

# The Clinical Research Center Research Practice Manual



## Guideline for Study Document and Data Handling – RPG-08

### Guideline

#### Purpose

This Guideline provides functional definitions for common data management terms; guidance on the maintenance of study files, regulatory files and source documentation; and links to additional resources for obtaining information on documentation and data handling requirements within Children's Hospital Boston and various federal agencies.

#### Definitions

**Case Report Form (CRF)** – a printed, optical or electronic document designed to record all of the protocol-required information to be reported to the sponsor on each trial subject. (ICH GCP 1.11)

**Regulatory Binder (or Files)** - is the source that provides a complete and thorough history of the research study from protocol development to study completion. The binders or files include all study-specific information and regulatory documentation including IRB approved protocols, amendments, informed consent, case report forms, FDA 1571 and 1572 if applicable and recruitment materials.

**Source Data** – information contained within source documents that represent the original documentation of findings and observations of subjects participating in clinical research studies (ICH GCP 1.51)

**Source Documents** – original documents, data and records such as medical records, laboratory results, x-rays, pharmacy records and subject diaries. (ICH GCP 1.52)

### Procedure

#### Research Study Files

Prior to the start of the study, study staff should prepare a secure location for the storage of study data and supporting documentation. Research records should be locked when not in use and access should be restricted to authorized staff only. Security of research data may include maintaining a locked cabinet within an office, or storage within an office in a clinic that is locked when not in use. The following subsections describe research study files maintained for most clinical research studies. Investigators should refer to sponsor-specific requirements for study specific procedures.

### **Regulatory Binder/Files**

The regulatory binders or files include all regulatory documentation necessary for the conduct of the study. The Principal Investigator should designate a study staff member to assume primary responsibility for maintaining the regulatory files including all regulatory correspondence with the IRB, the study sponsor; and the FDA if applicable; the IRB approved protocols and amendments; the IRB approved informed consents, recruitment materials and other necessary regulatory documents. The organization and sequence of sections of the regulatory files may vary depending on the type of the study and is at the discretion of the Principal Investigator or study sponsor.

The CHB Education Quality Improvement Program (EQuIP) provides guidance for constructing a study Regulatory Binder. Contact the EQuIP staff and/or visit the EQuIP web page for more information.

[http://www.childrenshospital.org/cfapps/research/data\\_admin/Site2207/mainpageS2207P0.html](http://www.childrenshospital.org/cfapps/research/data_admin/Site2207/mainpageS2207P0.html)

### **Subject Files:**

The subject files contain all completed case report forms for the study subjects. CRFs that will be used as source documents should be signed and dated by the person completing the form. Typically, source documents and subject research data files are stored separately to maintain subject confidentiality. In the case that is necessary to store source documents with subject research data files, all subject identifiers and protected health information (PHI) must be removed or blacked out from the source document. Subject files are generally maintained in chronological order by Study ID number and by study visit within the unique subject folders; but document filing may differ by protocol and is at the discretion of the Principal Investigator.

#### **Paper and electronic CRFs**

Hard copy CRFs should be filed and stored electronically using systems that mimic procedures used to store hard copy files.

Electronic CRFs require the installation of an electronic system that is validated within the infrastructure of the clinical research unit, ensuring its reliability and precision, as well as its expected performance. (ICH 5.5.3a. and FDA Guidance for Industry: Computerized System used in Clinical Trials.) Best practice methods for paper CRF management also apply to electronic CRF management, i.e. procedures are required for data collection, document protection, error detection and correction, electronic signature, audit trails, etc. Please refer to CRC Research Practice Guideline for Data Collection for specifics on how CRFs should be used for data collection.

### **Study ID Assignment Log:**

The study ID assignment Log is an essential study document; it serves as the primary source for linking the subjects' unique study identification numbers to the subjects' identifiable, protected health information (PHI) such as name and medical record number. No two subjects should ever be assigned the same ID number, even if the original subject who was first assigned the ID number drops out or withdraws from the study. The Study ID Assignment Log might also be called the study Enrollment Log or Subject ID Log.

The procedure of assigning a study ID to a subject may take many forms. One typical scenario is as follows: A potential subject is approached for entry in a research study. Informed consent is obtained and criteria necessary for enrollment are reviewed. The

subject is determined to be eligible. The study coordinator retrieves the study ID

Assignments of study IDs occur in chronological order. As subjects are enrolled, they are assigned the very next available ID number on the log. See the Sample Study ID log below:

ID	ame	Name	of Birth (d/yy)	ct MRN	Enrolled (d/yy)
			2	99	03
		as	5	67	03
			0	88	03

Available ID →

### **Screening Log**

Some studies require extensive screening procedures to determine subject eligibility. For these studies, the Principal Investigator might choose to use a Screening Log in addition to the Study ID Log. When a Screening Log is used, potential subjects are initially assigned a screening ID number to be used when collecting screening data to determine eligibility or during the screening phase of the study. The screening log contains limited information about all potential subjects approached for enrollment in the study and will likely include reasons for ineligibility. Only those subjects that meet eligibility requirements and consent to participate will be enrolled in the study and only these subjects will be entered on the Study ID Assignment Log and assigned a final study ID. (See the [at the end of this document](#)).

### **Source Documents:**

Source documents are often reviewed by study monitors and auditors to verify that study subjects exist, that study events actually occurred, and that data recorded on CRFs are accurate and complete. As such, source documentation provides physical evidence that allows for reconstruction and evaluation of a study. The Principal Investigator must establish source documentation requirements prior to the start of the study for each data element collected.

Typical examples of source documents include the subject's medical record, laboratory reports, radiology reports, subject diaries, research surveys, and questionnaires, pharmacy dispensing records, etc. For some studies, some or all of the data forms might also serve as the source documents. If a data form represents the document in which an observation is first recorded, it is considered the source document for those data, e.g. a research interview form including date of form completion and ID or signature of the person conducting the interview. It is often helpful to create a list or log of the sources from which data are to be obtained for each data form and to maintain instructions for form completion in the study Manual of Operations (MOO). For more guidance on development of the MOO, refer to CRC Research Practice Guideline for Developing a Manual of Operations.

### **Shadow Files:**

Shadow files typically refer to copies of some or all of a subject's medical record that is maintained by study staff to verify data recorded on study CRFs. The shadow file generally contains only the pertinent clinical information related to the subjects' care during the research protocol and additional research records that may not be filed in the subjects' medical record. The documents contained in the shadow file are NOT considered original source documents, as they are copies. Monitors and FDA auditors will require access to the original source documents or certified copies of the original source documents during site monitoring visits or inspections.

### **Research Data and Medical Records:**

A patient's medical records represent a permanent and legal record of all clinical information pertaining to a patient. As such, once entered, information cannot be deleted from a medical record. Thus, it is important for investigators to consider what information, if any, obtained for the specific research study should be documented in a subject's medical record. The CHB Office of Clinical Investigations has developed guidelines to assist investigators in determining what research information, if any, should be stored in a subject's medical record. Included in the [guidance document](#) are informed consent statements with suggested wording for informing subjects of information that will be included in their medical records.

### Related Content

- Sample Study ID Log

Contact the CRC for assistance with creating your Study ID logs and creating study ID numbers. For more examples of logs refer to the EQUIP website:

[http://www.childrenshospital.org/cfapps/research/data\\_admin/Site2207/mainpageS2207P0.html](http://www.childrenshospital.org/cfapps/research/data_admin/Site2207/mainpageS2207P0.html)

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<b>Study Title</b> <b>Study ID Assignment Log</b>
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<b>To be maintained by the Principal Investigator or Study Coordinator. <u>For subject confidentiality, this should be kept locked in a secure location at all times.</u> These data should not be entered in the Study Data Management System.</b>
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Study ID#	Last Name	First Name	Date of Birth	MR#	Date of Enrollment
001-7					
002-1					
003-9					
004-2					
005-8					
006-4					
007-6					
008-4					
009-1					
010-0					
011-3					
012-5					
013-6					
014-3					
015-6					
016-7					
017-1					

- Sample Screening Log

<b>Study Title</b> <b>Screening Log</b>
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<b>To be maintained by the Principal Investigator or Study Coordinator. <u>For subject confidentiality, this should be kept locked in a secure location at all times.</u> These data should not be entered in the Data Management System.</b>
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Screening ID#	Name, last, first	MR#	Date of Birth	Date Screened	Eligible Y/N	Reason if not Eligible	Enrolled Y/N	Reason if not Enrolled
001					Yes No		Yes No	
002					Yes No		Yes No	
003					Yes No		Yes No	
004					Yes No		Yes No	
005					Yes No		Yes No	
006					Yes No		Yes No	
007					Yes No		Yes No	
008					Yes No		Yes No	
009					Yes No		Yes No	
010					Yes No		Yes No	
011					Yes No		Yes No	
012					Yes No		Yes No	
013					Yes No		Yes No	
014					Yes No		Yes No	

## References

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[http://www.frsq.gouv.qc.ca/en/SOP/procedures/SOP\\_24.pdf](http://www.frsq.gouv.qc.ca/en/SOP/procedures/SOP_24.pdf).

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**Disclaimer:** Should Hospital and CRC policies conflict, Hospital policy will supersede CRC policy in all cases.