, the following should be the minimum items to be reviewed:

- Annual Institution Worksheet approval letter from CIRB to the Principal Investigator (PI) for study specific worksheet (local context)
- Documentation that CIRB approval was obtained prior to patient registration
- Unanticipated problems, serious non-compliance and/or continuing non-compliance problems as defined by OHRP are reported (see www.hhs.gov/ohrp/regulations-and-policy/guidance/reviewing-unanticipated-problems/index.html)

5.2.2 Review of the Local Institutional Review Board (LIRB) - IRB of Record

For each protocol selected for review, the following should be the minimum items to be reviewed:

- Documentation of full-board initial IRB approval
- Documentation of full-board IRB annual reapproval
- Documentation of timely IRB approval (or disapproval) of protocol amendments that affect more than minimal risk
- Documentation of IRB approval or reapproval prior to patient registration
- Documentation of expedited review done appropriately
- Documentation of internal safety reports submitted timely
- Documentation of external safety reports (when required by the local IRB) submitted timely

The following descriptive terms should be used in assessing compliance:

- Delayed reapproval: Protocol reapproval by the IRB delayed up to one year
- Expired reapproval: Protocol reapproval by the IRB delayed for greater than one year
- Missing reapproval: Missing documentation of protocol reapproval (e.g., no letter from IRB stating reapproval granted, IRB minutes not available)
- Expedited review: Expedited review conducted instead of full-board review (see www.hhs.gov/ohrp/regulations-and-policy/guidance/guidance-on-expedited-review-procedures/index.html)
- Other: Any regulatory concern not described above

Amendments (addendums or updates) must be approved (or disapproved) by the IRB of record within 90 calendar days of posting on the CTSU website. For studies reviewed/conducted at sites outside of the U.S., amendments must be approved within 120 days to allow for local regulatory authority review, applicable translations, and review by the IRB of record. Amendments that are editorial or administrative in nature are exempt from the 90 calendar day requirement, may be deemed a lesser deficiency. Typographical corrections, rephrasing a sentence/section to add clarity, reformatting the document and/or changes made related to contact information are examples of an editorial or administrative change.

Unanticipated problems, serious non-compliance and/or continuing non-compliance problems as defined by OHRP (see: www.hhs.gov/ohrp/regulations-and-policy/guidance/reviewing-unanticipated-problems/index.html) including external safety reports must be reported to the IRB within 90 calendar days of posting on the CTSU website.

5.2.3 Listing of IRB Deficiency Types

The following are examples of critical, major and lesser deficiencies to be considered when assessing CIRB/IRB compliance. This list does not represent an all-inclusive list of possible deficiencies that may be found during a monitoring visit.

5.2.3.1 CIRB – IRB of Record

Critical CIRB Deficiency

- Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.1](#)

Major CIRB Deficiencies

- Unanticipated problems, Serious Non-Compliance and/or Continuing Non-Compliance (per OHRP) problems not reported
- Institution enrolls under an incorrect CTEP site code and the institution or institution CTEP site code is not covered by the CIRB
- Other (explain)

Lesser CIRB Deficiencies

- Copy of CIRB approval letter/study worksheet is not available or accessible at the time of the review
- Other (explain)

5.2.3.2 Local IRB – IRB of Record

Critical IRB Deficiency

- Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.1](#)

Major IRB Deficiencies

- Initial approval by expedited review instead of full-board review
- Expedited reapproval for situations other than approved exceptions
- Registration and/or treatment of patient prior to full IRB approval
- Reapproval delayed greater than 30 calendar days, but less than one year
- Registration of patient on protocol during a period of delayed reapproval or during a temporary suspension (i.e., Request for Rapid Amendment)
- Missing reapproval
- Expired reapproval
- Internal reportable adverse events reported late or not reported to the IRB
- Lack of documentation of IRB approval of a protocol amendment that affects more than minimal risk or IRB approval is greater than 90 calendar days (or 120 calendar days for sites outside of the U.S.) after Lead Academic Organization (LAO); this includes a 'Request for Rapid Amendment (RRA)' resulting from an Action Letter indicating temporary suspension of accrual with expedited review permitted
- Failure to submit or submitted after 90 calendar days, any reportable external safety report to the IRB that is considered an unanticipated

problem as defined by OHRP, unless there is a local IRB policy that does not mandate reporting of external safety reports

- Other (explain)

Lesser IRB Deficiencies

- Protocol reapproval delayed 30 calendar days or less
- Delayed reapproval for protocol closed to accrual for which all study participants have completed therapy
- Amendment editorial revision or administrative in nature, a specific document not submitted or not submitted timely to the local IRB
- Other (explain)

5.2.4 Review of the Informed Consent Content (ICC)

If the CIRB is utilized, a minimum of five (5) informed consent forms must be reviewed for content from the protocols selected for review. If there are more than ten (10) informed consent forms to review, then a random sample of at least 50% must be selected for review. Priority for selection must be given to registration trials. If deficiencies are noted, additional protocols may be reviewed for ICC at the monitor's discretion.

If the local IRB is utilized, an informed consent form must be reviewed for all protocols selected for review. The review of informed consent content is to ensure all elements are included per the federal regulations.

The following items must be reviewed for each CIRB and local IRB approved informed consent document selected:

- Omission of one or more required informed consent elements as listed in the model approved by the NCI and required per the federal regulations
- Omission of one or more risks/side effects as listed in the model informed consent document
- Omission of any revision to the informed consent document per an amendment or failure to revise an informed consent document in response to an NCI Action Letter regarding risks that require a change to the informed consent document
- Changes made to the informed consent document not approved by the IRB of record; for CIRB-approved consent forms, the only change allowed is the incorporation of the CIRB-approved boilerplate (local context)
- Multiple cumulative effects of lesser deficiencies for a given informed consent document

The following are examples of critical, major and lesser deficiencies to be considered when assessing ICC deficiencies. This list does not represent an all-inclusive list of possible deficiencies that may be found during a monitoring visit.

Critical ICC Deficiency

- Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.1](#)

Major ICC deficiencies

- Missing any of the following statements or language specific to the elements required per the federal regulations, when appropriate:
 - Involves research, purposes; duration of participation; description of procedures; identification of experimental procedures
 - Description of foreseeable risks or discomforts
 - Description of any benefits to subjects or others
 - Disclosure of alternative procedures or treatments
 - Description of the extent of confidentiality of records
 - Explanation regarding compensation and/or whether treatments are available if injury occurs, including who to contact if injury occurs
 - Explanation of whom to contact for answers to pertinent questions about the research and whom to contact for questions related to research subject's rights
 - Statement that participation is voluntary; refusal to participate involves no penalty or loss of benefits; subject may discontinue participation at any time
 - Unforeseeable risks to subject, embryo or fetus
 - Statement that circumstances in which subject's participation may be terminated by the investigator without subject consent
 - Statement of additional costs to subject that may result from participation in the study
 - Statement of consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject
 - Statement that significant new findings which may be related to subject's willingness to continue participation will be provided to subject
 - Disclosure of approximate number of subjects involved in the study
 - Statement: "A description of this clinical trials will be available on the www.clinicaltrials.gov, as required by US Law. This website will not include information that can identify you. At most, the website will include a summary of the results. You can search this website at any time"
- Statement that a copy of the consent form will be given to the subject
- Failure to revise the informed consent document in response to an NCI Action Letter regarding risks
- Significant or substantial changes to the consent form document deviating from the CIRB-approved boilerplate (other than local context) not approved by the CIRB

- Consent form document contains changes not approved by the IRB of record, including changes to questions that do not match the model consent form
- Multiple cumulative effect of lesser deficiencies for a given consent form
- Other (explain)

Lesser ICC Deficiencies

- Failure to have the informed consent document (after CIRB amendment approval) locally implemented within 30 calendar days of notification (posted on the CTSU website)
- Language/text is missing or added that is administrative or editorial in nature (e.g., rephrasing a sentence/section to add clarity, reformatting the document and/or changes made related to contact information are examples of an editorial or administrative change)
- IRB approved informed consent document with incorrect version date
- Other (explain)

5.2.5 Review of the Delegation of Tasks Log (DTL)

A Clinical Investigator is held responsible for the conduct of a clinical trial and ultimately the safety and well-being of the patients/study participants. Due to the nature and complexity of conducting clinical research, the Clinical Investigator may delegate activities/duties associated with the clinical trial to his/her staff.

To evaluate the roles and responsibilities of any individual contributing efforts to a clinical trial, a Delegation of Tasks Log (DTL) must be maintained. The DTL is to list anyone who contributes significant trial-related duties. This log is generated and maintained by institution and by protocol, by the responsible Clinical Investigator.

The monitor will review a minimum of five (5) DTLs. If there are more than ten (10) DTLs, then a random sample of at least 50% must be selected for review. Priority for selection must be given to registration trials. The monitor will review the log to evaluate appropriate implementation and maintenance. If deficiencies are noted, additional DTLs may be reviewed at the monitor's discretion.

The following are examples of major and lesser deficiencies to be considered when assessing compliance of the DTL. This list does not represent an all-inclusive list of possible deficiencies that may be found during a monitoring visit.

Critical DTL Deficiency

- Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.1](#)

Major DTL Deficiencies

- Performing tasks not assigned to individual
- Failure to sign DTL annually
- Individual performing study-related activities not listed on DTL

- Performing study-related activities without an approved DTL
- Other (explain)

Lesser DTL Deficiencies

- Other (explain)

5.2.6 Assessment of the Regulatory Documentation Review

Each item reviewed as part of the visit can be found to be Critical, Major, Lesser, OK, or Not Reviewed. If an item that was planned to be reviewed as part of the visit was not reviewed for any reason (e.g., insufficient time for monitor to review, etc.), this must be explained in the Regulatory Documentation section of the monitoring report.

One of the following designations must be used when assigning an assessment for the review of the Regulatory Documentation component:

Acceptable

- No deficiencies identified and no follow-up required
- Few lesser deficiencies identified and no follow-up required
- Any major deficiency identified during the review that was addressed and/or corrected prior to being notified of the monitoring visit for which a written and dated Corrective and Preventative Action (CAPA) plan exists and no further action is required by the CTMS, the institution, or the clinical investigator because no similar deficiency has occurred since the CAPA plan was implemented. However, this approach may not be applicable if a deficiency is associated with a safety concern and determined that further action is necessary (to be discussed with CTMB liaison). In either case, CTMB must receive a copy of the CAPA plan at the time the monitoring report is uploaded into the CTMB-AIS or by the date follow-up is due.

Acceptable Needs Follow-up

- Any major deficiency identified during the review not corrected and/or addressed **prior to** the visit
- Multiple lesser deficiencies identified

Unacceptable

- A single critical deficiency
- Multiple major deficiencies identified
- Multiple lesser deficiencies of a recurring nature found in most of the protocols or informed consent documents reviewed

If the Regulatory Documentation Review is rated as Acceptable Needs Follow-up or Unacceptable, the institution will be required to submit a written Corrective and Preventative Action (CAPA) plan and/or written response to the CTMS. A copy of the CAPA plan/response, along with an assessment of adequacy by CTMS must be

uploaded into the CTMB-AIS (for CTMB review) within 45 calendar days from the date the monitoring report is finalized, acknowledged by CTMB and submitted to the site/recipient.

For CDUS-monitored studies, a re-visit/re-audit is mandatory for any component rated as Unacceptable. The re-visit should be done no later than a year after an Unacceptable rating.

5.3 Review of Accountability of Investigational Agents and Pharmacy Operations

Agent accountability and storage procedures described in this section are required under federal regulations and NCI policy for study-supplied agents. See NCI/CTEP/PMB policies under: https://ctep.cancer.gov/branches/pmb/agent_management.htm.

The NCI does not endorse any electronic DARF (eDARF) pharmacy software package. Institutions that choose to use an electronic accountability system must ensure the database can produce a paper printout that is identical to the NCI DARF. Electronic accountability system database limitations are not valid reasons for improper accountability documentation per NCI policy.

5.3.1 Control Dispensing Area/Pharmacy

The Control Dispensing Area for each investigator is identified as the shipping address receiving the study-supplied agent from the supplier.

The Control Dispensing Area is responsible for:

- Direct receipt of study-supplied agent from the supplier
- Appropriate storage, accountability and security of study-supplied agent
- Dispensing study-supplied agent to patients/study participants as prescribed by investigator (IVR) or non-physician investigator (NP/IVR) writing orders is an authorized, study-eligible person with an active registration status in the CTEP Registration and Credential Repository (RCR), and is qualified to write orders per institutional policy, their local, state laws and regulations or follow applicable international requirements
- Overall agent accountability and inventory control including provision of agent to authorized, study-eligible physician investigator (IVR) with an active registration status in RCR at satellite dispensing areas, as applicable, oversight of satellite dispensing areas, and dissemination of study agent stock recovery information
- Timely return and final disposition of non-dispensed study-supplied agents (e.g., returns, authorized transfers or authorized local destructions)
- Physical destruction of patient returned study-supplied agents per applicable regulations and institutional policies and procedures

5.3.2 Satellite Dispensing Area/Pharmacy

The Satellite Dispensing Area receives study-supplied agent from a Control Dispensing Area. The Satellite Dispensing Area is under the direct responsibility and

oversight of the Control Dispensing Area.

The Satellite Dispensing Area is responsible for:

- Receiving study-supplied agent from the Control Dispensing Area
- Appropriate storage, accountability and security of study-supplied agent
- Dispensing study-supplied agent to patients/study participants as prescribed by authorized, study-eligible physician investigator (IVR) or non-physician investigator (NPIVR) writing orders is an authorized, study-eligible person with an active registration status in the CTEP Registration and Credential Repository (RCR), and is qualified to write orders per institutional policy, and their local, state laws and regulations, or follow applicable international requirements
- Timely return of non-dispensed study-supplied agent to the Control Pharmacy Dispensing Area for final disposition or destruction
- Physical destruction of patient returned study-supplied agents per applicable regulations and institutional policies and procedures

5.3.3 Imaging Studies/Radiopharmaceutical Therapy Agents/Cancer Control

Imaging and radiopharmaceutical therapy agents may or may not be managed by the pharmacy depending on the protocol. Imaging and radiopharmaceutical therapy agents are usually delivered directly to the imaging, radiation oncology, nuclear medicine or nuclear pharmacy department or center that is performing the imaging study or radiopharmaceutical therapy. Cancer control/prevention and imaging and radiopharmaceutical therapy agents are usually manufactured on-site or purchased from and distributed by commercial vendors. Even though these study agents are not usually distributed by the NCI, cancer control/imaging and radiopharmaceutical therapy studies should abide by the same NCI/CTEP policies. It is strongly suggested that NCI DARFs be utilized to track these study agents. If NCI DARFs are not utilized, the imaging study agent/radiopharmaceutical accountability logs must at least capture the same information as on the NCI DARFs. Some protocols will describe the record keeping processes.

5.3.4 Guidelines for Conducting the Pharmacy Review

There are challenges with categorizing a deficiency as critical, major or lesser for the pharmacy component of the visit. As a result, the CTMS monitors determine the rating based on identified non-compliance items. The monitor will review: drug accountability, proper use of NCI DARFs, adherence to appropriate storage and security measures and ensure required pharmacy procedures are being followed for NCI-sponsored and/or funded trials using study-supplied agents, including cancer control/prevention, imaging and radio-pharmaceutical therapy agents. DARFs are reviewed by protocol and study agent. When capturing the number of DARFs reviewed on the monitoring report, it is the number of study agents (including different 'strengths'), not the number of DARF pages. Cancer control/prevention, imaging and radiopharmaceutical therapy agents may be supplied by other vendors.

Findings such as any condition, practice, process or pattern that adversely affect the rights, safety or well-being of the patient/study participant and/or the quality and

integrity of the data; including serious violation of safeguards in place to ensure safety of a patient/study participant and/or manipulation and intentional misrepresentation of data, should be cited as a **Critical-Non-Compliance** (as defined under [Section 5.1](#)).

The following pages outline the various types of descriptions to assess overall **Compliance** and **Non-Compliance**:

NCI DARFs COMPLETELY AND CORRECTLY FILLED OUT

Compliance

- NCI DARF maintained and maintained completely, accurately and on a timely basis
- Oral NCI DARF maintained for oral study supplied agents, and maintained completely, accurately and on a timely basis
- DARF maintained to verify cancer control/imaging study-supplied agents are administered to patients/study participants
- Paper and/or electronic DARFs (eDARFs) contains all required information; paper printout of eDARF is identical to NCI DARF
- No erasures or whiteout used on paper DARF
- Corrections are lined out, initialed and dated on paper DARF
- Corrections are appropriately documented on eDARFs in electronic inventory system
- Study-supplied agent is dispensed to a registered patient/study participant is recorded on the appropriate DARF
- Multiple dose vials appropriately used for more than one patient/study participant and doses documented correctly on separate lines of the DARF
- No dispensing of study-supplied agent to a non-registered patient/study participant
- Patient/study participant returns of oral study-supplied agents are documented on the oral DARF
- Patient/study participant returns of non-oral, non-patient-specific agent supplies are not documented on the DARF
- Patient/study participant returns of non-oral, patient-specific agent supplies are documented on the DARF
- [For NCI sponsored study] NCI-supplied study agents are not repackaged or reshipped to other investigators or locations by mail or express carrier, only shipment of oral study agents directly to study subjects is allowed
- Study agent final disposition of inventory is documented on DARF

Non-Compliance

- NCI DARF not maintained or not maintained completely, accurately or on a timely basis
- Oral NCI DARF not maintained for oral study-supplied agents, not maintained completely, accurately or on a timely basis
- DARF not maintained to verify cancer control/imaging study supplied agents are administered to patients/study participants
- Paper and/or electronic DARFs (eDARFs) are not completed as required; paper printout of eDARF is not identical to the NCI DARF
- Erasures or whiteout used on paper DARF
- Corrections are not lined out, initialed and dated on paper DARF
- Corrections are not appropriately documented on eDARF in electronic inventory system
- Study-supplied agent is dispensed to a registered patient/study participant is not recorded on the appropriate DARF
- Multiple dose vials not used for more than one patient/study participant and/or doses not documented correctly on separate lines of the DARF
- Dispensing of study-supplied agent to a non-registered patient/study participant recorded on the DARF
- Patient/study participant returns of oral study-supplied agents not documented on the Oral DARF
- Patient/study participant returns of non-oral, non-patient-specific agent supplies are documented on the DARF
- Patient/study participant returns of non-oral, patient-specific agent supplies are not documented on the DARF
- [For NCI sponsored study] NCI-supplied study agents are repackaged and/or reshipped to other investigator or locations by mail or express carrier
- Study agent final disposition of inventory is not documented on DARF

DARFs PROTOCOL AND STUDY AGENT SPECIFIC

Compliance

- No substitution of any study-supplied agent, with non-study supplied study agent, including commercial agents
- DARF not maintained by Lot #
- Single DARF not used for more than one protocol
- Separate DARFs used for a protocol using multiple study agents
- Separate DARFs used for multiple agents by: strength, dosage form, and by ordering investigator
- Separate DARFs used for patients/study participant when patient-specific DARF must be maintained
- Study-supplied agent is not used for pre-clinical or laboratory studies without written approval by NCI

Non-Compliance

- Substitution of any study-supplied agent, with non-study supplied study agent, including commercial agents
- DARF maintained by Lot #
- Single DARF used for more than one protocol
- Single DARF used for a protocol using multiple study agents
- Single DARF used for multiple agent strengths, dosage forms, or ordering investigators
- Single DARF used for multiple patients/study participants when patient-specific DARF must be maintained
- Study-supplied agent used for pre-clinical or laboratory studies without written approval by NCI

SATELLITE RECORDS OF DISPENSING AREA

Compliance

- Satellite Dispensing Area DARF is used at each location where study-supplied agent is received from the Control dispensing area and is stored more than a day
- Satellite Dispensing Area records are available at the time of the review
- Satellite Dispensing Area and Control records match and are accurately maintained
- Unused and un-dispensed study-supplied agent is documented as returned to Control dispensing area; Satellite Dispensing Area appropriately returns study agent to Control pharmacy for final disposition/destruction

Non-Compliance

- No satellite DARFs in use when required (i.e., stored more than a day)
- Satellite DARFs not available at the time of the review
- Satellite and Control records do not match or are not accurately maintained
- Unused and un-dispensed study-supplied agent is not documented as returned to Control dispensing area; Satellite Dispensing Area is inappropriately transferring and/or locally destroying study-supplied agent

NCI DARFs KEPT AS PRIMARY TRANSACTION RECORD

Compliance

- Study-supplied agent order receipts/ documentation (paper or electronic) are retained and available for review
- Documentation on Control DARF of study-supplied agent transactions and local destruction
- Quantities accounted for in physical inventory, and quantities match with DARF

Non-Compliance

- Study-supplied agent order receipts/ documentation (paper or electronic) are not retained or not available for review
- No documentation on Control DARF of study-supplied agent transactions and local destruction
- Quantities not accounted for in physical inventory; quantities do not match DARF

RETURN OF STUDY AGENT [NCI-sponsored studies]

Compliance

- Study agent is transferred to authorized investigator or protocol with NCI written approval
- Study agent not returned to PMB and destroyed on-site per site's destruction policy, and study agent not supplied by PMB is not sent to PMB
- Return Form or documentation of local destruction authorization is maintained
- Unused/un-dispensed NCI-supplied study agent is returned, transferred or locally destroyed within 90 calendar days when requested by the NCI, or when patients/study participants are in follow-up, study is closed to enrollment and no NCI-supplied agent is being administered

Non-Compliance

- Study agent is transferred to investigator or protocol without NCI written approval
- Study agent returned to PMB that should have been destroyed on-site or study agent returned to PMB that was not supplied by PMB
- Return Form or documentation of local destruction not maintained
- Unused/un-dispensed NCI-supplied study agents not returned, transferred or locally destroyed within 90 calendar days when requested by the NCI, or when patients/study participants are in follow-up, study is closed to enrollment and no NCI-supplied study agent is being administered

STUDY AGENT STORAGE

Compliance

- Each study-supplied agent is stored separately by protocol, strength, dosage form (e.g., oral, injectable) and by ordering investigator
- Study-supplied agent is stored under proper temperature conditions; temperature monitoring documentation is maintained

Non-Compliance

- Study-supplied agent is not stored separately by protocol, strength, dosage form (e.g., oral, injectable) and/or by ordering investigator
- Study-supplied agent not stored under proper temperature conditions; temperature monitoring documentation not maintained

ADEQUATE SECURITY

Compliance

- Study-supplied agent is stored in a secure area
- Only authorized individuals have access to the secure areas

Non-Compliance

- Study-supplied agent is stored in an unsecured area
- Unauthorized individuals have access to a secure area without supervision

AUTHORIZED PRESCRIPTION(S)

Compliance

- [For NCI sponsored study] Prescribing investigator (IVR) or non-physician investigator (NPIVR) writing orders for study-supplied agent has an active registration status in the CTEP Registration and Credential Repository (RCR)
- Prescribing investigator (IVR) or non-physician investigator (NPIVR) is an authorized, study-eligible person, and is qualified to write orders per institutional policy, their local, state laws and regulations, and follow applicable international requirements
- Pharmacy has procedures in place to ensure the person prescribing and writing orders for study-supplied agent is an authorized person

Non-Compliance

- [For NCI sponsored study] Prescribing investigator (IVR) or non-physician investigator (NPIVR) writing orders for study-supplied agent does not have an active registration status in the CTEP Registration and Credential Repository (RCR)
- Prescribing investigator (IVR) or non-physician investigator (NPIVR) writing orders is not an authorized, study-eligible person, or is not qualified to write orders per institutional policy, their local, state laws and regulations, or follow applicable international requirements
- Pharmacy does not have procedures in place to ensure person prescribing and writing orders for study-supplied agent is an authorized person

5.3.5 Assessment of the Pharmacy Review

Monitor discretion can be used for minor problem(s) identified during the review of the pharmacy. The number of active patients/study participants on NCI-sponsored and/or funded clinical trials, and the number of open protocols reviewed should be considered in the evaluation.

Items reviewed under the pharmacy component must be assessed as one of the following:

- Critical-Non-Compliant*
- Non-Compliant
- Compliant
- Not Reviewed

* Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.3.4](#)

If an item that was planned to be reviewed as part of the monitoring visit was not reviewed for any reason, it must be explained in the pharmacy narrative of the monitoring report.

One of the following designations must be used when assigning an assessment for the review of the Pharmacy component:

Acceptable

- Compliance in all categories and no follow-up required
- Any Non-Compliance item identified during the review that was addressed and/or corrected prior to being notified of the monitoring visit for which a written and dated CAPA plan exists and no further action is required by the CTMS, the institution, or the clinical investigator because no similar deficiency has occurred since the CAPA plan was implemented. However, this approach may not be applicable if a deficiency is associated with a safety concern and determined that further action is necessary (to be discussed with CTMB liaison). In either case, CTMB must receive a copy of the CAPA plan at the time the monitoring report is uploaded into the CTMB-AIS or by the date follow-up is due.

Acceptable Needs Follow-up

- Any non-compliance identified during the review that requires follow-up

Unacceptable

- A single Critical-Non-Compliance
- Multiple Non-Compliance items
- Inability to track the 'chain-of-custody' of a study-supplied agent(s)

No Assessment Required

- No study-supplied agent in stock or in-use for the timeframe being reviewed
- This designation applies under the following two conditions:
 - The review of the pharmacy consists of only security, storage and review of pharmacy procedures to ensure person is authorized to prescribe or write orders and has an active status in the CTEP Registration and Credential Repository (RCR)
 - Review of security, storage and pharmacy procedures (described above) were found to be 'compliant'

If the Pharmacy Review is rated as Acceptable Needs Follow-up or Unacceptable, the institution will be required to submit a written Corrective and Preventative Action (CAPA) plan and/or written response to the CTMS. A copy of the CAPA plan/response, along with an assessment of adequacy by CTMS must be uploaded into the CTMB-AIS (for CTMB review) by the CTMS within 45 calendar days from the date the monitoring report is finalized, acknowledged by CTMB and submitted to the site/recipient.

For CDUS-monitored studies, re-visit/re-audit is mandatory for any component rated as Unacceptable. A re-visit should be done no later than a year after an Unacceptable rating or when there is sufficient activity to assess the effectiveness of the CAPA plan. If the pharmacy requires a re-visit due to non-compliance related to storage and/or security, it must be conducted on-site.

5.4 Review of Patient Case Records

Each patient case must be reviewed to determine if there are any critical, major, or lesser deficiencies in each of the following categories:

- Properly signed and dated informed consent document, including consent process
- Eligibility of a patient/study participant
- Correct treatment and treatment sequence
- Evaluation of disease outcome/tumor response
- Assessment and reporting of adverse events related to treatment
- General quality of the data collected

If records are not in English, then a qualified translator chosen by the monitor(s) or institution must be present. Source documentation of each patient case selected for review considered missing at the time of the monitoring visit must be supplied to CTMS within 10 business days of the monitoring visit.

5.4.1 Deficiency Type by Category

The following examples of deficiencies do not represent an all-inclusive list of possible deficiencies that may be found during a monitoring visit. The term 'intervention' is intended to include non-treatment studies such as cancer control, prevention, advanced imaging, etc.

Informed Consent – Critical Deficiencies

- Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.1](#)
- Consent form document not signed and dated by the patient/study participant (or parent/legally authorized representative, if applicable)
- Patient/study participant signature cannot be corroborated
- Consent form not protocol specific

Informed Consent – Major Deficiencies

- Failure to document the informed consent process with the study participant
- Patient/study participant signs consent form document containing changes not approved by the CIRB/IRB
- Consent form document missing
- Translated consent, short form or other form of translation not available or signed/dated by a non-English speaking patient/study participant
- Consent form not signed by patient prior to study registration/enrollment
- Consent form does not contain all required signatures
- Consent form used was not the most current IRB-approved version at the time of patient registration
- Consent form does not include updates or information required by IRB
- Re-consent not obtained as required
- Consent of ancillary/advanced imaging studies not executed properly
- Other (explain)

Eligibility – Critical Deficiency

- Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.1](#)

Eligibility – Major Deficiencies

- Review of documentation available confirms patient/study participant did not meet all eligibility criteria and/or eligibility requirements were not obtained within the timeframe as specified by the protocol
- Documentation missing; unable to confirm eligibility
[Exception: Patients deemed ineligible based on laboratory/pathology reports following registration and changes based on central review of material.]
- Other (explain)

Treatment – Critical Deficiencies

- Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.1](#)
- Incorrect agent/treatment/intervention used

Treatment – Major Deficiencies

- Additional agent/treatment/intervention used which is not permitted by protocol
- Dose deviations or incorrect calculations (error greater than +/- 10%)
- Dose modification/treatment/intervention not per protocol; incorrectly calculated
- Treatment/intervention incorrect, not administered correctly, or not adequately documented
- Timing and sequencing of treatment/intervention not per protocol
- Unjustified delays in treatment/intervention
- Other (explain)

Disease Outcome/Response – Critical Deficiency

- Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.1](#)

Disease Outcome/Response – Major Deficiencies

- Inaccurate documentation of initial sites of involvement
- Tumor measurements/evaluation of 'status of disease' not performed, not reported, or not documented per protocol
- Protocol-directed response criteria not followed
- Claimed response (i.e., partial response, complete response, stable) cannot be verified, or auditor/monitor could not verify the reported response
- Failure to detect cancer (as in a prevention study) or failure to identify cancer progression
- Other (explain)

Adverse Events – Critical Deficiency

- Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.1](#)

Adverse Events – Major Deficiencies

- Failure to report or delayed reporting of an adverse event that would require filing an expedited Adverse Event (AE) report
- Adverse events not assessed by the investigator in a timely manner (per protocol)
- Grades, types, or dates/duration of serious adverse events inaccurately recorded
- Adverse events cannot be substantiated
- Follow-up studies necessary to assess adverse events not performed
- Recurrent under- or over-reporting of adverse events
- Other (explain)

General Data Management Quality – Critical Deficiency

- Any finding identified before or during the review that meets the definition of a critical finding as defined under [Section 5.1](#)

General Data Management Quality – Major Deficiencies

- Recurrent missing documentation in the patient/study participant records
- Protocol-specified laboratory tests or other parameters not done, not reported, or not documented
- Protocol-specified diagnostic studies including baseline assessments not done, not reported, or not documented
- Protocol-specified research (Quality of Life forms, collection of research samples, etc.)/advanced imaging studies not done or submitted appropriately
- Frequent data inaccuracies; un-redacted data^a
- Errors in submitted data; data cannot be verified
- Delinquent data submission^b
- Other (explain)

^a Assigning a major or lesser deficiency is dependent on the number of instances and type of un-redacted data (e.g., security number, patient name, etc.).

^b Assigning a major or lesser deficiency is based on the following: extent of the delay, percentage or number of delinquent forms, type of form (baseline, treatment, follow-up, etc), phase of the trial, patient on active treatment versus follow-up, etc.

Assigning Lesser Deficiencies

As defined under Section 5.1, a lesser deficiency may be assigned under each of the above categories if it is judged to not have a significant impact on the outcome or interpretation of the study and is not described above as a major deficiency. An unacceptable frequency/quantity of lesser deficiencies should be treated as a major deficiency in determining the final assessment of a component.

5.4.2 Assessment of the Patient Case Review

Each category (Informed Consent, Eligibility, Treatment, Disease Outcome/Disease Response, Adverse Event, General Data Management Quality) for each patient case reviewed can be found to be Critical (as defined by under [Section 5.1](#)), Major, Lesser, OK or Not Reviewed. If one or more categories is not reviewed for any reason (e.g., subject did not receive treatment, insufficient time for monitor to review, etc.) it must be explained in the patient case section of the monitoring report.

One of the following designations must be used when assigning an assessment for the review of the Patient Case component:

Acceptable

- No deficiencies identified and no follow-up required
- Few lesser deficiencies identified and no follow-up required
- Any major deficiency identified during the review that was addressed and/or corrected prior to being notified of the monitoring visit for which a written and dated CAPA plan exists and no further action is required by the CTMS, the institution, or the clinical investigator because no similar deficiency has occurred since the CAPA plan was implemented. However, this approach may not be applicable if a deficiency is associated with a safety concern and determined that further action is necessary (to be discussed with CTMB liaison). In either case, CTMB must receive a copy of the CAPA plan at the time the monitoring report is uploaded into the CTMB-AIS or by the date follow-up is due.

Acceptable, Needs Follow-up

- Any major deficiency identified during the review not corrected and/or addressed **prior to** the visit
- Multiple lesser deficiencies identified

Unacceptable

- A single critical deficiency
- Multiple major deficiencies identified
- Multiple lesser deficiencies of a recurring nature found in most the patient cases reviewed

If the Patient Case Review is rated as Acceptable Needs Follow-up or Unacceptable, the institution will be required to submit a written Corrective and Preventative Action (CAPA) plan and/or written response to the CTMS. A copy of the CAPA plan/response must be uploaded into the CTMB-AIS (for CTMB review) by the CTMS within 45 calendar days from the date the monitoring report is finalized, acknowledged by CTMB and submitted to the site/recipient.

For CDUS-monitored studies, a re-visit/re-audit is mandatory for any component rated as Unacceptable. A re-visit should be done no later than a year after an Unacceptable rating or when sufficient new patients/study participants have enrolled since the previous monitoring visit/review. If sufficient new patients/study participants have not enrolled within a year from the previous visit, further discussion with CTMB is necessary prior requesting to post-pone the re-visit.

5.5 Role of the Investigator During the Monitoring Visit

The Clinical Investigator or designee and his/her research staff must be available throughout the monitoring visit to answer any questions and help the monitors locate necessary information in the source documents.

5.6 Exit Interview

It is expected that the responsible Clinical Investigator and designated staff be present at the exit interview whether the monitoring visit is conducted on-site or off-site. During the exit interview the monitor(s) will review with the institution, the preliminary findings, items reviewed just prior to the visit (if applicable), and discuss any recommendations from the monitor(s). If applicable, the monitors should mention the expectation of providing a CAPA plan/response to any findings and clarify the approximate timeframe of when the institution will need to submit their CAPA plan or follow-up response(s). The exit interview should be an opportunity for education, immediate dialogue, feedback, and clarification for both the institution staff and the monitors.

SECTION 6 REPORT OF FINDINGS AND POSSIBLE ACTIONS

6.1 Monitoring Report

6.1.1 Submission

CTMS generates and uploads the monitoring report into CTMB-AIS database for CTMB review. The report and a letter summarizing the findings is sent to the responsible clinical investigator at the site by CTMS. The monitoring report must be submitted to the institution within 6 weeks of the last day of the monitoring visit.

6.1.2 Content

The following information should be included in the Monitoring Report:

6.1.2.1 General Information

- Provide information specific to the institution such as number of patient cases reviewed, average annual accrual, and institution staff present at the visit
- Identify members of the monitoring team; indicating title and affiliation

6.1.2.2 Review of the Regulatory Documentation

- The CTMB-AIS will populate each protocol title for protocols reviewed and list the number patient cases selected for review, the IND drugs, treatment modalities used and the disease(s) studied in each protocol(if drug is NCI-supplied study agent)
- Designate whether critical, major, or lesser deficiencies were identified under CIRB/IRB and ICC and describe each critical, major or lesser deficiency; otherwise indicate OK
- Designate whether major or lesser deficiencies were identified for review of the Delegation of Tasks Log, if so, describe; otherwise indicate OK
- Indicate if any portion of the Regulatory Documentation review was reviewed off-site
- Provide an overall assessment for this component and indicate, if a CDUS-monitored study, if a re-visit is required, including timeframe

6.1.2.3 Review of the Pharmacy and Pharmacy Operations

- Indicate the number of DARFs reviewed (i.e., number of study agents reviewed), and the number of patients cross-checked against the DARF, if applicable
- For each item identified as Critical-Non-Compliance or Non-Compliance, select the appropriate Not Compliant description(s); otherwise indicate Compliant or Not Reviewed

- Summarize in the pharmacy narrative any items that require a CAPA plan/ response, any items not reviewed and explain why they were not reviewed (see Section 5.3.5); include guidance or recommendations provided to the institution. [Other examples of information that may be included under the pharmacy narrative may include descriptions of non-compliance issues not outlined in the monitoring guidelines; review of temperature logs and excursions; rationale of why IND or if study-supplied agents were not selected for review, if pharmacy review was performed remotely, the method(s) by which the inspection of study storage, drug inventory, temperature monitoring, security should be described, etc.]
- For review of the pharmacy component, provide an overall assessment (Acceptable, Acceptable needs F/U, or Unacceptable) and indicate, if a CDUS-monitored study, if a re-visit is required, including timeframe

6.1.2.4 Review of the Patient Cases

- For each category, indicate if critical, major or lesser deficiencies were found and describe; otherwise indicate OK or Not Reviewed (explain if not reviewed)
- The CTMB-AIS pre-populates and summarizes the deficiencies for each patient/study participant and category in a table; this table identifies the total number of critical, major and lesser deficiencies for the total patient cases reviewed
- Provide an overall assessment for this component and indicate if a CDUS-monitored study, if a re-visit is required, including timeframe

6.1.2.5 Monitoring Procedures

This section indicates monitoring procedures such as how the monitoring visit was conducted (on-site or remotely), if any items were reviewed as part of Centralized Monitoring and other pertinent information. A summary may also be included if any component of the audit was not completed or not done, and reason.

6.1.2.6 General Comments

This section may be used to indicate if any additional data or correspondence was submitted by the site to the CTMS following the visit.

6.1.2.7 Exit Interview

Indicate who was present and summarize discussion of the findings, clarifications requested by the institution staff, and any recommendations made by the monitor(s). If any portion of the visit was conducted off-site (in addition to Centralized Monitoring), the findings of that review should be discussed at the exit interview.

6.2 Corrective and Preventative Action (CAPA) Plan / Follow-up Response

As outlined under Sections 5.2.6, 5.3.5 and 5.4.2, CAPA plans/follow-up responses are uploaded in the CTMB-AIS by the CTMS. Other pertinent correspondence or documentation related to the monitoring visit may also be uploaded. It must be uploaded to the Document Management tab (in the CTMB-AIS) by corresponding CTEP Site Code and monitoring visit date.

6.3 Possible Actions Due to Findings and/or Delinquent Data

Data are to be submitted via Medidata Rave to CTMS every two weeks (eg, Treatment, Adverse Event, Follow-up). The data will undergo a centralized clinical Quality Assurance review at the CTMS and queries will be issued by CTMS staff directly within Rave. The queries will appear on a Task Summary Tab within Medidata Rave for the CRA/site staff at the site to resolve. The timeliness of data submissions and timeliness in resolving data queries will be tracked by CTMS staff. Metrics for timeliness will be followed and assessed on an ongoing basis.

All deficiencies identified during a monitoring visit need to be addressed in writing by the institution. It must consist of actions to be taken that address each concern and action to be taken in order to prevent future occurrences.

6.3.1 Probation of Clinical Investigator

If the concerns appear to be investigator specific, mentoring and retraining will be the primary focus, if appropriate. After further evaluation by CTMB in collaboration with the NCI ETCTN Program Director or the Investigational Drug Branch (IDB) Branch Chief, the investigator may be taken off probation if documentation exists that support the specific actions were taken.

Repeated and deliberate failure to comply with these monitoring guidelines will result in one or more of the following actions:

- Replace Clinical Investigator
- Re-analyze or retract published results
- Request a formal investigation by the Office of Research Integrity
- Revoke the Investigator's Form FDA 1572
- Privileges in participating on any NCI sponsored clinical study will be terminated

6.3.2 Probation of Participating Institutions

For the purpose of Site Performance Monitoring, data will be considered delinquent if it is greater than 4 weeks past due. Sites with data greater than 20% past due at the end of the quarter will be placed on probation.

If a participating site is deemed Unacceptable for the same component on two consecutive visits, the institution will be placed on probation. During the probationary period, accrual will be closely monitored with increased utilization of quality control procedures at the time of patient registration and timely review of data submission.

6.3.3 Suspension of Participating Institutions

If delinquent data issues persist and are not resolved, registration privileges will be suspended until all delinquent data are submitted.

If an institution fails to provide a CAPA plan for one or more components rated as Acceptable needs Follow-up or Unacceptable within the required 45 calendar days, the following actions will be imposed:

- A written notice will be provided by CTMB/CTMS to the Lead Clinical Investigator stating that the CAPA plan/response is overdue and a five business day grace period will be granted.
- follow-up or a CAPA plan is not received within the five business day grace period, the patient registration privileges at the site will be immediately suspended.
- If the institution is under the responsibility of a LAO or Lead Site of the study, all new patient registrations will be suspended from both the institution and the LAO or Lead Site of the study.
- If follow-up or a CAPA plan is not submitted during the five business day grace period, a written explanation from the Clinical Investigator detailing the reason for the delay must be included. Suspension of patient registration will not be lifted until the site submits the CAPA plan to the CTMB/CTMS, and is reviewed and approved by CTMB. Failure to submit a timely CAPA plan may result in permanent termination from participation in the ETCTN and/or other NCI programs.

6.3.4 Withdrawn Institutions

If improved performance is not documented at the time of the subsequent visit, the site may be permanently withdrawn. Any such action will be done in consultation with CTMB and the NCI ETCTN Program Director or the IDB Branch Chief. An off-cycle (for cause) visit may take place at any site, at any time, if patient/study participant safety or scientific misconduct is suspected.