Ottawa Health Science Network Research Ethics Board (OHSN-REB) /
Conseil d'éthique de la recherche du réseau de science de la santé d'Ottawa (CÉR-RSSO)
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OHSN-REB Standard Operating Procedure Addendum

Rationale: The OHSN-REB is a member of the and the Canadian Association of Research Ethics Boards (CAREB), and as approved by the OHSN-REB Executive Committee, has adopted the N2 - CAREB SOPs. To reflect specific OHSN-REB requirements, this addendum complements the N2- CAREB SOP noted below.

N2/CAREB SOP: # 404 – Ongoing REB Review Activities

N2-CAREB SOP Guidelines	OHSN-REB Standard Operating Procedure Addendum
Timelines for submission to OHSN-REB:	A Timeline Summary Table for Reportable Event submissions to OHSN-REB can be found in **Appendix 1** of this N2 CAREB SOP 404 Addendum. The timelines apply when OHSN-REB is the REB of Record.
5.2.2 Local AE's:	The Investigator is responsible to report Local AEs/ADRs to the REB of Record (e.g., OHSN, OCREB, or a qualified Board of Record (BOR) appointed by CTO) according to that board's SOPs. **<u>Local</u> AEs/ADRs Criteria for Reporting to OHSN-REB:** The investigator is required to report to the REB only those local AEs/ADRs that are deemed to be: • serious (any untoward medical occurrence in which one or more of the following apply: Requires in-patient hospitalization or prolongation of existing hospitalization, causes congenital malformation, results in persistent or significant disability or incapacity, is life-threatening and/or results in death), **AND** • unexpected (not identified in nature, severity or frequency in the risk information set out in the applicable product information (i.e.: Investigator's Brochure for an unapproved investigational product, Product Monograph for a marketed drug, etc.), **AND** • related/possibly related to the investigational product or other study intervention/treatment/procedure or to participation in the research (i.e., definitely, probably, possibly or unlikely related)

Definitions	
Definitely	Clearly related
Probably	Likely related
Possibly	Potentially related
Unlikely	Relationship is improbable, but not impossible

The Researcher must report the following to the REB within a time frame specified by the REB:	**AND** • points to increased risk/harm to research participants or others (an elevated likelihood of a similar event occurring to other participants in the study including greater risk of physical, psychological, economic, ethical or social harm than was previously known or recognized). o Upon becoming aware of a local AE/ADR, the investigator should assess whether the AE/ADR represents a reportable event. o If the investigator determines that an AE/ADR does not meet the criteria, but the sponsor subsequently determines that it does, the sponsor should report this determination to the QI/PI, and such reports must then be submitted to the REB. o The following local AEs/ADRs ordinarily should **NOT be reported to the REB**: • SAEs/SADRs that are considered expected as defined by the protocol and/or IB or PM. • SAEs that are considered not related to the investigational product or research procedures, whether the event is expected or not. • AEs/ADRs that are non-serious, whether expected or not. **Timelines for submission to OHSN-REB:** o If the investigator determines that the AE/ADR meets the criteria for reporting to the REB, the investigator must report it to the REB ***within seven calendar days*** of the incident, occurrence, outcome event, or when the Investigator becomes aware of the event or the new information. o If the AE/ADR is fatal or life threatening, it must be reported to the REB ***within three calendar days.*** **Timeline for reporting to Sponsor:** • All local AEs/ADRs that are deemed to be serious, unexpected, related/possibly related and involving greater risk must also be reported to the Sponsor **(whether the sponsor is industry or OHRI/OHIRC)** ***within 24 hours*** of when the Investigator becomes aware of the event or the new information. o When **OHRI is the sponsor**, the event must be reported to OHRI Clinical Research Administration at clinicalresearchadmin@ohri.ca. o When **OHIRC is the sponsor**, the event must be reported to the Clinical Research and Compliance office at clinicalresearch@ottawaheart.ca.
5.2.3 Non-Local (External) Adverse Events: Upon receipt of an external adverse event (EAE) or a periodic safety update or safety summary report, the	The Investigator is responsible for reporting Non-Local (External) AEs/ADRs to the REB of Record (e.g., OHSN, OCREB, or a qualified Board of Record (BOR) appointed by CTO) according to that board's SOPs. **Non-local (External) AEs/ADR, Periodic Safety Update Reports (i.e.: SUADRs, CIOMS) or Safety Summary Reports Criteria for Reporting to OHSN-REB:** • Individual non-local (external) AEs/ADRs, Periodic Safety Update Reports and Safety Summary Reports that **meet the following criteria** are reportable to the REB: o requires a change to the research (i.e.: changes to Protocol, Informed Consent Form, etc.) and/or requires notification to participants for safety reasons, **AND**

Researcher must determine if it meets the REB reporting criteria:

- serious (any untoward medical occurrence in which one or more of the following apply: Requires in-patient hospitalization or prolongation of existing hospitalization, causes congenital malformation, results in persistent or significant disability or incapacity, is life-threatening and/or results in death), **AND**
- unexpected in relation to the research and/or patient population (not identified in nature, severity or frequency in the risk information set out in the applicable product information (i.e.: Investigator's Brochure for an unapproved investigational product, Product Monograph for a marketed drug, etc.), **AND**
- related/possibly related to the investigational product or other study intervention/treatment/procedure, or to participation in the research:

Definitions	
Definitely	Clearly related
Probably	Likely related
Possibly	Potentially related
Unlikely	Relationship is improbable, but not impossible

AND

- points to increased risk/harm to research participants or others (an elevated likelihood of a similar event occurring to other participants in the study including greater risk of physical, psychological, economic, ethical or social harm than was previously known or recognized), **AND**

The individual AE reports or periodic safety updates or safety summary reports that **meet the reporting criteria** must be submitted to the REB within a time frame specified by the REB:

Content of submission to OHSN-REB:

- **Individual non-local (external) AEs/ADRs** and **Periodic Safety Update Reports (i.e.: SUADR listings, CIOMS)** or **Safety Summary Reports** that meet the criteria for reporting specified above, must only be reported to the REB with information that is meaningful and useful to the REB.

  The content of the submission should include, at a minimum:

  - ✓ Sponsor analysis of the significance of the event, or an analysis from the DSMB
  - ✓ A discussion of previous similar events (if appropriate)
  - ✓ Statement as to whether any changes are required to the approved documents (i.e.: changes to Protocol, consent form, etc.)
  - ✓ Statement as to whether immediate notification of participants is required
  - ✓ If applicable, other corrective actions to be taken by the sponsor in response to the event(s)

Timelines for submission to OHSN-REB:

- **Individual (non-local) external AEs/ADRs** should be reported to the REB ***no later than seven calendar days*** after receipt by the investigator.
- Sponsor submitted **Periodic Safety Update Reports (i.e.: SUADRs, CIOMS)** or **Safety Summary Reports** must be submitted to the REB ***no later than fifteen calendar days*** after receipt by the investigator

	Timeline for reporting to OHRI or OHIRC Clinical Research Administration: • When **OHRI or OHIRC is the sponsor** of a multi-centre trial, AEs/ADRs meeting the reporting criteria from the participating sites must also be reported to the Sponsor ***within 24 hours.*** For OHRI, report to Clinical Research Administration at clinicalresearchadmin@ohri.ca. For OHIRC, report to the Clinical Research and Compliance Office at clinicalresearch@ottawaheart.ca.
5.2.4 Other Reportable Events: Other Reportable Events must be reported within a time frame specified by the REB:	The Investigator is responsible to report other reportable events to the REB of Record (e.g., OHSN, OCREB, or a qualified Board of Record (BOR) appointed by CTO) according to that board's SOPs. **Examples of Other Reportable Events reportable to OHSN-REB:** • DSMB/C Report • Interim Analysis Results • Pregnant Partner Event: o The Pregnant Partner Reportable Event Form must be used for each pregnant partner event where data will be collected from a pregnant partner/child when a male research participant fathers a child while participating in a study that involves experimental therapy. o Pregnant partner/child information cannot be collected until the REB has reviewed/approved the reportable event and Pregnant Partner ICF, and consent has been obtained from the partner. • Sponsor Safety Notice, Action Letter or Alert that would cause the sponsor to modify the Investigator's Brochure, the research, or the consent form, or would prompt other action by the REB to ensure protection of research participants. • Information that is published from another research project that shows that an arm of the research study is of no therapeutic value • A change in Health Canada or FDA safety labelling therapy or withdrawal from marketing of a drug, device, health product, genetic therapy or biologic used in research • Any unanticipated problem or other event that could significantly impact the conduct of the research at the site (e.g.: concern of non-compliance) **Timeline for submission OHSN-REB:** • If OHSN-REB is the BOR, Other Reportable Events must be reported to the REB ***within 15 calendar days*** of receipt by the study team. **Timeline for reporting DSMB/C Reports to Institution:** • For **OHRI sponsored, investigator initiated, interventional trials**, all DSMB/C reports must also be forwarded to Clinical Research Administration (clinicalresearchadmin@ohri.ca) ***within 15 calendar days*** of receipt of the report by the study team. Please see the OHRI DSMB guidelines for the expected DSMB reporting requirements for OHRI sponsored, investigator-initiated interventional studies/trials (regulated and non-regulated).

	• For **<u>OHIRC</u> sponsored, investigator initiated, interventional trials**, all DSMB/C reports must also be sent to the Clinical Research and Compliance Office (ClinicalResearch@ottawaheart.ca) ***within 15 calendar days*** of receipt of the report by the study team.
5.2.5 Deviations to Previously Approved Research: Deviations must be reported within a time frame specified by the REB;	The Investigator is responsible to report deviations to the REB of Record (e.g., OHSN, OCREB, or a qualified Board of Record (BOR) appointed by CTO) according to that board's SOPs. **Criteria for Reportable Deviations to OHSN-REB:** • **Major deviations are reportable to the REB**. A major deviation is a more serious incident involving noncompliance with the protocol that may have a significant effect on the participant's rights, safety, or welfare, or the integrity of the data and could cause the sponsor/sponsor investigator to exclude the patient from the eligibility analysis and/or discontinue the patient from the study. Examples of major deviations include: o Change in procedure(s) initiated to eliminate immediate hazards to research participants, without prior REB approval; o Enrollment of an ineligible participant; o Deviation(s) in the consent process (wrong consent form version used, missing signatures, original consent form not located at research site); o Performance of a study procedure or test that was not included in the initially approved research project that may impact patient safety or the integrity of the data; o Failure to perform a study procedure that may impact patient safety or the integrity of the data; o Study procedures performed outside of protocol timelines that may impact the safety or integrity of the data; o Dosing errors/intervention errors that may impact patient safety or the integrity of the data. • Minor deviations are **not** reportable to the REB via the REB's Reportable Event Form but will be collected at the time of continuing review. Examples of minor deviations include: o Isolated case(s) of study procedure(s) being done outside of the protocol timeline that do not increase/create risk; o Isolated case(s) of missed or late lab tests that do not increase/create risk; o Isolated case(s) of missed/late treatment(s) that do not increase/create risk; o Lost medication diaries • For more details and examples, see the Guidance for Protocol Deviation Reporting document.

deviations that lead to an SAE should be reported within a time frame specified by the REB:	**Timeline for submission to OHSN-REB:** • **Major deviations** must be reported to the REB ***within 15 calendar days*** of the Investigator becoming aware of the deviation.
5.2.6 Privacy Incident/Breaches	The Investigator is responsible for reporting privacy breaches to the REB of Record (e.g., OHSN, OCREB, or a qualified Board of Record (BOR) appointed by CTO) according to that board's SOPs. **Reporting to Institution:** The Investigator is responsible for reporting privacy incidents/breaches to his/her Institution, according to that institution's SOPs: • **All TOH/OHRI** privacy incidents must be ***immediately*** reported to: o TOH Privacy Office via the Safety Learning System (SLS). Specify you are reporting a "privacy incident". For more information, please click on this link: https://theottawahospital.sharepoint.com/sites/myHospital/en/EmployeeServices/Staff-Safety/Pages/Employee-Incident-Reporting.aspx ▪ Resource o How to complete a Privacy Incident in SLS o Director of Clinical Research Administration by email to clinicalresearchadmin@ohri.ca o OHSN-REB Manager by email to rebadministration@toh.ca • **All UOHI/OHIRC** privacy incidents must be ***immediately*** reported to: o OHIRC Director, Clinical Research Administration by email to ClinicalResearch@ottawaheart.ca o UOHI Privacy Officer at extension # 13575, followed by completion of the OHIRC Issue Management form and a TOH SLS form. o OHSN-REB Manager by email to rebadministration@ohri.ca **Timeline for submission to OHSN-REB:** **After TOH/UOHI Privacy Office confirms that the privacy incident is in fact a breach of privacy according to PHIPA, REB reporting and Patient/SDM reporting will then be required.** • When OHSN-REB is the BOR, privacy breaches must be reported ***within 24 hours*** of the applicable Privacy Office informing the Investigator that the incident is in fact a privacy breach. • For incidents where personal health and/or identifying information was released externally, all participants involved in the privacy breach must be immediately informed as this may affect their willingness to continue participation in the trial/study. This communication must be documented in detail in the participant file. ▪ Resource o How to notify your patient when their privacy has been breached

5.2.7 Audit or Inspection Findings:	The Investigator is responsible for reporting audit or inspection findings to the REB of Record (e.g., OHSN, OCREB, or a qualified Board of Record (BOR) appointed by CTO) according to that board's SOPs. **Criteria for Reportable Audit or Inspection Findings to OHSN-REB:** • All **relevant** audit or inspection reports are reportable to OHSN-REB. • **Relevant** reports are those which include findings that could impact participant safety or welfare, the integrity of data and/or alter the REB's approval or favorable opinion to continue the research (i.e.: concerns of non-compliance). **Timeline for submission to OHSN-REB:** • When OHSN-REB is the BOR, all **relevant** audit and inspection reports must be reported to the REB ***within 15 calendar days*** of receipt by the study team.
5.2.8 Research Participant Complaint:	The Investigator is responsible for reporting participant complaints to the REB of Record (e.g., OHSN, OCREB, or a qualified Board of Record (BOR) appointed by CTO) according to that board's SOPs. • When OHSN-REB is the BOR, participant complaints must be reported **within 24 hours** of the Investigator/study team becoming aware of the complaint. • Investigators must report all participant complaints in CTO Stream to the assigned BOR, and to their applicable Institutional representatives according to the Streamlined Ethics Review System (SRERS) found in the CTO Stream system. The Institutional Representatives for OHRI and OHIRC according to the SRERS are as follows: o OHRI Institutional Representative, Amy Geertsma by email to rebadminstration@toh.ca o OHIRC Institutional Representative, by email to ClinicalResearch@ottawaheart.ca

Revision History		
Version Number	**Effective Date**	**Summary of Changes**
Version 3	January 12, 2022	Administrative changes (logos, rationale, etc.); Sections 5.2.2 and 5.2.3: added definitions, & instruction for OHIRC; Section 5.2.4: added instruction for OHIRC; Section 5.2.6: updated reporting requirements for privacy breaches; Section 5.2.8: corrected reporting timeline for participant complaints.
Version 2	October 1, 2019	Updated sections 5.2.2 and 5.2.3; added timelines section; added sections 5.2.4, 5.2.5, 5.2.6, 5.2.7, 5.2.8.
Version 1	June 1, 2015	Initial Version

This N2-CAREB SOP Addendum has been reviewed and approved by the OHSN-REB Administrative Committee.