Adverse Event Recording and Reporting for Non-CTIMP Studies

NJRO-GOV-SOP-005

Contents

1. Background/Introduction

It is essential that all Adverse Events (AEs) which occur during the course of a participant's involvement in a research project are appropriately recorded and reported in order to ensure their continuing safety. Having appropriate systems for the management of AEs is necessary for all studies, not just Clinical Trials of Investigational Medicinal Products (CTIMPs) and trials of Advanced Therapy Medicinal Products (ATMPs). Participants of interventional studies (including medical device trials) can also be affected by AEs; in addition, some observational studies may require AEs to be reported if specified by the study protocol.

2. Purpose

This SOP describes the process for recording, managing and reporting AEs for research studies not classified as CTIMPs or ATIMPs, where the study is sponsored by The Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH FT).

3. Scope of Document

This SOP is applicable to all Trust staff involved in involved research studies sponsored by NUTH FT which are interventional, or observational but require AE reporting. The SOP is also applicable to the NUTH FT Research & Development (R&D) team with responsibility for providing guidance on safety reporting.

4. Definitions

4.1 Terminology

4.1.1 Adverse Event

Any untoward medical occurrence in a study participant which does not necessarily have a causal relationship with the treatment under study (e.g. abnormal laboratory findings, unfavourable symptoms or diseases).

4.1.2. Serious Adverse Event (SAE)

Any AE that results in:

- death

- a life-threatening event (i.e. that places the participant at immediate risk of death as the event occurred, rather than an event that may have been life threatening had it been more severe) hospitalisation or prolongation of an existing hospitalisation
- a persistent or significant disability or incapacity
- a congenital anomaly or birth defect
- or is otherwise considered medically significant by the investigator

4.1.3 Causality

AEs should be assessed for causality and whether the event was related or unrelated to the intervention under study. Assessment must be by the Principal Investigator (PI), or an investigator who has been delegated this duty by the PI as documented on the study delegation log.

4.1.4 Severity

The term “severe” is used to describe the intensity of a specific event.

One common scale used to describe the severity of an event is:

- Mild: Discomfort is noticed, but there is no disruption of normal daily activities.
- Moderate: Discomfort is sufficient to reduce or affect normal daily activities.
- Severe: Discomfort is incapacitating, with inability to work or to perform normal daily activities.

The severity of an event is not the same as the seriousness, which is based on the patient/event outcome as described in section 1.1.2. An AE can be severe but not serious.

5. Roles and Responsibilities

There are a number of responsibilities when managing AEs. The Chief Investigator (CI) has overall responsibility for the conduct of the study.

For multi-centre studies the local Principal Investigator (PI) has responsibility for the conduct of the study at their local site. There should be one PI for each research site and for those studies conducted within NUTH FT the Trust is determined to be the research site rather than the individual hospital where the research takes place. For single-site studies, the CI and PI can be the same person.

The CI can decide how to record and report AEs and this information should be detailed in the protocol, including timeframe for AE reporting (which may be from consent to participate).

6. Procedures

6.1. Recording AEs

AEs are usually described on a data capture document, preferably as a specific section within the Case Report Form (CRF). Relevant information must also be recorded in the participant's medical notes. This should include:

- A description of the event;
- The date/time that it started and stopped;
- Severity of the event;
- Details of any actions taken in response to the event;
- Investigator assessment of relationship of the event to the intervention (if applicable).

The participant should be followed up by the research team until the event abates and as per protocol, with relevant information documented in the medical notes. A record of all AEs must be kept in the Trial Master File (TMF).

6.2. Reporting SAEs

The study team must report SAEs as specified by the study protocol (the usual timeframe is within 24 hours of awareness of the event). If the study is sponsored by NUTH FT the report must also be submitted to NUTH FT R&D by email to nuth.nuthsponsorship@nhs.net

If a research participant experiences a SAE and the CI determines the event to have been related to the intervention and unexpected (i.e. not in keeping with the known safety information related to the intervention), then the event should be reported to the relevant Research Ethics Committee (REC) by the CI within 15 days of them becoming aware of the event. The CI should use the National Health Service Health Research Authority (NHS HRA) Non-CTIMP Safety Report to REC form.

Related and unexpected events must also be reported through the DATIX Incident Reporting System by a member of the study team. The event must also be assessed to determine whether or not it constitutes a serious incident (SI). This is defined as an event or incident that resulted in unexpected or avoidable death, or serious harm, to one or more patients, staff, visitors or members of the public. If the

event has been classed as (or is suspected to be) a SI, an R&D manager will inform the Director of Quality and Effectiveness, via the Clinical Governance and Risk Department (CGARD), as soon as possible by telephone. (Please refer to NUTH FT "Serious Incident Reporting and Management Policy" for further information including categories of SIs.)

All SAEs involving a non-CE marked device under clinical investigation must also be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) Devices Division, whether initially considered to be device related or not. SAEs involving CE-marked devices in a post-market surveillance study are reportable to the MHRA Adverse Incident Centre, but reported under the requirements of Devices Vigilance. As with AEs, a record of all SAEs must be kept in the TMF.

6.3. **Annual Reporting**

Any SAEs that occur should also be included in the Annual Progress Report to the REC. This report should be submitted to the relevant REC 12 months after the date on which the favourable ethical opinion was given with annual progress reports submitted thereafter until the end of the study.

7. References

7.1. Research Governance Framework for Health and Social Care, 2nd edition 2005
7.2. Health Research Authority: Progress and Safety Reporting http://www.hra.nhs.uk/resources/during-and-after-your-study/progress-and-safetyreporting/
7.3. NUTH FT – Management and Reporting of Accidents and Incidents Policy
7.4. NUTH FT – Serious Incidents Reporting and Management Policy
7.5. MHRA: Notify about a device investigation - https://www.gov.uk/guidance/notify-mhra-about-a-clinical-investigation-for-a-medical-device
7.6. MHRA: Medical devices: guidance for manufacturers on vigilance - https://www.gov.uk/government/collections/medical-devices-guidance-for-manufacturers-on-vigilance

8. Appendices

N/A