

# MOB Report

5th Edition  
April 2016

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### ORGANIZATION INFO

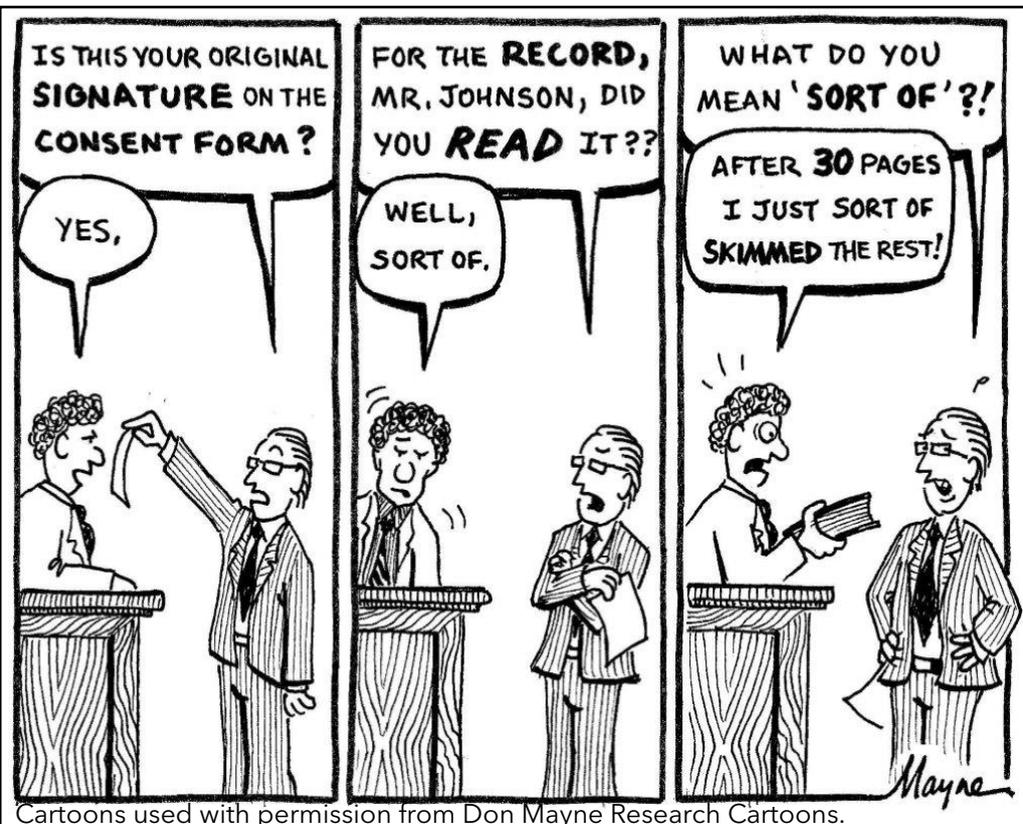
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## Obtaining Informed Consent: Overview and Tips

by Greg Lessing, BSc, Principal Clinical Manger (PPD)

The requirements for Informed Consent (IC) in DAIDS sponsored clinical trials are detailed within the DAIDS Policy on Source Documentation No.: DWD-POL-CL-04.00 and DWD-POL-CL-04.00A1 (Appendix1). This policy is in alignment with International Conference on Harmonisation (ICH) guidelines and the applicable sections of the Code of Federal Regulations (CFR). It is highly recommended (and a requirement in some countries) that research staff understand/are trained on the content of the various regulations. The summary below provides a useful list to ensure that sites are compliant with the DAIDS requirements for IC and to reduce the number of observations arising from monitoring visits and audits.

**TOP TIP:** It is important to note that the requirements for IC are documented in a number of places; ICH/Good Clinical Practices (GCP), CFR, local/national Investigational Review Board (IRB)/Independent Ethics Committee (IEC) requirements, as well as the protocol and site Standard Operation Procedures (SOPs)/policies. Although the majority of these regulations or policies mirror each other in many aspects, there are occasions when an institutional or local policy or regulation is stricter in a specific category. Please remember that an auditor always expects that the strictest regulation is followed.

1. Initial IC is defined as the screening and enrollment informed consent when first agreeing to participate in a protocol. For the initial IC, the process of obtaining informed consent must be completed prior to the conduct of any study related activities. The activities permitted are detailed in the study protocol and the specific consent form, and should be examined carefully by the site conducting the research.

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2. Subsequent IC is defined as any informed consent required during the subjects participation in the study. The requirement for subsequent IC is that they be signed prior to any study procedures described, or at the soonest opportunity following receipt of IRB/IEC approval.

3. The IC process should be carefully documented in the source documentation. The process includes documentation that the subject understood the information and was provided with a signed copy of the IC. All aspects of the process require documentation, including date, time (especially where the consent is signed on the same day as randomization), a description of the process to ensure that it was not coercive, information was provided in a language understood by the subject, the subject was provided ample opportunity to review and ask questions, and the subject's questions were answered. Although many sites often feel documentation is not necessary due to the existence of the actual Informed Consent Form (ICF), the lack of source documenting this procedure is a frequent audit finding.

**TOP TIP:** Create an IC Checklist to ensure all requirements of the IC process have been achieved.

4. Further to point #3 above, sites are encouraged to compile an IC SOP/policy, retain this policy in the site files and ensure compliance consistently across all subjects. As long as such a SOP/policy complies with all the requirements and is followed consistently, the practice of maintaining such a document often results in significant decreases in the number and severity of IC findings.

5. IC should always be documented by use of a written consent form using the most recent version of an ICF that has been approved by the local IRB/IEC and DAIDS.

6. IC must be obtained for all clinical trial subjects participating in a clinical trial prior to the conduct of any protocol related activities.

7. The executed ICF signed by the subject and other applicable signatories should be retained in the subject's research record or in a separate file. Whichever practice is followed; however, should be followed uniformly throughout all subjects enrolled. Missing or lost ICFs result in major audit findings.

**TOP TIP:** In the event of litigation by a subject due to injury from participation in a clinical trial, the IC is the only legal document describing what the subject has provided consent for. As we all know, the IC is a layman's interpretation of the content of often extensive clinical trial protocols. It is essential that the site and clinical staff conducting the research ensure that the subject is appropriately informed through careful review of this document. From a legal perspective, this part of the research process is the most important.

8. The subject documents IC by providing a legible, legal and valid name and signature in ink. Initials should not be used for last name and it is strongly recommended that initials are not used for a first name, except in cases where it is acceptable per the policy(s) of the institution conducting the research and where this is the method of signature used routinely by the subject for legal signature purposes. The form must be signed by all required individuals and it is not acceptable for research staff to complete any field on behalf of another party.

9. Signatures on the consent form may include the person who conducted the consent process, a witness to the consent process, translator, or others depending on the requirements of the local law or IRB/IEC.

10. In the event that a subject is not able to write or sign their name, the site should review local law, institutional and IRB/IEC policy to ensure that these subjects can be enrolled in clinical research. Should it be permitted, the site should document that the subject is incapable of providing a traditional, handwritten name and signature, and will utilize a mark or thumb print as is acceptable by the requirements of local law, institutional and IRB/IEC policy.

11. Although sites are not necessarily required to verify the use of a legal name, in the event that a site becomes aware that a subject has not used a legal name, the subject should sign a new consent form with their legal name. The site should notify the local IRB/IEC and retain documented records of the notification in the site file. It is important for the site to retain documentation of the use of an alias.

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12. IC must be conducted in a language that is understood by the subject or their representative. In this case, IRB/IEC approvals of the translated consent forms should be retained in the site files. A translator may be used to facilitate the informed consent discussion with the subject; however, the presence of a translator does not substitute the need for the informed consent to be in a language understood by the subject. It is important to note that enrolling subjects that speak languages foreign to the site should be carefully considered. There are wide ranging ethical and legal ramifications, especially where it cannot be verified that the subject understood the content of the ICF.

13. The subject must be offered a signed copy of the ICF. If the subject refuses a copy, this refusal should be carefully documented in the source notes.

**TOP TIP:** One of the reasons that the requirement exists for a subject to be offered a signed copy is to ensure that they have the emergency contact details contained within the ICF. Auditors heavily scrutinize these contact details, and one would be surprised how often this results in audit findings. Often critical audit findings as this are seen as having a direct impact on subject safety!

14. 45 CFR 46 provides further explanation of requirements for special populations in research, including prisoners, pregnant women, fetuses, children, wards of the state, or foster children. On rare occasions, the IRB/IEC may waive the requirement for parental consent of adolescents per 45 CFR 46.408(c) if local law permits.

15. Requirements for assent of children and permission of parents or legal guardians is determined by the IRB/IEC and is required per the provisions of 45 CFR 46. Local law where research is taking place determines the definition of a 'minor' and local IRB/IEC will determine the age for obtaining assent.

**TOP TIP:** Whenever dealing with vulnerable populations as described in point #14 above, be especially conscious of the requirement for legal informed consent. The legalities of engaging vulnerable subjects in clinical research are defined in more detail in 45 CFR 46 and ICH/GCP, but are usually determined by local law and IRB/IEC.

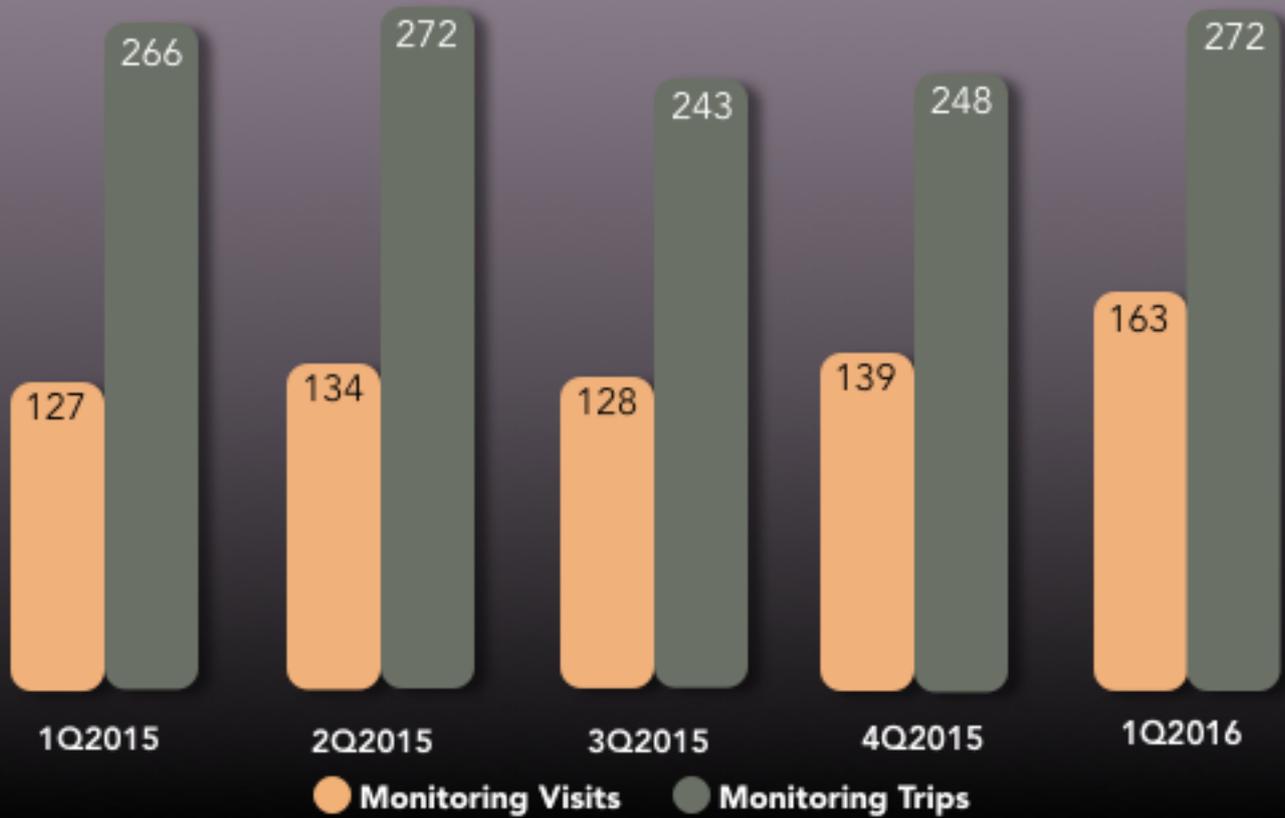
16. In the event that a revised consent form is required (protocol amendment or any new/updated information to subjects requiring a new version of the consent form), this should be obtained at the soonest opportunity after IRB/IEC approval is received. In cases where the safety of the subject is impacted and routine subject visits are infrequent, it is recommended to recall subjects to re-consent. Wherever an immediate risk to safety is observed, instructions and mechanisms (ie. Dear Participant letters) for informing subjects immediately will be communicated by the DAIDS. ■

# Monitoring Metrics

Overview of Monitoring Visits and Trips to Date

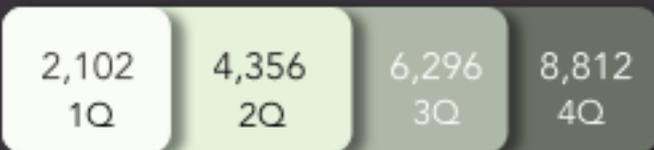
## Monitoring Trips and Visits

Over the past 5 quarters, OCSO has conducted a total of 691 Monitoring Visits and 1,301 Monitoring Trips.



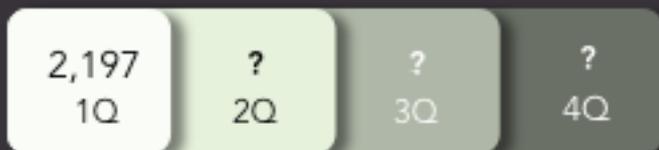
### Record Review 2015

(Running Total)



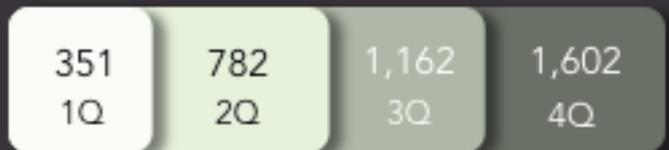
### Record Review 2016

(Running Total)



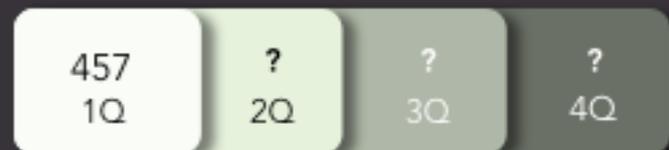
### Pharmacy Assessment 2015

(Running Total)



### Pharmacy Assessment 2016

(Running Total)



# Monitor Spotlight: Latin America



## Meet the team of monitors and managers in Latin America:

**Gabriel Antonio Luciano (Brazil)** has a bachelor's degree in Pharmacy and Biochemistry from Faculdade de Ciências Farmacêuticas de Ribeirão Preto of Universidade de São Paulo in Brazil. Gabriel joined Pharmaceutical Product Development (PPD) in 2008 as a Project Assistant, and became a Clinical Research Associate (CRA) in 2011, when he started working on the Clinical Site and Study Monitoring (CSSM) team. He is also a member of the Global Pharmacy Services (GPS) team, performing specialized pharmacy assessments for DAIDS. Gabriel enjoys practicing sports and loves to monitor DAIDS studies in other countries, having visited Peru, Chile, Ecuador and the USA. Gabriel is also known among the CRAs at PPD's office in Brazil as one of the best companions for performing co-monitoring visits.

**Augusto Mamoro Kuriki (Brazil)** has a bachelor's degree in Pharmacy from Faculdades Metropolitanas Unidas (FMU) in Sao Paulo, Brazil. He joined PPD in 2008 and works as a CRA for the CSSM team. He is experienced in different therapeutic areas such as circulatory, oncology, transplant, lupus and respiratory diseases. Augusto likes to practice sports, such as soccer and jogging, and loves to travel and explore different places.

**Giovanna Pastor Cauna (Peru)** has a medical doctor degree from Universidad Nacional Mayor de San Marcos in Lima, Peru. Giovanna worked as a physician after receiving her university degree, and since 2001 she has been involved in Clinical Research, coordinating and assisting clinical research sites. She also worked as a CRA for sponsors/Contract Research Organizations (CROs). Giovanna joined PPD in 2007 as a CRA and her career has developed within the CSSM group, and recently become a Clinical Team Manager (CTM). Giovanna is engaged in activities related to the Catholic Church within her community, loves to travel and spend time with her family. She lives with her parents and whenever possible travels to Germany to visit her brother to stay close to her two adorable young nephews.

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**Veronica Santos (Brazil)** is a registered pharmacist and graduated at the University of São Paulo with a Bachelor of Science (BS) degree in Pharmacy. She also holds a PhD in Clinical Pharmacology from the same university. She started working with Regulatory Affairs in 1997 and became a CRA in 1999. She started her career at PPD in 2004 as a Senior CRA, and was promoted to CTM in 2006. She has managed studies in Brazil, Peru, Chile, Ecuador, Argentina, and Mexico and has also provided Good Clinical Practice training workshops in Brazil, Ecuador, Peru and Mozambique. Veronica loves to spend time with her family, especially her 5-year old goddaughter, besides doing outdoor activities. She has four terrible cats.

**Rocío Canales Negrón (Peru)** holds a bachelor's degree in Information Science from Universidad Católica PUCP and Project Management Specialist degree from UPC. She has experience in clinical trials as administrative support since 2005. Rocío joined PPD in 2008 and the CSSM team in early 2015. She has been in charge of facilities and procurement issues for PPD office in Lima, since 2010. She lives a happy life with her husband Roberto and their young son Adrián. They love to spend time together, going to the beach and to the countryside.

**Mabel Jota (Peru)** holds a Bachelor's Degree in Pharmacy and Biochemistry from Universidad Nacional Mayor de San Marcos in Lima, Peru. She has been a member of the Peruvian Pharmacist College since 2009. She started working in clinical research in 2008 as a Trainee in the Pharma Industry. She joined PPD in 2009, and became a CRA in 2010. She is the most recent addition to the CSSM team. She and her husband Erick have a one year-old baby who was born the same day as Mabel: double birthday party with two cakes and lots of gifts on March 9th.

**Cynthia Aguilar (Peru)** has a Pharmacist Degree from Universidad Nacional San Luis Gonzaga in Ica, Peru. Prior to joining PPD in August 2009, she worked as a Pharmacist Assistant and as a Study Coordinator. She became a member of the CSSM team in 2010, but shortly after had to take leave for some months to start another wonderful experience: being a mom! She has gladly returned to the CSSM team after maternity leave, resuming her work as a CRA for the DAIDS studies.

**José Bacellar Jr. (Brazil)** has a bachelor's degree in Pharmacy and Biochemistry from the University of São Paulo. He joined PPD for an internship in 2005, while still in college, and became a CRA in 2007 upon graduating. He joined the CSSM team in 2010, maintaining monitoring activities for commercial studies in parallel. In December 2014, he made a life decision: taking a year off on sabbatical to travel and study. He lived in Los Angeles for three months with a friend, and later made other smaller trips. During this year off, he studied music and literature. In March 2016 he returned to PPD, back to the CSSM group, with lots of energy and stories to tell. ■