

From: [OC GCP Questions](#)
To: [REDACTED]
Subject: Your Opinion towards transcribed data which are considered as source data while original records are being discarded?
Date: Tuesday, June 03, 2014 2:47:52 PM

Good afternoon—

Thank you for your inquiry. Regarding your e-mail below, based on the limited information provided, it appears that the situation you describe may not conflict with FDA regulatory requirements. Such transcription may be considered "Certified Copies. The term "Certified Copy" is defined in FDA's Final Guidance Computerized Systems Used in Clinical Investigations (the one you referenced) as: "A certified copy is a copy of original information that has been verified, as indicated by a dated signature, as an exact copy having all of the same attributes and information as the original." See: <http://www.fda.gov/OHRMS/DOCKETS/98fr/04d-0440-gdl0002.pdf>

We are frequently asked if sites may archive records by converting paper documents into an electronic format—in essence, creating certified copies of source documents. Neither FDA's regulations nor the ICH E-6 Good Clinical Practice: Consolidated Guidance <http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM073122.pdf> defines certified copy", however, the term is mentioned in the E6 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)."

Although the term "certified copy" is not defined in the ICH E6 guidance, we attempted to define this term in the CCT Guidance referenced above:

"Certified Copy means a copy of original information that has been verified, as indicated by dated signature, as an exact copy having all of the same attributes and information as the original."

The use of certified copies as described above generally applies to situations where original records are copied to a different media for archiving purposes and the originals are destroyed. However, if it is decided to have a certified copy substitute for the original, it would be desirable to have a "standard operating procedure" (SOP) describing how such copies would be made, verified, and documented. The person who certifies the copy as an accurate and complete representation of the original, having all of the same attributes and information should be the same person who actually made the copy from the original. Certification should be accomplished by having the person who makes the copy, sign or initial and date the copy to indicate it meets the requirements of a certified copy as described above. This should be described in the SOP and can be accomplished by initialing and dating each copy or by initialing and dating a document certifying copies in bulk. Whichever method is used the SOP should describe the procedure. (There are many ways to accomplish this, and the procedures described above are only suggested examples.)

Burning a CD at the end of the study, converting e-mails into a PDF format or adopting a procedure to make certified copies are all acceptable methods to achieve study related documents.

(FDA does not have any regulatory requirements as to the type of CD or DVD that might be used to preserve information (presumably to meet the regulatory requirements concerning clinical data/records). A company just needs to make certain that whatever media it uses does so in a manner that preserves the integrity of the original data/information.

Please also see guidance on 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>

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

Kind regards,

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Senior Health Policy Analyst
Office of Good Clinical Practice
Office of the Commissioner, FDA

This communication does not constitute a written advisory opinion under 21 CFR 10.85, but rather is an informal communication under 21 CFR 10.85(k) which represents the best judgment of the employee providing it. This information does not necessarily represent the formal position of FDA, and does not bind or otherwise obligate or commit the agency to the views expressed.

From: [Redacted]

Sent: Tuesday, June 03, 2014 2:42 AM

To: OC GCP Questions

Cc: [Redacted]

Subject: Your Opinion towards transcribed data which are considered as source data while original records are being discarded?

Dear whom it may concern,

Hello,

I'm [redacted], an GCP auditor in [redacted]. I'd appreciate it if you could provide your opinion towards transcribed data which are considered as source data while original records are being discarded as described below;

For a particular site, measurement of Height/Weight and blood pressure/heart rate are generated from a device which automatically prints out these measurements when patients measure their study required vital signs. The print-out paper (primary record) is thermo-sensitive, and has vital signs, date/time information but no documented identification of patient. It is calibrated annually, and used for measuring vital signs of all patients seen in the clinic including patients in clinical trial.

During a typical patient visit for a clinical trial, a study nurse accompanies the patient during vital signs measurement and then goes on consultation visit with the investigator. Investigator transcribes these vital signs into an electronic medical chart/record, and both investigator and study nurse verified the transcribed information against the print-out paper (primary record). The same investigator acknowledges in electronic medical chart for this confirmation. This piece of print-out is then discarded without any photocopy kept in site files. Investigator and sponsor (CRA) agreed to use transcribed data for required vital signs as source data before subject enrolment commences.

In this case, can the transcribed data in electronic medical chart be considered as source data, and

can original records be discarded?

Yours sincerely,
[Redacted]