From: OC GCP Questions
To: [redacted]
Subject: Web-based source documentation
Date: Friday, April 03, 2015 1:04:00 PM

Good afternoon –

Many institutions and sites are going to a fully electronic record system. Your EMR can be your source record.

You may also want to look at FDA's Compliance Program Guidance Manual (CPGM) for the FDA inspection of clinical investigators during a bioresearch monitoring (BIMO) inspection of a clinical study site, available at: http://www.fda.gov/ICECI/EnforcementActions/BioresearchMonitoring/ucm133562.htm In particular, you may want to review Part III, Inspectional, which identifies some of the things an FDA investigator will look for during a clinical investigator site inspection.

ICH E-6 Good Clinical Practice: Consolidated Guidance
http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM073122.pdf
Please see this guidance for definitions for "source data" and "source document":

"1.51 Source Data: All information in original records and certified copies of original records of clinical findings, observations, or other activities in a clinical trial necessary for the reconstruction and evaluation of the trial. Source data are contained in source documents (original records or certified copies)."

"1.52 Source Documents: Original documents, data, and records (e.g., hospital records, clinical and office charts, laboratory notes, memoranda, subjects' diaries or evaluation checklists, pharmacy dispensing records, recorded data from automated instruments, copies or transcriptions certified after verification as being accurate and complete, microfiches, photographic negatives, microfilm or magnetic media, x-rays, subject files, and records kept at the pharmacy, at the laboratories, and at medico-technical departments involved in the clinical trial)."

Regarding medical records of study subjects, monitors and auditors will want to at least spot check the completeness of these records at the source which is the subject's chart/medical record. How they view them is at the sponsor or clinical investigator discretion however. Either looking over the shoulder of a study staff member or having limited access to the medical records is common.

The reason at least a spot check is necessary is that the records can be selectively copied. So even though they are certified copies they may not be complete records. The monitor/auditor is checking to ensure that study inclusion/exclusion are met and that there are no concomitant issues that would preclude the individual's participation in the study or confound the results.

In general, during an inspection FDA usually reviews original (source) records or certified copies of clinical trial records. For example, during an inspection of a clinical investigator (CI), the FDA investigator will evaluate the CI's practices and procedures to determine compliance with applicable regulations. Quite often CIs maintain copies of certain records in their study files, e.g., records from a hospital or other institution that must maintain the originals. FDA refers to these as shadow files. While it is acceptable to keep shadow files in the study records, should FDA conduct a bioresearch monitoring (BIMO) inspection of the study in question, the FDA investigator will expect to review at least a portion of the original source documents for such shadow files to verify their authenticity, even if the copies in the shadow files are certified as authentic copies.

The guidances listed below might be helpful to you.

Part 11 –Electronic Records --

http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM126953.pdf

Computerized Systems Used in Clinical Investigations –

http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM070266.pdf

Electronic Source Data in Clinical Investigations –

http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM328691.pdf
This document includes information related to the creation and maintenance of electronic case report

forms(eCRF). It describes and electronic medical record (EMR) as a possible data originator for an eCRF. However, section IV. of the document states that, although adequate controls need to be in place to ensure confidence in the reliability, quality and integrity of electronic source data, performance standards for EMRs may be regulated by other authorities and FDA does not intend to assess compliance of EMRs with part 11.

I hope this information is helpful. Please contact us again at gcp.questions@fda.hhs.gov should you have additional questions.

Kind regards,

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From: [redacted]
Sent: Friday, April 03, 2015 12:03 PM
To: OC GCP Questions
Subject: Web-based source documentation

Hello,

I would like clarification on an issue related to electronic source documents. Web-based direct entry Case Report Forms are sometimes defined as the source documents as well. Study source data is maintained externally and routine access to study data is limited to study personnel and data managers. This can create issues related to patient continuity of care due to the lack of availability in the medical record of clinical data obtained during study participation. In addition to any institutional/local policies that may apply, are there Regulatory Requirements or Good Clinical Practice guidelines that apply to this situation?

Thank you for your assistance.
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