Performance Report
Public Health Funding & Accountability Agreement

Board of Health:	Ottawa Public Health
Report Date:	2 February, 2016
Indicator:	Indicator 4.2: % of the influenza vaccine stored/administered by the PHU for the 2015/16flu season.

Instructions

This report template should be used when the Ministry of Health and Long-Term Care (the "ministry") has identified a Performance Variance* and requests a Performance Report (see section 5.5 of the Public Health Funding & Accountability Agreement (PHFAA)).

Please enter information in the all boxes below. Please submit one report per Performance Variance. Please send the completed report to PHUIndicators@ontario.ca. If you have any questions about completing this report, please send an email to PHUIndicators@ontario.ca.

*Performance Variance as defined in section 1.2 (Definitions) of the PHFAA means the inability to achieve a Performance Target as set out in Schedule "D", as identified by the Province.

In the following boxes, please provide the details requested about the issue(s) contributing to the Performance Variance:

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A. Cause

Provide a brief explanation of the cause of the issue:

- *What factors or events prevented achievement of the Performance Target?*

There was a performance variance on the PHFAA influenza vaccine wastage target for the 2015/16 influenza season which is set by the MOHLTC at 0.3%. The overall wastage of influenza vaccine for this reporting period was 1.0% (95/9600 doses). 0.2% wastage was caused by damages and expired doses, contaminated needles and unused within 30 minutes of vaccine preparation at community clinics. The additional wastage resulted from a cold chain incident at one clinic (54 doses) and not returning unused vaccine (18 doses) from a satellite clinic.

Context:
Cold Chain incident
An important component of the influenza program is to ensure that vaccines are available for all people who need them. A media promotional event at one of OPH's final public vaccination clinics presented an opportunity to immunize more residents than originally expected. The public turnout was indeed larger than normal and required that additional vaccine be delivered to the clinic. The uptake of the additional vaccine was modest and unused vaccine vials were repackaged with ice and returned to the OPH Vaccine Centre and placed into the freezer instead of the vaccine refrigerator.

The following causes have been identified as leading to the occurrence of the influenza vaccine wastage incident on November 16, 2015:

Root Causes
1. Clinic volume- due to the media event there was an unexpected volume of clients and thus required an additional vaccine delivery. An overestimate of supply resulted in a large amount of multi-dose vials to be returned at the end of the clinic.

2. The wrapped package containing the multi-dose vaccine vials was not labelled with the handling and/or storage instructions

Underlying Factors
1.1. Established protocols: The Cold Chain Maintenance for School and Flu Immunization Clinics procedure (the vaccine handling procedure hereafter) did not clearly include and/or articulate a procedure on how to handle incomplete multi-dose vaccine vials. It does cover the handling of single-dose vials.
1.2. Staff reminders: Clear accountabilities of roles and responsiblities of clinic staff including the packing and return of vaccines was communicated at the begining of the new flu season and was covered during the annual

A. Cause

orientation/training for clinic supervisors, but reminders were not sent during the flu season.
1.3. Product handling and labelling. The vaccine handling procedure did not specify the requirement to label the package(s) containing incomplete vaccine vials prior to transportation.

Returning unused vaccine incident
To increase access, influenza vaccine was provided to the OPH Sexual Health Clinic for their clients who wished to be immunized. Subsequently, in consultation with Ministry staff OPH decided to retain doses for what appeared to be a longer influenza season. Inadvertently 18 doses from the sateliite office were not returned to the government pharmacy prior to expiration and were wasted.

B. Impact

Provide a brief explanation of the impact or anticipated impact of not achieving the performance target:

- *How has the issue(s) affected program or service delivery?*

These two incidents did not affect patient care but did impact meeting the PHFAA influenza vaccine wastage target for the 2015/16 influenza season. The overall influenza wastage was 1.0%.

C. Plans for Resolution to Address the Performance Variance

Provide a brief explanation of the board of health's plans to improve performance:

- *What steps has the board of health **taken** or **is taking** to address the issue(s) that have led to the performance variance?*
- *Please describe any process changes, organizational changes, planning changes, and/or monitoring changes that the board of health is **planning** to implement to resolve the issue(s).*
- *Please outline the expected completion dates of the steps the board of health is taking to improve performance.*
- *What is the expected date that all steps will be completed?*
- *Please describe the monitoring schedule to ensure that planned changes are having the intended results.*

The following action items have been implemented by the VPD staff and will be subject to ongoing quality assurance by the VPD program manager/ designate:

Cold chain incident
Clinic procedures:

- The vaccine handling procedure will be revised to include the specific handling and storing of incomplete multi-dose vaccine vials.
- The revised vaccine handling procedure will be communicated to all VPD staff now (February 2016), at the annual orientation before the next flu season and reminders will be sent during flu season.
- A refreshed checklist for the clinic lead which includes specific double checks on returned vaccine vials (new and used) will be implemented.

Vaccine staff will be required to take an orientation program that includes the specific handling of incomplete multi-dose vaccine vials and demonstration of the handling of incomplete multi dose vials, for supervisors and clinic leads, and will be delivered in the 2-4 weeks preceding the first immunization clinic each year (September 2016)

Enhance package labelling

- The VPD team will prepare pre-printed courier instructions and labels for affixing to each paper bag and any packages being collected by the couriers. (February 2016)
- The VPD team will require all staff to use the instructions and labels for all vaccine packages leaving or returning to OPH (February 2016)

Ensuring courier awareness

- In addition to orientation of all courier staff, an additional mandatory summer refresher session will be required. (September 2016)
- Monitoring compliance to the vaccine handling procedure will continue to be exercised on an ongoing basis (ongoing)

D. Plans for Resolution to Address Impacts of the Performance Variance

Provide a brief explanation of the board of health's plans to address the impacts of the performance variance:

- *What steps has the board of health **taken** or **is taking** to address the impacts of the performance variance?*
- *Please describe any process changes, organizational changes, planning changes, and/or monitoring changes that the board of health is **planning** to implement to resolve the issue(s).*
- *Please outline the expected completion dates of the steps the board of health is taking to resolve the issue(s).*
- *What is the expected date that all steps will be completed?*
- *Please describe the monitoring schedule to ensure that planned changes are having the intended results.*

As the amount of influenza vaccine wasted in this single incident exceeded the annual target set by MOHLTC, and considering the fact that this incident took place at the last vaccination clinic this season, no further actions can be done to address the impact of missing this annual target. By implementing OPH's planned actions to address the performance variance, OPH shall be able to avoid missing the annual target in the future.

Returning unused vaccine incident
In the future the Vaccine Preventable Diseases team will track lot expiry dates for doses provided to the Sexual Health Clinic and will proactively confirm if they were used in advance of the expiry date allowing sufficient time for return of unused doses to the provincial pharmacy.

Ministry Support

Please identify any provincial level supports which you feel would help the board of health to resolve the issue(s) or improve performance.

Please note that the purpose of this section is not to identify the need for additional funding. Funding approval is based on the annual Program-Based Grants approval process.

No additional provincial-level support is needed to resolve this issue

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Contact Information for Ministry Follow-Up

Please provide contact information for someone that the ministry can follow-up with for any questions about the Performance Report.

Contact:

Name: Marie-Claude Turcotte

Title: Program Manager, Vaccine Preventable Disease Programs

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The Medical Officer of Health is required to review and approve the completed Performance Report.

Approved by (Name): Dr. Isra Levy

Signature:
Medical Officer of Health

Date (dd/mm/yyyy): 8 April 2016