RA-203 Document Control

1. **PURPOSE:**
   The purpose of this Standard Operating Procedure (SOP) is to ensure that controlled documents related to clinical research are appropriately managed at UTRGV. The purpose of "control" is to assure that documents used in more than one location are A) properly situated where needed, and B) can be withdrawn and re-issued when changed, assuring that only current, non-obsolete versions of the documents are in place.

2. **SCOPE:**
   For purposes of this SOP, "Controlled Document" will refer to documents used to regulate the management and processes associated with clinical research studies at UTRGV. These are documents originated by UTRGV Investigators and/or research staff when UTRGV and its associated clinics and departments are the primary/central or only location for the research. This includes SOPs.

   Multi-site documents that are sent to UTRGV from a sponsor and/or CRO are also considered controlled, but subject only to sections 6.1, 6.6 and 6.7 by UTRGV Research staff. The other elements of control on sponsor provided documents are performed by the sponsor/CRO at a central level before they are distributed to researchers at UTRGV.

3. **RESPONSIBLE INDIVIDUALS:**
   The Principal Investigator (PI) is responsible for determining which documents need to be controlled. The Research or Regulatory Coordinator may be delegated to implement and maintain a document control system that includes the following:
   - Coordinates reviews and revisions of quality system documents
   - Maintains Master File to ensure active and revised documents are provided to staff that must contain Document Number, Title, Revision Level and Review date
   - Archives superseded or obsolete documents
   - Reviews SOP prior to use
   - Ensures that all routine operations and activities are documented by SOPs
   - Creates or delegates creation of documents

Other Designated Research Personnel are responsible for the following:
- Verifying that the official version of the document is used

- Review and determine need for new procedures or revision of procedures and to convey that need to their immediate supervisor

4. RELATED TERMS AND DEFINITIONS:

Controlled Document
Florence eBinders™

Please reference the Standard Operating Procedures Glossary of Terms for complete definitions of terms in this SOP.

5. POLICY STATEMENT

This policy applies to all Principal Investigators (PI) and delegated research staff responsible for document control.

6. PROCEDURE:

6.1 Research staff will be knowledgeable of various types of controlled documents used for clinical research. Examples of controlled documents include the following:

- Protocol (including monitoring plan)
- Protocol amendments
- Case report forms (CRFs)
- Informed consent form (ICF)
- Investigator Brochure
- Equivalent medical device study documents (Investigational Plan, Report of Prior Investigations)
- Adverse event (AE) reporting forms
- Standard Operating Procedures (SOPs)
- Other FDA documents: All other documents that are developed for clinical study purposes are considered non-controlled.

6.2 Version Control and Naming Convention for documents originated by site investigators or staff**:**

6.2.1 All controlled documents need to be dated and/or version numbered in sequential order and systematically named, especially if they belong to a series or set of documents e.g., protocol, informed consent form.

6.2.2 The first draft of the protocol should be labelled with a version number and dated, for example ‘Draft version 0.1 and dated. Further draft versions should be labelled ‘Draft version 0.2, 0.3’ etc. and dated.

6.2.3 The final original version of the protocol may be labelled 'Final Version 1.0' and dated before being submitted for the appropriate approvals.

6.2.4 If amendments are necessary following review of the protocol, then subsequent versions of the protocol may be labelled 'Draft Version 1.1, 1.2' while still being drafted and reviewed and the version re-submitted for approval should be labelled 'Final Version 2.0' and dated.

6.2.5 If the protocol is then amended again during the study, then the version submitted for approval of the amendment will be labelled 'Final Version 3.0' and so on.

6.2.6 Other considerations that should be on the document when appropriate:

- Effective date, expiration date or next review dates if applicable. It may be necessary to also include date issued and date printed.
- Page numbers – It is recommended that pages are numbered as "Page X of Y".
- Confidential – If the document is confidential, mark "Confidential".
- Document identification- e.g., a title, department name
- Approvals - It may be necessary to include signature and date of Author, Reviewer and Authorizer with titles of signatories e.g., for SOPs, protocols.
- Copyright as appropriate – Insert copyright information if necessary.
- Reason for Change – If it is a revision of the control document, state reason for change and list changes.
- Referencing - When reference is made to another controlled document, you may use the instruction "see/refer to *Document Title*". The version number may be excluded.

6.3 Document Initiation and Approval Procedures for documents originated by site investigators or staff:

6.3.1 The PI or designated research personnel will use the procedures below for the drafting, review, approval, and revision of controlled documents.

6.3.2 Determine which documents are needed for developing regulatory submissions, collecting data or other study information, and/or performing any other study-related function.

6.3.3 Determine who will draft the first version of a given document (the author) and any related appendices (list of attachments) to be included with the document.

6.3.4 Determine who must review and approve the first draft and succeeding drafts

6.3.5 Use templates or guidelines for developing new documents (where available) and initiate the document drafting process.

6.3.6 Complete the document control noting version date in the document number section and in the footer of the document.

6.3.7 Circulate the draft if it needs further review securing signature/review date, comments, and suggestions from all specified reviewers.

6.3.8 Revise the document per initial review process. If any revisions are not incorporated, the author will notify the affected reviewer(s) of the reason(s) for not including the revision(s). The author will negotiate a resolution, documenting any significant differences in the space provided on the Document Control Form.

6.3.9 Continue to circulate the revised document to all signatories until the review process is complete. The document will have a version date for each review and then a final version date.

6.3.10 Ensure all required reviewer approvals are indicated by entries in the Signature and Approval Date boxes on the controlled document.

6.3.11 Upon final signature of the last reviewer, the authorized person should sign and date the controlled document in the space provided to indicate responsibility for that document.

6.3.12 Following final approval, designated research personnel will assign all newly approved documents a version number and effective date.

6.3.13 The original approved document and Document Control Form(s) will be retained in the appropriate archive file or section of the Regulatory Master File.

6.3.14 For new, non-controlled documents, there are no specific required procedures to follow for development, but department administration must approve the development of new documents and their final version.

6.4 Document Review/ Change Procedures:

6.4.1 Each respective department will review controlled documents periodically or as needed by circumstances (e.g., new federal or state regulation, new University or institutional policy or procedure, or need for update of Investigational Brochure, etc.).

6.4.2 If revisions are needed in a controlled document, the research designee will do the following:

- Have the author of the change(s) circulate the revised draft with a copy of the original, clearly noting the changes, using the Document Control Form as its cover.

- Continue to give updated and revised controlled documents a new version number (01, 02, etc.) and a current effective date.
- Document periodic review and updates by maintaining an accurate table of modifications form or version log for each controlled document.
- Watermark prior version of the controlled document "Obsolete" and save copy for the appropriate archive file or section of the Regulatory Master File.
- Update any related tables or indices, as appropriate.
- Distribute updated, final documents. Use clear communication to all parties that includes:
    - which version(s) are now obsolete and should no longer be used
    - which version(s) are current and should be used going forward
    - what the changes to the document(s) are. Include a date these changes were/will be effective, if possible.
- Keep and file all of this communication, including attachments, if applicable.

6.5 Revision of Non-Controlled Documents:

6.5.1 When revisions are needed in a non-controlled document, the author of the non-controlled document or a designee will do the following:

- Make the change(s) and circulate the revised draft with a copy of the original, clearly noting the changes and why they are needed.
- Continue to give updated and revised non-controlled documents a new version number (01, 02, etc.) and current effective date.
- Mark prior version of the document "Obsolete" and save copy for the appropriate archive file (see specific SOP for location).
- Update any related tables or appendices, as appropriate.

6.6 Document Implementation Procedures:

6.6.1 The Investigator will ensure that all appropriate staff are trained in the proper use of the new or revised document.

6.6.2 The Investigator will make a list of all affected parties and appropriate regulatory authorities (IRB, FDA) who must be notified of changes to applicable documents and notify them in writing when the changes are implemented (or prior to implementing, if appropriate).

6.6.3 The Investigator will keep and file all of the above-mentioned communication. Including attachments, if applicable.

6.6.4 The research designee will provide the updated version of appropriate documents to affected parties.

6.6.5 The research designee will keep and file the communication of the above-mentioned document distribution.

6.7 Storage and Archiving:

6.7.1 Controlled documents should be stored in an area, room or electronic platform restricted to authorized individuals only. If the controlled documents are part of essential documents, they should be part of the Research Master/Regulatory File (see SOP RA-201) and archived appropriately (see SOP DM-504).

6.7.2 Old versions of controlled documents must be archived in a separate file.

- Obsolete paper documents that are retained for reference or legal obligations are water marked "OBSOLETE" and kept separate from active documents.
- Obsolete electronic documents are removed from the folders containing, and labelled as, current documents. They are renamed in a manner that clearly indicates they are no longer to be used and moved into a folder containing, and labelled as, old/obsolete/archived documents. For storage and archiving of electronic records, see SOP RA-205
- Any obsolete documents that need to be reactivated must be reviewed, approved and released in the same manner as newly established documents.
- At least one copy of all obsolete paper documents must be archived.

6.7.3 Documents will be archived in electronic storage to:

- prevent their continued use.
- facilitate easier access for retrieval purposes.
- limit documents to a read-only format to protect them against unauthorized changes made to the document.
- be available for historical data review.
- provide an audit trail.

REFERENCES:

- 21 CFR 812.100 General Responsibilities of Investigators
- ICH E6, 2.13 The Principles of ICH GCP
- ICH E6, 5.1 Quality Assurance and Quality Control
- UTRGV RA-201
- UTRGV RA-205
- UTRGV DM- 504
- URTGV GA-101

FORMS OR ATTACHMENTS:

None