



The following Motion and Documents were considered by the Board Learning and Discovery Committee by electronic vote on March 5, 2013:

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Agenda Title: **Proposed Revisions to the University of Alberta's Research Policy**

APPROVED MOTION: THAT the Board Learning and Discovery Committee, acting with delegated authority of the Board of Governors, and on the recommendation of the GFC Executive Committee, approve the proposed changes to the UAPPOL Research Policy, as submitted by the Office of the Vice-President (Research) and as set forth in Attachment 1, to take effect upon final approval.

Final Item: 1

**OUTLINE OF ISSUE**

 Agenda Title: **Proposed Revisions to the University of Alberta's Research Policy**

**Motion:** THAT the Board Learning and Discovery Committee, acting with delegated authority of the Board of Governors, and on the recommendation of the GFC Executive Committee, approve the proposed changes to the UAPPOL Research Policy, as submitted by the Office of the Vice-President (Research) and as set forth in Attachment 1, to take effect upon final approval.

**Item**

Action Requested	<input checked="" type="checkbox"/> Approval <input type="checkbox"/> Recommendation <input type="checkbox"/> Discussion/Advice <input type="checkbox"/> Information
Proposed by	Office of the Vice-President (Research)
Presenter	Lorne A Babiuk, Vice-President (Research)
Subject	Proposed revisions to the University's Policy to include a reference to research records, and also incorporate several editorial changes

**Details**

Responsibility	Vice-President (Research)
The Purpose of the Proposal is (please be specific)	To revise the current Research Policy so that it makes specific reference to research records
The Impact of the Proposal is	The current Research Policy makes no reference to research records, and a 2011 audit by IAS raised this omission as part of its review of information technology and protection of research participants' data. With this revision, the Research Policy will become the "parent" policy for several new Procedures dealing with various issues related to research records.
Replaces/Revises (eg, policies, resolutions)	These revisions would replace the current wording in the Research Policy which was approved by the Board Educational Affairs Committee and General Faculties Council Executive in June 2004
Timeline/Implementation Date	Upon final approval
Estimated Cost	n/a
Sources of Funding	n/a
Notes	<p>The proposed revisions to the current Research Policy are "tracked" in the attached document. Also included, for information only, are the four draft Procedures that have been developed. A Summary of Due Diligence for the Research Policy is also attached for members' information.</p> <p>Once the revised Research Policy has been approved, consultation will proceed on the draft Procedures. Following consultation, the Procedures will be approved by the relevant Vice-Presidents.</p>

**Alignment/Compliance**

Alignment with Guiding Docs	Dare to Discover, Dare to Deliver
Compliance with Legislation, Policy and/or Procedure Relevant to the Proposal (please quote legislation and include identifying section numbers)	<p>1. <b>Post-Secondary Learning Act (PSLA):</b> The PSLA gives the Board of Governors the authority to "develop, manage and operate, alone or in co-operation with any person or organization, programs, services and facilities for the educational or cultural advancement of the people of Alberta" (Section 60(1)). Subject to the authority of the Board of Governors, the General Faculties Council has responsibility over "academic affairs" (Section 26(1)) and can "make recommendations to the board with</p>

1. respect to affiliation with other institutions” (Section 26(1)(o)).  
[...]

**2. GFC Executive Committee Terms of Reference (Section 3 (Mandate of the Committee)):**

**“5. Agendas of General Faculties Council**

GFC has delegated to the Executive Committee the authority to decide which items are placed on a GFC Agenda, and the order in which those agenda items appear on each GFC agenda. [...]

With respect to recommendations from other bodies and other GFC committees, [...] the role of the Executive Committee shall be to examine and debate the substance of reports or recommendations and to decide if an item is ready to be forwarded to the full governing body. The Executive Committee may decide to refer a proposal back to the originating body, to refer the proposal to another body or individual for study or review, or to take other action in order to ready a proposal for consideration by General Faculties Council. When the GFC Executive Committee forwards a proposal to GFC, it shall make a recommendation that GFC endorse; endorse with suggested amendments; not endorse; or forward the proposal with no comment.  
[...]

**3. GFC Policy: Section 3, GFC Executive Committee Terms of Reference (Mandate of the Committee),** states: “To act as the executive body of General Faculties Council and, in general, carry out the functions delegated to it by General Faculties Council.

1. **Urgent Matters:** The power to deal with any matters that cannot be deferred is delegated to the Executive Committee which shall determine which matters are to be considered urgent.

2. **Routine Matters:** Matters which are routine in carrying out the policies approved by General Faculties Council are delegated to the Executive Committee.  
[...]

**3. Board Learning and Discovery Committee Mandate:** “Except as provided in paragraph 4 hereof and in the Board’s General Committee Terms of Reference, the Committee shall, in accordance with the Committee’s responsibilities with powers granted under the *Post-Secondary Learning Act*, monitor, evaluate, advise and make decisions on behalf of the Board with respect to matters concerning the teaching and research affairs of the University, including proposals coming from the administration and from General Faculties Council (the “GFC”), and shall consider future educational expectations and challenges to be faced by the University. The Committee shall also include any other matter delegated to the Committee by the Board.”

Without limiting the generality of the foregoing the Committee shall:

Item No. 1

	<p>b. review, provide feedback and approve teaching and research policies;</p> <p>j. ensure that the academic teaching and research activities at the University are administered and undertaken in a manner consistent with the vision and mission of the University;</p> <p>[...].</p>
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**Routing** (Include meeting dates)

Consultative Route (parties who have seen the proposal and in what capacity)	The attached Summary of Due Diligence (Attachment 6) outlines the various stakeholders who have been consulted during the discussions that have led to the proposed revisions to the University’s Research Policy
Approval Route (Governance) (including meeting dates)	<p>Board Learning and Discovery Committee – February 25, 2013 (for information and discussion)</p> <p>General Faculties Council Executive Committee – March 4, 2013 (for recommendation)</p> <p>Board Learning and Discovery Committee – March 5, 2013 by electronic vote (for approval)</p>
Final Approver	Board Learning and Discovery Committee

Attachments:

1. Research Policy (with “tracked” changes) – **for approval** (2 pages)
2. Draft of “Responding to and Reporting of Information Privacy and Security Breaches Procedure” – for information only (4 pages)
3. Draft of “Research Records Stewardship Guidance Procedure” – for information only (6 pages)
4. Draft of “Research Records Stewardship Guidance Procedure Appendix A: Research Records Management and Preservation Guidelines” – for information only (3 pages)
5. Draft of “Research Records Stewardship Guidance Procedure Appendix B: Research Records Classification Guidelines” – for information only (4 pages)
6. Summary of Due Diligence (2 pages)

*Prepared by:* Katharine Moore, Office of the Vice-President (Research) (492 0868)

**U of A Policies and Procedures On-Line (UAPPOL)**

**Original Approval Date:** June 14, 2004

**Most Recent Approval Date:**

## Research Policy

<b>Office of Accountability:</b>	Vice-President (Research)
<b>Office of Administrative Responsibility:</b>	Vice-President (Research)
<b>Approver:</b>	<del>Board of Governors (BEAC) and General Faculties Council (GFC Executive Committee)</del> <u>Board Learning and Discovery Committee</u>
<b>Scope:</b>	Compliance with this University-wide policy extends to all members of the University community.

### Overview

The University of Alberta serves the community by the dissemination of knowledge through teaching and the discovery of knowledge through research. As one of Canada's largest research-intensive universities, the University of Alberta is committed to excellence in research based on the highest national and international standards, and to actively promoting the important role of research in teaching.

### Purpose

The policy states the University position with regard to its research activities.

### POLICY

As part of its commitment to the creation and dissemination of knowledge, the University of Alberta will foster an environment of open inquiry and academic freedom in which individuals can pursue scholarly activities. To this end, the University will

- ~~Ensure~~Promote the highest standards of practice and ethical conduct.
- Ensure that human research participants are treated safely and with respect.
- Ensure that teaching and research activities ~~with~~involving animals are ~~done~~performed with full respect for animal welfare.
- Ensure that principles of stewardship are applied to research records, protecting the integrity of the assets.
- ~~Be dedicated to s~~Supporting and ~~developing~~ research and scholarship through prudent resource management and the securing of external funding.

All research must be compatible with established University policy and procedure, and comply with the terms and conditions agreed upon with granting agencies and donors.

### DEFINITIONS

Any definitions listed in the following table apply to this document only with no implied or intended institution-wide use. [▲ Top](#)

**U of A Policies and Procedures On-Line (UAPPOL)****Research Records**

Research information assets supporting both research and operational needs. This includes administrative information and records produced for analytic or evidentiary purposes.

**RELATED LINKS**

Should a link fail, please contact [uappol@ualberta.ca](mailto:uappol@ualberta.ca). [[▲Top](#)]

[Post-Secondary Learning Act](#) (Government of Alberta).

**PUBLISHED PROCEDURES OF THIS POLICY**

[Research Administration Procedure \(Roles and Responsibilities\)](#)

DEVELOPMENT LEAD: Harry Davis

VERSION  DRAFT DATE: 21 January 2013

PARENT POLICY: Information Access and Protection of Privacy Policy *NOTE: This header will be removed for UAPPOL publication*

<b>Go to:</b>	<a href="#">[Purpose]</a>	<a href="#">[PROCEDURE]</a>	<a href="#">[DEFINITIONS]</a>	<a href="#">[FORMS]</a>	<a href="#">[RELATED LINKS]</a>
This procedure is governed by its parent policy. Questions regarding this procedure should be addressed to the Office of Administrative Responsibility.					

## Responding to and Reporting of Information Privacy and Security Breaches Procedure

<b>Office of Administrative Responsibility:</b>	<a href="#">Information and Privacy Office</a>
<b>Approver:</b>	<a href="#">Provost &amp; Vice-President (Academic)</a>
<b>Scope:</b>	<a href="#">Compliance with University procedure extends to all members of the University community</a>

### Overview

The University of Alberta as a public body under the **Alberta Freedom of Information and Protection of Privacy Act (FOIPPA)** must protect **personal information, health information, sensitive and confidential information and research data and records** under its custody or control against such risks as unauthorized access, collection, use, disclosure or destruction. From time to time through the business, service and research functions of the university, the university may gain access to **health information** as defined in the **Alberta Health Information Act (HIA)**. In these relationships the university must also protect such information against unauthorized access, collection, use disclosure or destruction in accordance with the provisions of the HIA.

### Purpose

- The purpose of this procedure is to provide education about **information security breaches** of personal information, health information, sensitive and confidential information, or research data and records and the steps necessary in identifying, containing, investigating, assessing, analyzing, reporting, and notifying in the event of a breach, as well as education to prevention of privacy breaches from occurring.

### **PROCEDURE**

- 1) Any member of the University community who becomes aware that an information security breach has occurred must:
  - a) Take immediate action to stop and contain the breach and secure the affected records, systems or digital media, revoking access and correcting weaknesses in physical security.
  - b) Immediately contact the Information and Privacy Office and the Information Technology Security Officer (within 24 hours of detecting a breach)

### 2) RISK ASSESSMENT

In most cases, the more sensitive the information (personal or confidential information), the greater the potential harm to the individuals affected by an information security breach..

Upon notification of an information security breach, the Information and Privacy Office (IPO) and the Information Technology Security Officer (ISTO) will convene a process to determine the risks associated with the breach including consideration of the following elements and the need to notify affected individuals:

- a. Is there a relationship between the unauthorized recipients and the information?
- b. What potential harm to the individuals will result from the breach?
  - i. Personal security risk
  - ii. Identity theft or fraud
  - iii. Loss of business or employment opportunity
  - iv. Hurt, humiliation, damage to reputation or relationships
  - v. Risk to public health or safety
- c. What potential harm could result to the university?
  - i. Loss of trust in the university
  - ii. Loss of assets
  - iii. Financial or legal exposure
  - iv. Reputational damage?

### 3) NOTIFICATION

- a) Based on the results of the risk assessment, the IPO and ISTO will decide whether to notify individuals affected by the breach, when and how they will be notified, and what information will be included in the notification.
- b) The IPO and ISTO will consult with General Counsel and Risk Management in the decision to notify affected individuals.
  - i) Depending on the circumstances, notification could include some or all of the following:
    - (1) Description of the breach
    - (2) Specifics of the information inappropriately accessed, collected, used or disclosed
    - (3) Steps taken so far to address the breach and future steps planned to prevent further breaches
    - (4) Additional information as to how individuals can protect themselves against identity theft or fraud
    - (5) Contact information or an individual (including position title) within the University who can answer questions or provide further information about the breach.
    - (6) If the breach involves human research data or records, contact the Research Ethics Office.
    - (7) If the breach involves human health information obtained from a custodian (eg, Alberta Health Services), contact the custodian.
    - (8) Document the cause and circumstances that gave rise to the privacy breach. (See attached Information Security Breach Reporting Form)
    - (9) Produce an inventory of the personal or sensitive or confidential information that was or may have been lost or compromised. (List all of the data elements of the personal information (including health information) or sensitive or confidential business information exposed through the breach.



- (10) Identify the parties and individuals whose personal information or confidential information has been disclosed, accessed, stolen or lost as a result of the breach. (employees, students, research subjects, contractors, service providers, other organizations)
  - (11) Identify the office, department or faculty that is responsible for the administration of the personal or confidential information involved in the breach.
  - (12) Include all other relevant information
- 4) PREVENTION
- a) Once immediate steps have been taken to contain the breach and mitigate risks associated with the breach, steps must be taken to prevent future occurrences. The IPO and ISTO:
    - i) may conduct a security audit of both operational, physical and technical security
    - ii) develop policies and procedures for the collection use, access and security of personal and sensitive or confidential information
    - iii) Conduct staff training to ensure the protection and prevention plan has been implemented

## **DEFINITIONS**

Any definitions listed in the following table apply to this document only with no implied or intended institution-wide use. [▲Top](#)

<b>Freedom of Information and Protection of Privacy Act</b>	The <i>Freedom of Information and Protection of Privacy Act</i> , Statute of Alberta, Chapter F-25, as amended from time to time.
<b>Personal information</b>	Personal information is defined as per Section 1(n) of the <i>Freedom of Information and Protection of Privacy Act</i> .
<b>Health information</b>	Health information is defined in Section 1 (k) of the <i>Health Information Act</i>
<b>Health Information Act</b>	<i>Health Information Act</i> , Statute of Alberta Chapter H-5 as amended from time to time
<b>Privacy Breach</b>	A privacy breach occurs when there is unauthorized access to or collection, use, disclosure, or disposal of personal or health information. Examples might be <ul style="list-style-type: none"><li>• Information collected in error</li><li>• Information used or disclosed for a purpose NOT consistent with the original collection</li><li>• Lost or misplaced personal information</li><li>• Stolen or displaced files, laptops, data drives or disks or thumb drives</li><li>• Hacking of databases</li><li>• Accidental or deliberate disclosure of private information to unauthorized persons or groups</li><li>• Accidental or deliberate disclosure of personal information in</li></ul>

DEVELOPMENT LEAD: Harry Davis

VERSION # DRAFT DATE: 21 January 2013

PARENT POLICY: Information Access and Protection of Privacy Policy *NOTE: This header will be removed for UAPPOL publication*

	email or other electronic communications.
<b>Sensitive or Confidential Information</b>	<p>Sensitive or confidential information refers to all information that has been collected or compiled in the conduct of operating the programs and services of the University and may include, but is not limited to:</p> <ul style="list-style-type: none"><li>• Confidential business information of third parties;</li><li>• Confidential information collected or compiled in the process of hiring or evaluating employees of the University;</li><li>• Information collected or compiled in the process of law enforcement investigations;</li><li>• Advice, proposals or recommendations, consultations or deliberations of the governing and administrative authorities of the University;</li><li>• Information, the disclosure of which would harm the economic interests of the University;</li><li>• Any information to which legal privilege including client-solicitor privilege may apply.</li></ul>
<b>Research Records</b>	Research information assets supporting both research and operational needs. This includes administrative information and records produced for analytic or evidentiary purposes.

## **FORMS**

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[Government of Alberta Privacy Breach Reporting Form](#)

## **RELATED LINKS**

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Do not delete RELATED LINKS heading or above message. A link to the Parent Policy and a list of all of its Procedures and Appendices will be generated below automatically at publication.

Further RELATED LINKS are optional. List hyperlinks to further information that the user may need to fully understand this PROCEDURE. This may include links to other documents in UAPPOL, legislation, agreements, or external regulations. Links should only lead to the official publication source for these documents on a site that will always be current and updated (such as the Government of Alberta Queen's Printer site).

List links in alphabetical order, indicating title of link and destination, as in the following examples:

[Health Information Act \(Government of Alberta\)](#)

[Information Technology Use and Management Policy \(UAPPOL\)](#)

<b>Go to:</b>	<a href="#">[Purpose]</a>	<a href="#">[PROCEDURE]</a>	<a href="#">[DEFINITIONS]</a>	<a href="#">[FORMS]</a>	<a href="#">[RELATED LINKS]</a>
<p>This procedure is governed by its parent policy. Questions regarding this procedure should be addressed to the Office of Administrative Responsibility.</p>					

## Research Records Stewardship Guidance Procedure

<b>Office of Administrative Responsibility:</b>	Office of the Vice-President (Research)
<b>Approver:</b>	Vice-President (Research)
<b>Scope:</b>	Compliance with University procedure extends to all members of the University community.

### Overview

The University and its members are responsible for the stewardship of the **research records** created, acquired, managed or preserved. Good stewardship procedures will ensure that research records are managed and preserved for future scholarship, that research records can be verified and that **confidential, personally identifying** and/or **sensitive** information is appropriately safeguarded.

### Purpose

- To provide principle-based guidance for **research records** stewardship
- To advise on best practices in research records management and preservation
- To define key considerations in the production of research data and records containing identifiable information on human participants
- To define key considerations and minimum requirements for research records retention

## PROCEDURE

1. RESEARCH RECORDS must be appropriately managed for defined time periods or for reasonable longer periods [described below], and shared where appropriate. If research records are not designated for a permanent collection, the timing and process for their destruction should be documented. See Appendix A.

2. RESPONSIBILITY. The Principal Investigator (PI) is responsible for the collection, maintenance, confidentiality, and secure retention of research records until such time that the Institution assumes responsibility for its management and preservation. The PI should also ensure that all personnel involved with the research understand and adhere to established practices that are consistent with these procedures.

3. CREATION AND RETENTION OF RESEARCH RECORDS. Different kinds of research records will require different standards for collection, maintenance, privacy and retention.

- a. In general, research records should be created, stored, used and retained in accordance with the highest standards of scientific and academic practice relative to the PI's discipline or field.
- b. Research records must be retained in sufficient detail to enable the researchers and the University to respond to questions about research methods, rigour, accuracy and authenticity, to demonstrate that the results are reproducible and to document the relative contributions of the research team.
- c. Research records may contain sensitive or confidential information, separate and apart from personally identifiable information. That information should be appropriately managed and safeguarded. If called upon, the researcher and the University should be able to show compliance with pertinent contractual obligations, and institutional and externally imposed requirements and regulations governing the conduct of the research.
- d. With regard to records of **research involving humans**, respect for privacy is a fundamental concern in the creation and retention of research records. Researchers and research ethics boards (REBs) are expected to identify and minimize privacy risks, keeping in mind that a matter that is not sensitive or embarrassing for the researcher may be so for the participant. The *Tri-Council Policy Statement Ethical Conduct for Research Involving Humans* discusses privacy and confidentiality and provides the framework for research ethics board review and approval. [See *UAPPOL Human Research Ethics Policy and Procedures*]. The Health Information Act sets out specific requirements concerning the use of health information in research. Among other things, following ethics approval and the decision by a custodian to disclose the health information, a researcher must enter into a formal agreement with the custodian. The data agreement will include any conditions imposed by the custodian relating to the use, protection, disclosure, return or disposal of the health information, and any requirement imposed by the custodian to provide safeguards against the identification, direct or indirect, of an individual who is the subject of the health information.
- e. Research agreements may involve access by the researcher to proprietary or confidential information from a company or sponsor. **[Harry Davis to provide a general statement here.]**

#### 4. MANAGING AND PRESERVING RESEARCH RECORDS.

The University and its researchers each have roles and responsibilities in the management and stewardship of research records. The partnership between the institution and researcher is essential for a complete lifecycle management of research records. Researchers depend on the institution to enable their development of research records requiring the institution to be responsive to the overall environment for research record management and stewardship. The University has a mandate to provide an environment supportive of the management and stewardship of research records while the researchers are expected to carry out this mandate through individual projects and programs.

- a. Institutional roles and responsibilities: The institution's role is to provide an environment supportive of sound research records management and stewardship. The substantial investment in research records, including the significant human, intellectual and financial capital, results in the production of valuable assets requiring proper management and stewardship. The University assumes responsibility for the long-term protection of these assets.
- b. Researcher roles and responsibilities: The researcher's role is to produce research records of high quality. He/she has a responsibility to manage research records using today's best practices.
- c. The value of research records can increase through their reuse or repurposing [see item d regarding the value of administrative records]. Maximizing the value of research records is conditional on making these records widely available for new uses. The Institution has an obligation to facilitate the advancement of knowledge in all disciplines by encouraging researchers to share data. Sharing data strengthens our collective capacity to meet scholarly

standards of openness by providing opportunities to further analyze, replicate, verify and refine research findings. Such opportunities enhance progress within fields of research, avoid duplication of primary collection of data, as well as support the expansion of inter-disciplinary research. Greater availability of research data will contribute to improved training for graduate and undergraduate students, and, through the secondary analysis of existing data, make possible significant economies of scale. In addition, institutions and researchers, whose work is publicly funded, have a special obligation to openness and accountability in research.

- d. Part of the environment that the Institution is to provide and support is preservation services. The transfer of stewardship responsibility for research records from the researcher to the Institution is articulated in the Research Data Management and Preservation Guidelines document.
- e. The articulation of the primary stewardship responsibilities for all parties throughout the research lifecycle should be made at the very beginning of a research project in a Data Management Plan. Such plans are described in more detail in the Research Data Management and Preservation Guidelines document.

5. IDENTIFIABLE INFORMATION For the purposes of this policy, it is important to note that human research ethics applications require a statement outlining the procedures researchers will use to securely store research records including the length of time the research records will be stored, the location of storage, the identity of the person responsible for storage of research records, and the procedures that will ensure secure storage. Researchers have a duty to treat research participants' identifiable information in a confidential manner. Ethical concerns regarding privacy decrease as it becomes more difficult (or impossible) to associate information with a particular individual. These concerns also vary with the sensitivity of the information and the extent to which access, use or disclosure may harm an individual or group.

The easiest way to protect participants is through the collection and use of **anonymized** data, although this is not always possible or desirable. With anonymized data it is not possible to link new information to individuals within a dataset, or to return results to participants. A "next best" alternative is to use **de-identified** data: the data are provided to the researcher in de-identified form and the existing key code is accessible only to a custodian or trusted third party who is independent of the researcher. The last alternative is for researchers to collect data in identifiable form and take measures to de-identify the data as soon as possible. Where it is not feasible to use anonymized data for research, the ethical duty of confidentiality and the use of appropriate measures to safeguard information become paramount. Researchers are expected to consult their REB if they are uncertain about whether information proposed for use in research is identifiable.

Electronic storage and analysis of data may heighten risks of re-identification and researchers and REBs should be vigilant in their efforts to recognize and reduce these risks.

6. RETENTION Research record retention periods will vary depending on the research discipline, research purpose and type of records involved.

a. Research records must be retained for not less than:

- five (5) years after the end of a research project's records collection and recording period;
- five (5) years from the submission of a final project report;
- five (5) years from the date of publication of a report of the project research; or,
- five (5) years from the date a degree related to a particular research project is awarded to a student

whichever occurs last.

b. The conditions for research records that must be retained for longer periods are:

- if required to protect intellectual property rights;
- if the research records are deemed to have long-term value determined by the wider research community and the preservation services provided by the Institution;
- if retention is required for the continuity of scientific research or if the research records are potentially useful for future research by the PI or other researchers;
- if such research records are subject to specific federal or provincial regulations requiring longer retention periods. For example: *Canada's Food and Drug Regulations* require certain clinical trial records to be stored for twenty-five (25) years;
- if required by the terms of a research sponsorship agreement; or,
- if any allegations regarding the conduct of the research arise during the research activity, such as allegations of academic misconduct or conflict of interest.

c. Future use of research records may be subject to the provisions of applicable privacy legislation or, for example, the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2).

d. With regard to human participant research generally, records do not have to be destroyed, provided the researcher's Data Management Plan (see 4f above) has a clear statement about appropriate records management, storage and retention. For research involving health information, the agreement between the custodian and the researcher will determine data storage and management.

e. Research records must be stored securely and protected with all the precautions appropriate to their sensitivity and privacy.

7. FUNDING COUNCILS may have specific policies and directives about sharing and preserving research data produced through projects they fund. Researchers should anticipate such requirements regarding research data and act accordingly. Some examples are:

- The Social Sciences and Humanities Research Council (SSHRC) Policy on Data Sharing states that all research data collected with the use of SSHRC funds must be preserved and made available for use by others within a reasonable period of time;
- Canadian Institutes of Health Research (CIHR) grantees must deposit bioinformatics, atomic and molecular coordinates data into the appropriate public database immediately upon publication of research results;
- CIHR grantees must retain original data sets arising from CIHR-funded research for a minimum of five years after the end of the grant. This applies to all data, whether published or not;
- Collections of animal, culture, plant or geological specimens, or archaeological artifacts ("collections") collected by a grantee with Tri-Council grant funds are the property of the University.

8. DISPOSITION Destruction of research records must be carried out so that sensitive, confidential and/or personal information cannot practicably be read or reconstructed. In some cases it may be advisable to document the manner and time of destruction.

## **DEFINITIONS**

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<b>Research records</b>	Research information assets supporting both research and operational needs. This includes administrative information and records produced for analytic or evidentiary purposes. Research records include those documents and records and materials captured by or for a researcher that are necessary to document, reconstruct, evaluate, and validate research results and the events and processes leading to the acquisition of those results. Research records may be in many forms including but not limited to laboratory notebooks, survey documents, questionnaires, interview notes, transcripts, machine-generated data or performance outputs, recruitment materials, consent forms, correspondence, other documents, computer files, audio or video recordings, photographs including negatives, slides, x-ray films, samples of compounds, organisms (including cell lines, microorganisms, viruses, plants, animals) and components of organisms.
<b>Research data</b>	Research records captured in a digital format, including raw data (unprocessed observations of particular phenomena), processed data (data produced when raw data has been calibrated or corrected) and derived data (which present a summary or specific view of raw data).
<b>Confidential information</b>	Information disclosed to a researcher with the ethical and/or legal obligation that it will safeguarded from unauthorized access, use, disclosure, modification, loss or theft.
<b>Personally identifying</b>	The information identifies a specific individual through direct identifiers (eg name, personal health number) or through a combination of indirect identifiers (eg, date of birth, unique personal characteristic, place of residence).
<b>Identifiable information</b>	Information that may be reasonably expected to identify an individual, alone or in combination with other available information, is considered identifiable information (or information that is identifiable).
<b>Anonymous information</b>	Information that never had identifiers associated with it.
<b>Anonymized information</b>	The information is irrevocably stripped of direct identifiers, a code is not kept to allow future re-linkage and risk of re-identification of individuals from remaining indirect identifiers is low or very low.
<b>De-identify</b>	To remove direct identifiers from data
<b>Coded information</b>	Direct identifiers are removed from the information and replaced with a code. Depending on access to the code, it may be possible to re-identify specific participants.
<b>Privacy</b>	Privacy risks arise at all stages of the research life cycle, including initial collection of information, use and analysis to address research questions, dissemination of findings, storage and retention of information, and disposal of records or devices on which information is

stored. Research privacy risks relate to identifiable information and the potential harms participants, or groups to which they belong, may experience from the collection, use and disclosure of personal information.

## **FORMS**

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Forms are optional. If not in use, do not delete “FORMS” heading. Delete this row and change above message to read “There are no forms for this Procedure.” Do not delete back-to-top hyperlink.

If this section is used, list hyperlinks to all forms for this procedure.

## **RELATED LINKS**

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List links in alphabetical order, indicating title of link and destination, as in the following examples:

Health Information Act (Government of Alberta)

Canadian Institutes of Health Research (Government of Canada)

Social Sciences and Humanities Research Council of Canada (Government of Canada)

Natural Sciences and Engineering Research Council of Canada (Government of Canada)



Original Approval Date: (Effective Date: ) Most Recent Approval Date:

(Add "Effective Date" only if different than "Approval Date")

Most Recent Editorial Date: 21 January 2013

Parent Policy: Research Policy

## Research Records Stewardship Guidance Procedure

### Appendix A: Research Records Management and Preservation Guidelines

<b>Office of Administrative Responsibility:</b>	Office of the Vice-President (Research) and University of Alberta Libraries
<b>Approver:</b>	Vice-President (Research)
<b>Scope:</b>	Compliance with University procedure extends to all members of the University community

#### OVERVIEW

Researchers at the University of Alberta and the Institution share responsibility for the stewardship of the **research records** created, acquired, managed and preserved. Good stewardship procedures will ensure that research records are managed and preserved for future scholarship, that research findings can be verified and that confidential, personally identifying and/or sensitive information is appropriately safeguarded.

#### PURPOSE

- To provide principle-based guidance for research records stewardship
- To advise on best practices in research records management, data sharing and preservation
- To define key considerations in the production of research records containing identifiable information on human subjects
- To define key considerations and minimum requirements for research records retention

#### GUIDELINES

##### 1. Research Records Management Plan

Increasingly, funding agencies are requiring researchers to include a records management plan when applying for funds. Such plans recognize the stages through which research records will be produced, managed, documented, stored, disseminated and deposited (with either a staging or a preservation repository). Furthermore, these plans will identify the data stewards across a project's lifecycle. Such stewards may be an individual or an organizational unit. A plan should include a copy of a project's Records Policy (see below) outlining the principles and conditions of records sharing, access and preservation. Statements of agreement should be included from organizations identified and willing to provide services and act as records stewards through the project lifecycle and thereafter. A plan will also include a description about how sensitive records will be treated.

2. Records Policy

A Records policy formalizes the chain of accountability for managing research records and articulates the roles and responsibilities of research members. Topics covered in a records policy include a statement on ownership and stewardship; administrative, technical and physical safeguards for the research records; access conditions, including open and exclusive access; consequences of a security breach or violation; terms around the dissemination of research records; and deposit agreements with a preservation repository.

3. Records Curation

The University of Alberta Libraries, in partnership with other units on campus that have a mandate to support research activities, collectively provides services for records curation. Among the coordinated activities making up records curation are preparing records management plans, choosing and implementing metadata standards and ontologies, identifying procedures and mechanisms for managing and preserving sensitive records, selecting a repository service (staging or preservation), identifying digital objects for dissemination and preservation, and selecting tools and services to support these activities.

4. Research Metadata

Metadata consists of information describing activities performed across the research lifecycle that provides context for research records, including a project's proposal, data collection instruments, structured descriptions (such as ontologies), data documentation and research outputs. Collectively, such information is essential for long-term preservation. Standards-based metadata facilitates access, preservation, increases comparability with other data and enables interoperability. Researchers should consult with metadata experts, either with the University of Alberta Libraries or metadata specialists within the primary discipline of the research, to identify appropriate standards and tools to assist in the production of metadata. Such consultations should include representatives from the dissemination and preservation services for the data (if the same agency or organization is not providing both dissemination and preservation, then each should be consulted since the metadata requirements often vary).

5. Attribution of Research Records Products

The norms around research records citation are changing in many disciplines. Many scholarly publishers are now requiring researchers to provide links to their records when they submit findings for publication. Support through new technologies, such as digital object identifiers (DOIs) and registries for DOIs (such as DataCite), researchers can obtain a permanent identifier for objects that allow a standard method for the long-term location for research records. These identifiers can be used in citations much in the same way that ISBNs are used to identify publications uniquely. Through the Web, DOIs allow linking published articles with the records upon which research findings are based. Credit can be attributed to researchers through the use of DOIs when others publish findings on the same records.

## **DEFINITIONS**

Any definitions listed in the following table apply to this document only with no implied or intended institution-wide use. [▲ Top](#)

<b>Research Records</b>	Research information assets supporting both research and operational needs. This includes administrative information and records produced for analytic or evidentiary purposes.
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**RELATED LINKS**

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DRAFT

<b>Go to:</b>	<a href="#">[Purpose]</a>	<a href="#">[PROCEDURE]</a>	<a href="#">[DEFINITIONS]</a>	<a href="#">[FORMS]</a>	<a href="#">[RELATED LINKS]</a>
This procedure is governed by its parent policy. Questions regarding this procedure should be addressed to the Office of Administrative Responsibility.					

## Research Records Stewardship Guidance Procedure Appendix B: Research Records Classification Guidelines

<b>Office of Administrative Responsibility:</b>	Vice-Provost (Information Technology)
<b>Approver:</b>	Provost and Vice-President (Academic) and Vice-President (Research)
<b>Scope:</b>	Compliance with University procedure extends to all members of the University community.

### Purpose

To provide a classification system for various kinds of sensitivity levels associated with research records. Researchers may use this system to inform practice for handling their research information assets.

### **PROCEDURE**

Researchers will determine the security and disclosure risk that applies to their research information assets. This assessment should address records for both research and operational activities. A research project will likely contain a variety of records with different risk classifications.

As part of planning their research activities, researchers must do a security and disclosure risk assessment impact of their work, and handle their research records to the highest standard based on that assessment. Research records fall into one of four categories, and these categories are to be used in undertaking the risk assessment:

#### 1. CLASSIFICATION OF RESEARCH RECORDS

##### a. **UNRESTRICTED RESEARCH RECORDS**

##### i. Description

Research records containing information that is not considered a security or disclosure risk. Unrestricted information includes but is not limited to information deemed public by legislation or through a policy of routine disclosure and active dissemination.

##### ii. Examples of Unrestricted Research Records (this list is not exhaustive)

- Public research Information
- Research Meeting Agendas and Minutes
- Background research papers with no copyright restrictions
- Description of a data collection instrument

## b. **PROTECTED RESEARCH RECORDS**

### i. Description

Information that is available to authorized individuals for the purpose of research activities. Information in this category is considered private and its disclosure would be considered inappropriate and contravenes acceptable norms. The level of harm to the subjects of research or the institution, however, would be low.

### ii. Examples of Protected Research Records (this list is not exhaustive)

- Draft research proposals
- Research planning documents
- The names and locations of employees working on a research project

## c. **CONFIDENTIAL RESEARCH RECORDS**

### i. Description

The disclosure of information in this category is considered potentially harmful to the subjects of research or could threaten the institution's competitive advantage, damage partnerships, relationships and reputation. A breach of confidential research records would cause serious harm.

### ii. Examples of Confidential Research Records (this list is not exhaustive)

- Research data with personal information
- Third party information submitted in confidence
- The identity of the subjects in a sampling frame or a population

## d. **RESTRICTED RESEARCH RECORDS**

### i. Description

Research information that if released could cause serious harm to the subjects of research, society or the host institution.

### ii. Examples of Restricted Research Records (this list is not exhaustive)

- Research data with personal health information
- Release of information for creating a deadly virus
- Disclosure of the nesting sites of an endangered species

## 2. **EXAMPLES OF RISK IMPACTS:**

### a. **Unrestricted Research Records**

- Little or no impact

- If lost, changed or denied, would not result in injury to an individual or organization
  
- b. Protected Research Records
  - Unfair competitive advantage
  - Disruption to research operations if not available
  - Low degree of risk if corrupted or modified
  
- c. Confidential Research Records
  - Loss of reputation or competitive advantage
  - Loss of personal/individual privacy
  - Financial loss
  - High degree of risk if corrupted or modified
  
- d. Restricted Research Records
  - Loss of life
  - Extreme or serious injury
  - Loss of public confidence
  - Destruction of partnerships and relationships
  - Extreme risk if corrupted

### 3. QUESTIONS ABOUT CLASSIFYING RESEARCH RECORDS

If researchers are in doubt about how to classify their research records, they should consult with staff in the Research Ethics Office.

## **DEFINITIONS**

Any definitions listed in the following table apply to this document only with no implied or intended institution-wide use. [▲Top](#)

<b>Research Records</b>	Research information assets supporting both research and operational needs. This includes administrative information and records produced for analytic or evidentiary purposes.
<b>Unrestricted Research Records</b>	Research records containing information that is not considered a security or disclosure risk.
<b>Protected Research Records</b>	Records in this category are considered private and their disclosure would be considered inappropriate and contravene acceptable norms. The level of harm to the subjects of research or the institution,

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	however, would be low.
<b>Confidential Research Records</b>	Records in this category are considered potentially harmful to the subjects of research or could threaten the institution's competitive advantage, damage partnerships, relationships and reputation. A breach of confidential records would cause serious harm.
<b>Restricted Research Records</b>	Records that if released could cause catastrophic harm to the subjects of research, society or the host institution.

## **FORMS**

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Forms are optional. If not in use, do not delete "FORMS" heading. Delete this row and change above message to read "There are no forms for this Procedure." Do not delete back-to-top hyperlink.

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List links in alphabetical order, indicating title of link and destination, as in the following examples:

**SUMMARY OF DUE DILIGENCE**  
Proposed Revisions to UAPPOL Research Policy

<b>Stakeholder (name of group/committee/unit/person consulted)</b>	<b>Brief description of activity and outcome</b>
Katharine Moore, Office of the Vice-President (Research)	Development Liaison
Research Records Working Group	<p>In response to an issue raised in the “IT Security - Protection of Research Participants’ Data” audit carried out by IAS, Associate Vice-President (Research) Richard Fedorak created a working group in November 2011 comprised of representatives from Vice-Provost (Information Technology) Office, Research Ethics Office, Libraries, Information and Privacy Office, Northern Alberta Clinical Trials and Research Centre, Office of the Vice-President (Research); the Chief Information Officer from the Faculty of Medicine and Dentistry was also a member of the Working Group.</p> <p>The Working Group met nine times over the next 15 months, primarily working on drafting several new Procedures related to research records, consulting with outside bodies (Alberta Health, Alberta Health Services, University of Saskatchewan, University of British Columbia, University of Toronto) about policies and procedures they currently have in place about this topic. The Working Group concluded that revisions to the UAPPOL Research Policy were needed, namely adding a specific reference to research records, in order to proceed with consultation on the new draft Procedures.</p>
External and Internal Stakeholders Meeting	On 20 June 2012, representatives from AHS Information and Privacy, AHS Records Management, the Health Information Act Policy Unit of Alberta Health, the Office of the Information and Privacy Commissioner, University of Alberta Museums and Collections Services, and the University’s Centre for Health Evidence met with the Working Group to review the proposed Research Policy revisions and draft Procedures. This group of stakeholders provided context for work on this topic being carried out in other jurisdictions, and offered a number of comments on all the documents which were incorporated in subsequent drafts.
University Research Policy Committee (URPC)	URPC is primarily composed of the Associate Deans (Research) from all Faculties. At its meeting on 28 September 2012, URPC reviewed the proposed changes to the Research Policy, and offered comments and suggestions on the draft Procedures. URPC indicated its support for the documents.
Associate Vice-President (Research)	Following the discussion at the Working Group meeting on 16 January 2013, Richard Fedorak concluded that the proposed changes to the Research Policy and the new draft Procedures relating to research records were ready for wider consultation in the University prior to seeking formal approval of the documents
Internal Audit Services (IAS)	An update on progress related to the 2011 audit recommendations was provided to IAS on 21 January 2013
Manager, Policy Standards Office, Office of Risk Management	Katharine Moore met with Gwen Bauer on 6 February to review the documents and determine the appropriate route forward. Ms Bauer’s advice was to seek approval for the proposed revisions to the Research Policy as soon as possible, thereby providing the “parent” policy for the new Procedures. Once the revisions to the Research Policy are approved, consultation can begin on the draft Procedures.
Governance Office	In 2004, both the Board Educational Affairs Committee (through delegated authority from the Board of Governors) and the GFC Executive Committee (through delegated authority from General Faculties Council) approved the Research Policy. On the advice of the Governance Office on 12 February, the Board Learning and Discovery Committee (BLDC) will be the sole approver of the revised Research Policy.
AASUA	Ms Bauer provided copies of the proposed revisions to the Research Policy and drafts of the new Procedures to the AASUA on 8 February 2013 for comment
Deans’ Council	Members of Deans’ Council were sent background information, the proposed revisions to the Research Policy, and the draft Procedures on 13 February, and they were invited to provide feedback to the Office of the Vice-President (Research)



President's Advisory Council of Chairs (PACC)	PACC members discussed the proposed revisions to the Research Policy and the draft Procedures at their meeting on 19 February
General Faculties Council Executive Committee (GFC Executive)	GFC Executive will review the revisions to the Research Policy at its meeting on 4 March and will be asked to make a recommendation to the Board Learning and Discovery Committee (BLDC)
Board Learning and Development Committee (BLDC)	<p>Under delegated authority from the Board of Governors, BLDC is empowered to approve the proposed revisions to the UAPPOL Research Policy. BLDC will discuss the revisions at its meeting on 25 February, but not vote. GFC Executive will be asked to review the revisions at its meeting on 4 March and make a recommendation to BLDC. BLDC will then hold an electronic vote on the approval of the revisions. The revised Research Policy would take effect immediately following the BLDC vote.</p> <p>The draft Procedures are provided to BLDC members <u>as background information only</u>. Once the revised Research Policy is approved, consultation on and formal approval of the draft Procedures by the relevant Vice-Presidents will proceed.</p>