PATIENT CHART REVIEW

Review of a patient chart involves the following:
- Review of the primary record to determine compliance to protocol requirements
- Review of the primary record to determine adequate source documentation is available to support all reported data
- Review of data collection forms to determine accurate reporting of research data
- Assessment of documentation practices at the study site

Use the protocol as a guide for review of each case. Sections of most relevance include:
- Sec. 5 – Eligibility
- Sec. 7 – Treatment Plan
- Sec. 8 – Toxicities/Dose Modifications/Adverse Event Reporting
- Sec. 9 – Study Calendar
- Sec. 10 – Disease/Endpoint Assessment
- Sec. 14 – Data Submission Schedule
- Sec. 15 – Special Instructions
- SWOG Best Practices memo (effective 6/1/23) that provides guidance and clarification for expectations on protocol compliance.

Non-RAVE cases: A copy of the data collection forms that have been submitted to each group's Data Operations Office will be provided for each case. SWOG cases will include an Evaluation Summary Sheet with pertinent information such as off treatment date, survival status, data submission status, etc. Queries or data needing clarification should be flagged in the Notes section of the Evaluation Summary Sheet. These items should be verified and addressed in the narrative provided by the auditor.

RAVE cases: SWOG studies will be reviewed online by logging into iMedidata. Queries may be entered and resolved online. PDFs of the data collection forms will be provided for non-SWOG studies.

The auditor may choose to work alone or request an Oncology Research Professional (ORP) to assist during the review. If utilizing an EMR, the site must provide a summary or instructions on how to navigate the EMR and an ORP or other knowledgeable person to guide the auditors in navigating the EMR must be available the first morning of the audit.

ELIGIBILITY

There are no exceptions to the eligibility criteria allowed!

Every item on the eligibility checklist must be verified, including:
- Verify diagnosis by review of pathology reports to confirm histology and stage of disease. Stratification factors of study must also be confirmed.
- Verify all pre-study tests were done within required time frame and values are within institutional and protocol limits.

- Review past history of patient including any previous treatment to rule out exclusion criteria, including prohibited medication.
- Review current history of patient to determine if there are any co-morbid conditions that prohibit entry.
- SWOG Best Practices require the registering investigator sign the Eligibility Checklist or affirmation of eligibility or the Registration Worksheet prior to registration. Verify the investigator has signed the affirmation of eligibility or the Registration Worksheet (or comparable documentation).

Clarifications for eligibility

- If labs are done to assess general health and the ability to receive treatment (CBCs, chemistries, etc.) then the most recent values should be evaluated to determine eligibility. If the labs are done for disease assessment (PSA, etc.) then any lab value during the required timeframe is adequate to determine eligibility.
- If the timeframe for prestudy tests ends on a holiday or weekend, the limit may be extended to the next working day.
- Supporting documents such as lab results, x-ray reports, etc. need to be available for source documentation; a provider's progress note alone will not suffice.
- Chart notes to address each individual entry criterion is preferable but as a minimum, a signed eligibility checklist to support exclusion criteria is adequate. A general note that states patient met all exclusion or inclusion criteria is not sufficient unless a detailed list of the criteria is included.

TREATMENT COMPLIANCE WITH PROTOCOL

Verify that the patient was treated per protocol:
- Establish the patient received the assigned treatment.
- Establish in the primary record, the patient's actual height and weight. Verify body surface area (BSA) was calculated correctly, if applicable.
- Verify treatment started within required timeframes.
- Check dates of treatment, medication, duration, and route of administration were per study parameters.
- Verify doses of medication were calculated according to protocol specifications.
- Verify that dose modifications were performed per protocol requirements.
- Determine any inappropriate use of non-protocol therapy.
- Verify other treatment modalities such as surgery or RT.

Clarifications for treatment

- Dose calculations should follow Policy #38 Dosing Principles unless specified otherwise in the protocol.
- Study drug use must be documented in the research record. Drug orders or a copy of prescriptions as well as documentation of drug administration through chemo

flowsheets, progress notes, etc. must be available. Verification through pharmacy records alone is not adequate.

- o Name of agent, quantity, dose dispensed, start date or date dispensed, and missed doses should all be documented.
- o Oral medications must show quantity and dose, start date, and quantity returned or other documentation of compliance such as Intake Calendar, pill diary or progress note.
- o Dose modifications or treatment delays must be documented in sufficient detail to support and provide explanation for the change. Documentation should include reason for change and actual dosage change or reason for hold.
- o Concomitant medications should be documented per protocol requirements, with stop dates, if applicable, to support washout periods.

DISEASE ASSESSMENT/RESPONSE DETERMINATION

Verify that disease assessment/response is evaluated according to protocol:
- Determine that measurable disease vs. evaluable disease was determined appropriately at baseline.
- Determine that evaluation of status of disease/endpoints was performed according to protocol.
- Verify that protocol-directed response criteria were followed by reviewing reports of x-rays and scans, pathology reports, lab reports, and records of physical examinations.
- Verify reports of scans or physical assessments to confirm a reported CR or PR.

Clarifications for disease assessment/response determination

- o For clinical or laboratory-based endpoints, documentation of the specifics of the event or test result must be present through a chart note, lab report, radiology report, etc.
- o Disease assessments must use a consistent method from baseline throughout the study.
- o PET-CT: Documentation that the CT performed as part of a PET-CT is of identical diagnostic quality to a diagnostic CT, then the CT portion of the PET-CT can be used for RECIST measurements and can be used interchangeably with conventional CT.
- o Full body scans, if applicable, must include the full body and not stop at mid-thigh.
- o Tumor measurements should be performed by a consistent reviewer and must be documented. Notations of "smaller, larger or the same" are not adequate.

TOXICITY ASSESSMENT

Verify that toxicities were assessed according to protocol, using baseline and required follow-up studies:
- Verify toxicities are recorded and graded according to the applicable CTCAE version.
- Verify that attribution and status was assigned by a qualified person.

- Verify all toxicities are coded and recorded on the CRF according to the Group's reporting criteria.
- Verify Serious Adverse Events (SAEs) and adverse events of special interest were reported in CTEP-AERS within required timeframes.

Clarifications for toxicity assessment

- o Toxicity or symptoms including those reported by the subject must be documented and assessed for clinical significance by:
- 1) Grading per applicable CTCAE,
- 2) A written description,
- 3) Relationship to drug for SAEs or reportable AEs,
- 4) Attribution of unrelated, unlikely, possible, probable, definite.
- o If non-study staff (i.e. ER staff) document toxicities then study staff must document grade, etc.
- o Absence of toxicity should be documented or it appears that side effects were not assessed.
- o When reporting toxicity, the worst grade documented since last reporting should be reported.

DATA QUALITY

The primary record will be compared to the protocol data collection forms to:
- Determine accuracy in the reporting of all study parameters.
- Verify that data has been submitted in a timely fashion (including pathology and imaging submissions for central review).
- Verify that research specimens have been submitted at specified time points in a timely fashion.
- Verify QOL and PRO forms have been submitted per protocol.
- Verify that good documentation practices are in use, i.e. all corrections made by drawing a single line through the error and initialing and dating the correction, no white out or write over.

Clarifications for data quality

- o Performance status: A numeric value using the Zubrod/ECOG scale should be documented. Values recorded as KPS must be converted to Zubrod. A performance status that can be inferred from the narrative will be accepted although the site should be educated about proper documentation expectations.
- o Good documentation practices: All source documents must be signed and dated and ALCOA (Attributable, Legible, Current, Original, and Accurate).
- o SWOG's expectations are for organized, sequential, adequate documentation that has been tagged to identify key information. It is not the auditor's responsibility to search for documentation. The auditor may choose to work alone or alongside site

personnel, and will ask for help finding documents. The auditor will give general feedback about the quality of source documentation.

- A Site.Authority.Log should be on file at each institution to cover all studies not covered by an electronic CTSU Delegation of Tasks Log. All staff who participate in the research process must sign this log and the PI must note what responsibilities they have authority to perform. The log must be updated as personnel come and go. This log must be available during the audit so that auditors may verify signatures or initials on data or areas of responsibility if concerns or questions arise.

NOTES ON AUDITOR DOCUMENTATION OF AUDIT FINDINGS

- Give specific details (cycle # or date, actual dose given vs required dose, specific toxicities that were not reported, etc.)
- Make note of any protocol exceptions approved by the Study Coordinator or Study Chair
- Make note of general information whether positive or negative (i.e. organized charts and good source documentation, illegible provider's progress notes, multiple missing documents that had to be retrieved by the ORP)
- A "major" deficiency is a variance from protocol-specified procedures that makes the resulting data questionable. A "lesser" deficiency is one that does not affect the outcome or interpretation of the study.

Multiple lesser deviations within a category may be treated as a major deviation. The QA representative can provide guidance on assessment of deficiencies as major vs lesser.

The ORP should be provided the opportunity to locate missing documents and any findings should be reviewed with the ORP upon completion of each chart.

In addition to meeting the objectives of determining that protocol requirements were met and that data was accurately documented on the data collection forms, an important aspect of the audit process is education. Institutions have the opportunity to have their data management practices scrutinized, critiqued, and advice given. Although SWOG has never had a study submitted to the FDA to support a New Drug Application (NDA), there are several potential FDA registration studies active at this time. If the FDA inspects one of our institutions, a major focus of their investigation is meeting good clinical practice (GCP) requirements for good source documentation. The study sponsor must show a good faith effort to correct source documentation deficiencies.

Auditors have an opportunity to provide guidance on proper research practices that the site may not otherwise receive. Although an important part of the audit process is to identify deficiencies, it is important that auditors do not act in a punitive or judgmental fashion but focus on the teaching and guidance aspects of the audit.