COMMUNITY LIVING
Kingston and District

Inspiring Possibilities

Quality Improvement Report 2019

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Community Living Kingston and District is a CARF-accredited organization

Overview of Quality Improvement Process

Community Living Kingston and District is committed to having a performance measurement and management process. The organization commonly describes this as its Quality Improvement process.

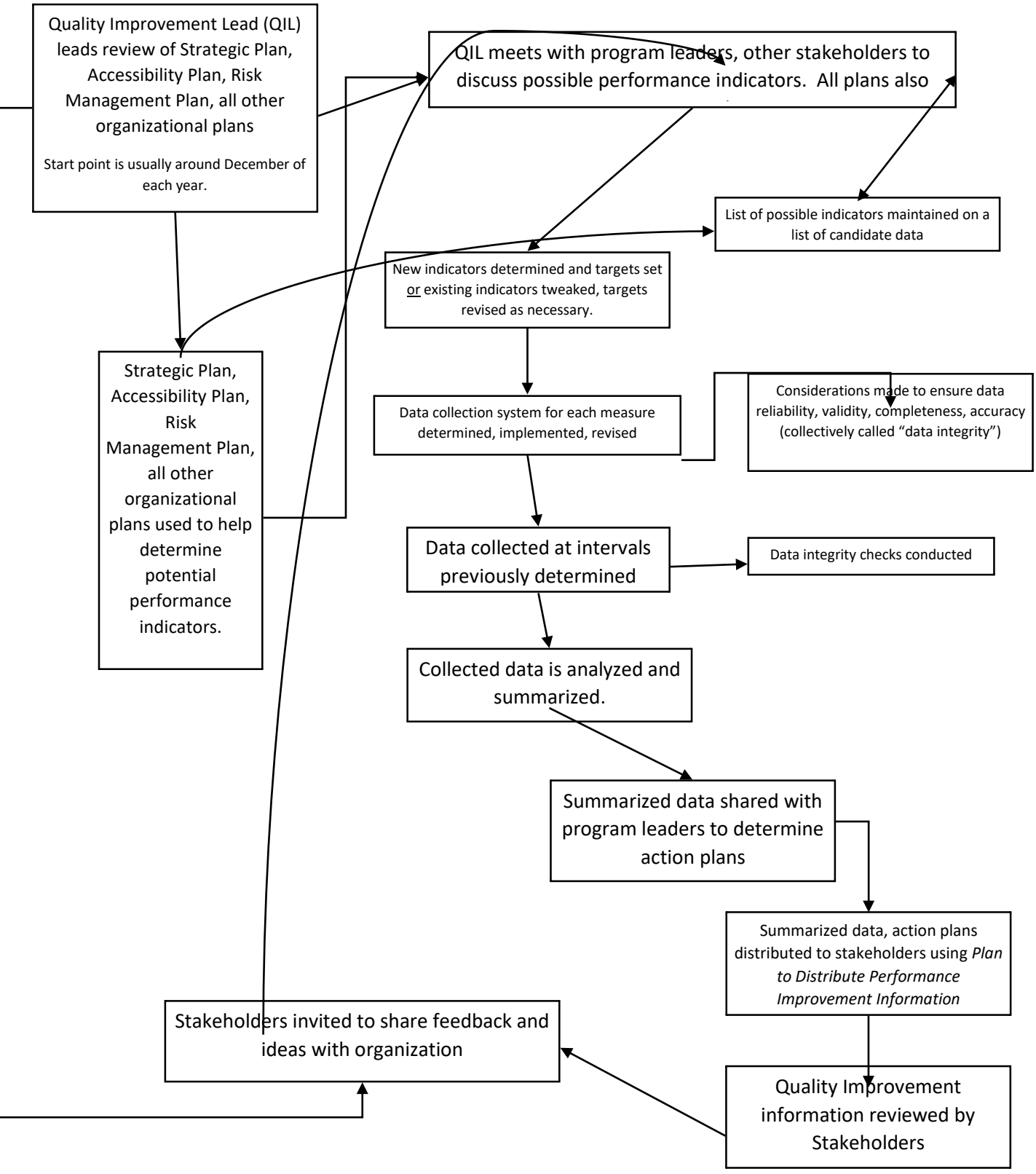
The mission of Community Living Kingston and District is to ensure that people with intellectual disabilities have every opportunity to participate fully in our community with dignity and independence.

The mission of the Quality Improvement process is to ensure that the organization's mission is being achieved, through clear and accountable processes and objectives.

Program(s) involved in Quality Improvement Process (all seek CARF accreditation)	Objectives of Program	Personnel Responsibilities Related to Process
Residential Services	Provide group living supports to individuals in a way that ensures that all needs are met, including opportunities to access community activities of their choosing.	<u>For all programs:</u> Quality Improvement Lead sets out framework for data collection, analyzes data, etc. Assists with determination of performance measures. Ensures that organizational plans are developed with input of persons served and staff. Program Manager and Coordinators responsible for ensuring that data is collected and turned in and oversee completion of any action plans. Program staff collect data and implement action plans. Additional/supplemental responsibilities noted on QI flow chart that follows.
Community Inclusion Programs	To promote community inclusion and allow persons served the opportunity to participate in volunteer, recreational, and educational opportunities of their choosing.	
Community Services (includes Supported Independent Living, Enhanced SIL and Gananoque)	Support people to live as independently as possible while ensuring opportunities to participate in community activities of their choosing.	
Respite Services	Provide families or caregivers a break from regular responsibilities in a manner that ensures that their loved ones receive stable, effective support.	
Family Support	Provide support to families providing support to loved ones with a disability. Support includes navigating the system and promoting access to services and resources.	
Family Home	Facilitate a stable, long-lasting relationship between individuals and 'homeshare' families that provide support to them.	
Child Care Resource Consultant Services	Support the full inclusion of children that face challenges aged 0-12 in licensed child care programs.	
Employment Services (includes Kwik Shred)	Promote work opportunities for persons served.	

Overview of Quality Improvement Process

The following flow chart outlines Community Living Kingston and District's Quality Improvement process.



Strategic Planning Implementation Teams
Updated December 2018

The following is an update to the Strategic Plan developed in 2014. This Plan can be found in the 2017 Quality Improvement Report. This update provides information and detail on the progress made to implement the primary goals of the strategic plan. The plan itself will be renewed in the fall of 2019.

Board Investment
The following motion was passed by the board of directors at its meeting of January 23, 2017:

MOVED by Linda Lam SECOND by Karen Cornish **that the Board of Directors authorize the use of up to $110,000 from Board Reserves to support the projects as outlined in the four proposals.**

Projects:

- Innovative Housing Committee - $35,000 + benefits for a part time position
- Social Enterprise - $45,000 for 6-month contract + $5,000 for website
- Talent Management and Succession Planning – "Leaders in Professional Practice." $10,000 over 2 years
- Community Inclusion – two, 2-minute videos about participants, $6,000

Social Enterprise Committee Update
Based on previous recommendations from the committee, Kwik Shred has implemented many changes this past year, including:

1. Increased our paper shredding prices and a minimum charge to community customers.
2. Participated in Queen's University procurement tradeshow which resulted in more shredding contracts.
3. All workers at Kwik Shred have partial uniforms (hats/polo shirts).
4. Workers completed all Health & Safety and MCSS compliance policy reviews (much of this information had to be modified so that people could understand i.e. – pictures, symbols and simple language).
5. Many safety measures were implemented at the Kwik Shred site – clean air ventilation system, professional industrial cleaning completed, safety signs posted, lock out measures installed, equipment maintenance training and maintenance routines put in place, supervisor training for all CLKD employees (working in an industrial environment), etc.
6. Additional warehouse space was rented to allow for safe storage of the shredded paper.
7. The metal sales continue to provide a financial asset to Kwik Shred, the first tractor trailer load of baled paper went to Strathcona Paper and we anxiously await their response regarding future shipments and revenue.
8. Nine people with intellectual disabilities who are working at Kwik Shred now earn minimum wage.

The Co-op owners have received People First training in regards to their responsibility as cooperative owners. All cooperatives have updated their bylaws, consulted and received ongoing legal and accounting advice.

All 43 people working at the Cooperatives and Kwik Shred will be offered to participate in the Personal Planning Process through the resources from MCSS- EMF grant.

Work from the Service Ontario contract continues to be bountiful however the future of this contract remains a concern as Kwik Shred needs to replace major equipment and secure lease of building/s etc.

The Board of Directors funding for a marketing position will be mobilized early in 2019.

CLKD also hopes to pursue a couple of social enterprises in 2019 – catering business from our Days Road location; possible renovation to one of our properties to allow for meeting rooms/conferences etc.; and another partnership at Queen's University – all of these businesses will be structured to allow meaningful employment opportunities for persons served.

Employment Services is hoping to build its capacity by providing employment supports to people purchasing service with Passport funding.

Innovative and Affordable Housing Update
This planning group meets regularly with the main focus being to re-group and determine next steps based on the changes within our organization. Colleen Kelly-Jansen had assumed the lead for the working group since the outcomes envisioned closely aligned with her work with SIL and Enhanced supports in the agency. Now that Colleen has changed her role, she will no longer act as the lead. Our newest manager, Rob Yeo, now fulfills this role. Rob has a wealth of experience including extensive work in mental health and with the City of Kingston on homelessness initiatives.

At this point, the committee has moved forward with the Community Development Housing Outreach Worker position (Sherry Jarvis). Sherry is working with CLKD employees and other community partners such as the Housing Outreach Coordinator for the DSO to explore innovative housing options for persons served. This will include securing funds for housing development projects, particularly as a collaborative venture.

The committee has also started to review the Housing Series with the Empowering Possibilities Podcasts https://empoweringability.podbean.com/ and will be connecting with Janet Klees, an Executive Director from the Durham Region around some of the work they are doing in that area.

Talent Management and Succession Planning Update
In 2017, CLKD experienced several changes to management positions with multiple positions being filled via promotion, a clear illustration of the value of talent management that identifies and prepares employees for taking on positions of greater responsibility.

Additionally, the organization continues to direct efforts toward developing staff members to be “Leaders in Professional Practice.” Examples of that include the identification of staff taking on ‘lead roles’ around Q-Straint/vehicle safety training and Sexuality and Abuse Awareness, as well as committees with lead staff around Person Centred Planning and Peer Mentoring and Support. The organization is still looking into options to develop an internal Mental Health First Aid trainer.

Community Inclusion Two Minute Video
There are two short videos that were completed in 2017 that illustrate the lives and celebrate the accomplishments of individuals supported in the Options program. Both are professionally done and will be used for promotional and public awareness purposes.

Risk Management Plan- 2019

Introduction

Community Living Kingston and District developed its first formal Risk Management Plan in 2007. This plan was developed in recognition of the fact that risk is inherent in providing supports for persons served in the community. This plan was reviewed and revised in November 2018. It will be reviewed again no later than December 2019.

Purpose

Risk Management involves activities that deal with uncertainty and potentially harmful future events. The purpose of this Risk Management Plan is to:

- Identify and minimize risk to Community Living Kingston and District, the individuals served by the agency, and the agency's staff and volunteers.
- Address risk and increase awareness about identifying risk and how to minimize it.
- Assist in preventing harmful events
- Protect the individuals supported by the agency
- Protect the agency's profile and assets
- Ensure the continuity of service provided by the agency.
- Utilize a practical and common sense approach that considers the needs of the individuals being supported first and foremost.

This Risk Management Plan coexists with the agency's policy on Risk Management (Policy # FN 1.08) and there may be significant overlap between the two.

Community Living Kingston and District's Approach to Risk

Risk exists in the day-to-day operations of Community Living Kingston and District. This risk is minimized somewhat by the agency's cooperation with monitoring bodies such as the Workplace Safety and Insurance Board and the Public Services Health and Safety Association, the Social Inclusion Act of Ontario, as well as by compliance with CARF Accreditation Standards and the province's Quality Assurance Measures. The organization also seeks to develop partnerships with other community organizations wherever possible. Internally, a Management team led by the Executive Director, who reports directly to the Board of Directors, manages and monitors the organization.

Where necessary and appropriate, individual risk assessments are completed in an effort to determine the level of risk faced by the individuals, staff members and the organization as a whole and the safeguards necessary to mitigate these risks. An example of this is with the individual bathing protocols for those assisted by staff members with their bathing routines. All individual bathing protocols will include a risk assessment.

The Risk Management plan is developed and reviewed by the Management team, who are similarly responsible for its implementation.

General Strategies Used to Address Risk

On an everyday basis, the agency minimizes risk by using training, policies and procedures, equipment and tools, and supervision. In addition, the following techniques are used to manage risk:

Avoidance: Discontinuing an activity or not offering a service.
Modification: Implementing activities to reduce the level of risk to an acceptable level (e.g., implementing policies and procedures)
Retention: Accepting all or part of the risk and preparing for potential consequences by accepting deductible costs or self-insuring

Sharing: Purchasing insurance, sharing responsibility with another organization or contracting the service to another business.

Specific Strategies Used to Address Risk

People

Area of Risk	Persons Served and Families
Type of Potential Risk	Injuries and Accidents
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Policies and Procedures are followed and regularly reviewed with staff · Staff receive orientation and training in a number of areas, including safety and prevention (e.g., CPI, First Aid/CPR, WHMIS 2015, Q-Straint are mandatory. ASIST and Mental Health First Aid have been added as requested) · Injuries and accidents are reported and reviewed to identify any trends · Specific interventions are noted in individual plans and Positive Behaviour Support Plans are developed as needed. PBSPs are monitored by an assigned Behaviour Therapist and psychologist · Individual risk assessments are developed as needed · Policies and procedures related to client handling require mechanical lifts to be used wherever possible · External and internal Health and Safety Inspections · Bathing protocols developed in Residential Services · Policy related to client bathing · Emergency signage in vehicles, and safety inspections required before vehicle use · Fire safety training with all teams · Controlled acts training by nurse in place · Trend analysis completed related to slips, trips, and falls. - Joint Health and Safety Committee completion of site inspections at least annually
Results of Actions Used to Manage Risk	· There was one significant injury to a persons served, who fell off of an elevated vehicle lift (see updated training strategy, below).
New Strategies to be Adopted This Year	· All staff will be required to complete Slips, Trips and Falls training through Surge. - Given the complexity of some persons served in Community Services, specifically around drug use and overdose potential, naloxone training should be looked into for staff (this was listed last year, but not completed). - Updated training to be developed around Q-Straint and use of van lifts. Training will be standardized and more trainers brought on board. All existing staff to receive retraining. Transportation protocols to be developed for all persons served. - Joint Staff Education Committee has approved 30 staff to attend Mental Health First Aid training in early 2019. - To ensure better internal inspections, certified worker reps from the JHSC will commence monthly inspections.

Area of Risk	Persons Served and Families
Type of Potential Risk	Missing Persons
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	High

Current Strategies Used Manage Risk	· Specific protocols/interventions developed as needed · Missing persons protocol/search kit at CIP · Policy related to client distress (Operations 4.05) · Manager On-Call system available to assist in these circumstances · Serious Occurrence reports filed with MCSS · Annual staff review of emergency procedures
Results of Actions Used to Manage Risk	There were no reports of missing persons this year.
New Strategies to be Adopted This Year	- All staff to review client distress policy in Surge in 2019.

Area of Risk	Persons Served and Families
Type of Potential Risk	Violence and Trauma
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Staff trained to assess safety and potential crisis (CPI) · Code of conduct used to reinforce acceptable behaviour at CIP · Abuse education for all persons served, and staff review abuse policies annually · CPI trainers available to do team-specific Applied Physical Training for teams that face significant behaviour challenges.
Results of Actions to Manage Risk	There were two minor injuries related to violence on the part of a person served this year.
New Strategies to be Adopted This Year	CPI training has been revamped by the parent agency. All staff receiving full re-training when certification lapses, rather than shorter refresher training.

Area of Risk	Persons Served and Families
Type of Potential Risk	Violation of Private or Confidential Information
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Policies OP 1.01 and 3.04 address confidentiality of information · Nucleus Labs system is password protected so that users have access on a need-to-know basis. HR Policy 1.19 addresses the use of electronic records system. · Nucleus system is monitored for possible security breaches, and all data is backed up. · Contract with Service First for security of networked documents in place. - Training around confidentiality put in place via Surge Learning Management System. All staff required to complete in 2018/19. - Privacy and Confidentiality training completed at all new staff orientation sessions
Results of Actions to Manage Risk	There were no major issues related to violation of confidential information.
New Strategies to be Adopted This Year	-Policy related to use of personal devices to access agency information to be developed (held over from last year). -Procedure to be developed to ensure that temporary download folders are cleared on all computers on a regular basis (held over from last year). -Paper files of persons served to be digitized and uploaded to Nucleus.

Area of Risk	Persons Served
Type of Potential Risk	Abuse and Neglect
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	· Policy OP 2.05 addresses abuse and neglect · Board Policy 16 addresses rights and how to make a complaint · Employees and volunteers are screened and supervised · Mistreatment, abuse, and neglect is reported to appropriate authorities · Reports of all abuse/neglect filed with MCSS · All staff and volunteers required to complete annual training on abuse prevention and reporting · All persons served receive annual education on abuse prevention. Specialized classes can be facilitated by Cathy Lawrence and Catharine Gibson. - Abuse education training provided to all new staff at New Staff Orientation sessions early in employment
Results of Actions to Manage Risk	· There were no major issues related to abuse/neglect this year..
New Strategies to be Adopted This Year	- Online training for staff to be implemented into new Surge Learning management system

Area of Risk	Employees
Type of Potential Risk	Injuries and accidents
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Joint Health and Safety Committee of Management and Union representatives · Policies HR 3.01 to 3.15 address employee safety. Includes policies related to lifting, slips, trips and falls, and client handling · Orientation and training for staff includes safety (CPI, WHMIS 2015) · Major injuries and accidents are reported and reviewed for trends with recommendations made to employer by Joint Health and Safety Committee · WSIB coverage, health benefits · External and internal health and safety inspections · Ministry of Labour inspections · All staff annually review policy on workplace violence prevention, as well as general health and safety refreshers · Emergency signage in vehicles; safety checklist to be completed before each use of a vehicle · Ladder safety training completed with teams as needed. · Orientation at CIP includes tips on how to avoid banging head in accessible vehicles · Bump caps required for use by staff when utilizing accessible vehicles. - MSD prevention and safe driving videos reviewed by new staff as part of new staff orientation. - Cell phones provided to Residential staff for emergency use if in community.
Results of Actions Used to	· Bump caps were instituted in 2016 as a direct result of another concussion related to use of accessible vehicles. There were no reported injuries of this sort in 2018.

Manage Risk	- There were two lost-time injuries in the organization this year, one due to a staff who injured themselves assisting a person served with a transfer. The other was related to a staff member tripping over a floor drain.
New Strategies to be Adopted This Year	- More thorough driver education on accessible vans to be developed in 2018-19 and introduced to all new staff as well as existing staff that request it. - All staff to be required to do further training around MSD prevention in Surge. - Footwear requirements put in place in January 2019 to reduce risk of Slips, Trips and Falls. - Safety training implemented as required training in Surge for all staff in 2019.

Area of Risk	Employees
Type of Potential Risk	Illness or mental health
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Low
Current Strategies Used Manage Risk	· Flu shot clinic held annually · All employees have sick time for use when ill · Fit testing (respirators) for all employees · Policies related to infection control and pandemic preparedness - Joint Wellness at Work Committee
Results of Actions Used to Manage Risk	· There were no illness issues of significance this year.
New Strategies to be Adopted This Year	- Internal Mental Health First Aid training to be explored (with internal trainers) - Peer Support and Peer Mentoring teams to be fully operationalized

Area of Risk	Employees
Type of Potential Risk	Communicable Diseases
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Low
Current Strategies Used Manage Risk	· Employees requested to disclose any contagious disease · Agency will pay for required immunizations as applicable to employee's work situation · Policies HR 3.09 and 3.10 address disease and infection control. Policy HR 3.14 addresses respiratory protection program · Employees informed of persons served that may have communicable diseases · Flu shot clinic held annually -Respiratory protection program. Team of Fit testers (for respiratory protection) expanded. All staff to be re-fitted in 2018 and 2019. - Training around communicable diseases put in place in Surge.
Results of Actions Used to Manage Risk	· There were no issues related to communicable diseases this year.
New Strategies to be Adopted This Year	External health and safety audit through PSHSA completed November 2018 with report and recommendations/suggestions to be reviewed and implemented as warranted in early 2019

Area of Risk	Employees
Type of Potential Risk	Staff Turnover
Frequency (Likelihood)	High
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Competitive benefits · Staff recognition program · Formal monitoring of turnover by HR Director · Leadership Development Bursary Fund · Exit interview process · Human Resources section of policy manual designed to ensure a safe workplace · Participation in provincial HR strategy with OASIS and MCSS · Implementation of Core Competencies training. - Wellness at Work Committee to attempt to assist in advancing strategies that would assist to quell turnover - Hiring practice where staff are interviewed and screened in advance of actual hiring needs put in place in order to decrease issues related to lag time in hiring
Results of Actions Used to Manage Risk	· Staff turnover was much higher than usual this year.
New Strategies to be Adopted This Year	- Broad review of exit interview results. - Incentive program put in place for staff to refer potential new employees. - Explore further social media avenues for recruitment - Staff retention task force put in place in January 2019 to explore ways to better retain staff (see survey later in report).

Area of Risk	Employees
Type of Potential Risk	Employment Practices Violation
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· HR policy and procedures · Staff code of conduct and discipline policy · Employment Standards Act · Collective Agreement with CUPE 2635
Results of Actions Used to Manage Risk	· There were no employment standards violations this year.
New Strategies to be Adopted This Year	None formal.

Area of Risk	Employees
Type of Potential Risk	Workplace Violence, Harassment
Frequency (Likelihood)	Low

Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	· CPI Training · Positive Behaviour Support Plans · Manager on-call system for assistance · Additional staffing at homes with high needs · Annual staff review of policies related to workplace violence prevention and harassment (training completed in Surge) - Annual review of harassment policy by JHSC - Supervisor training around harassment, sexual harassment and workplace violence training last done in 2017. To be completed again on regular basis.
Results of Actions Used to Manage Risk	There were no harassment complaints put forth this year.
New Strategies to be Adopted This Year	- All supervisors to be re-trained (via Surge) around harassment policies and their expectations/roles. - All staff retrained on Harassment policies via Surge in 2019.

Area of Risk	Board of Directors
Type of Potential Risk	Criminal activity, fraud, theft, legal requirements, liability, board turnover
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Liability Insurance · Governance policies and procedures · Board member recruitment and screening, Board nominating committee · Policy FN 1.08 addresses many issues related to risk and fraud
Results of Actions Used to Manage Risk	· There were no concerns related to Board conduct this year.
New Strategies to be Adopted This Year	As noted in external health and safety audit, review of legal obligation with Board where health and safety obligations are concerned to be considered.

Area of Risk	Community
Type of Potential Risk	Complaints
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Complaints procedure · Proactive communication and input · Complaints may be directed to Executive Director with expectation of open dialogue
Results of Actions Used to Manage Risk	· Complaints were minimal this year (see summary of complaints in this report).
New Strategies to be Adopted This Year	None

Property and Assets

Area of Risk	Buildings
Type of Potential Risk	Damage
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Low
Current Strategies Used Manage Risk	· Insurance and deductibles · Adherence to all provincial fire and building code regulations · Policy FN 1.08 addresses many of these issues
Results of Actions Used to Manage Risk	· Damage to buildings was not a significant concern this year.
New Strategies to be Adopted This Year	None

Area of Risk	Vehicles
Type of Potential Risk	Damage, accidents, theft
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Insurance and deductibles · Policies HR 1.10 and FN 1.08 address many issues · Completion of safety checks prior to each use. - 40 staff per year required to submit updated driver's abstracts - Staff required to self-disclose driving infractions exceeding 3 demerit points
Results of Actions Used to Manage Risk	· While there were accidents with damage to vehicles this year, these were easily managed within our insurance policies.
New Strategies to be Adopted This Year	- Transportation Committee, chaired by Janet Barry, put in place in 2018 to review transportation practices within the agency. Report issued by committee in early 2019, which included a wide variety of recommendations around safety practices and driver training. Recommendations to be implemented by agency in 2019-20.

Area of Risk	Furnishings, Supplies, Equipment
Type of Potential Risk	Damage, theft
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Low
Current Strategies Used Manage Risk	· Insurance and deductibles · Policy OP 1.03 addresses client home and property issues · Policy FN 1.08 addresses many issues related to risk management
Results of Actions Used to Manage Risk	· There were no significant issues related to damage or theft this year.

New Strategies to be Adopted This Year	None

Area of Risk	Technology
Type of Potential Risk	Security information management, privacy and confidentiality, theft, damage
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	□□Office sites are monitored or alarmed at all times - Technology Plan addresses information security - Insurance - Monitoring of information by Nucleus Labs and by Service First - Cybersecurity training in Surge
Results of Actions Used to Manage Risk	· There were no significant issues in this area this year.
New Strategies to be Adopted This Year	None formal.

Financial

Area of Risk	Financial Practice
Type of Potential Risk	Fraud, legal requirements, investment losses
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	· Finance policies · Insurance · External audit completed annually · Experienced finance staff · Revenue Canada audits - Access to finance offices is limited to key parties through fob system
Results of Actions Used to Manage Risk	There were no reported concerns related to financial practices this year.
New Strategies to be Adopted This Year	None

Area of Risk	Financial Practice
Type of Potential Risk	Individualized/Direct Funding: A component of the rates charged for these arrangements is designed to cover overhead/administration/etc., which in reality ends up funding organization wide pressures as they arise. As this revenue grows there is risk that CLKD will begin to budget for this flexibility on an annual basis and there would be vulnerability should this revenue decrease in the future.
Frequency	Moderate

(Likelihood)	
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Billing for individualized funding is frequent, meaning that it is recovered quickly. · Intricate reporting systems between the programs offering service and the finance department are in place, assuring up-to-date information on budget needs and incoming funds.
Results of Actions Used to Manage Risk	There were no issues related to this area this year, but vigilance is required.
New Strategies to be Adopted This Year	None

Organization

Area of Risk	Reputation and Profile
Type of Potential Risk	Negative media coverage, loss of credibility
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Avoid activities that threaten the organization's profile or may cause a negative impact on its reputation · Membership in provincial organizations (Community Living Ontario, etc.) · Adherence to goal and vision statement · Policies related to social media use and media relations
Results of Actions Used to Manage Risk	There were no significant issues related to reputation and profile this year..
New Strategies to be Adopted This Year	None

Area of Risk	Service Capacity
Type of Potential Risk	Ability to serve populations that increasingly include issues with homelessness, legal issues, high vulnerability, addictions
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	· Increased scrutiny over who is accepted into services, based on these needs · Some training available to staff as opportunity arises. - Increased requests for clinical supports
Results of Actions Used to Manage Risk	· While concerns around serving these populations continue, we were able to manage them this year.
New Strategies to be Adopted This Year	None formal.

Area of Risk	Governance
Type of Potential Risk	Low membership
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	Low
Current Strategies Used Manage Risk	The Board moved to a 'closed membership' structure this year after extensive consultation.
Results of Actions Used to Manage Risk	This new structure was adopted in 2017.
New Strategies to be Adopted This Year	None.

Area of Risk	Financial Practice, Legal
Type of Potential Risk	There are inherent risks involved in administering private funds for families, as CLKD could be deemed to be the employer, even though families are hiring workers privately.
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	CLKD discontinued this practice in April 2018 except for a small number of arrangements that are funded through base budget dollars as well as temporary/emergency funding approvals. Risk is mitigated for those arrangements that remain through signed contracts with families that clearly define the roles and responsibilities of each party and an explicit understanding that CLKD will only issue payments directly to families on a reimbursement basis. CLKD has also worked to educate individuals and families about the legal responsibilities that are associated with hiring workers and administering private funds.

Inclusion of risk reduction into performance improvement activities

Where possible, performance indicators will be developed to assist with risk reduction. Multiple business function measures were gleaned at least partially from a desire to manage identified risks.

Accessibility Plan 2018-19

Introduction

Community Living Kingston and District has completed formal Accessibility Plans on an annual basis since 2007.

Community Living Kingston and District's Accessibility Plan addresses accessibility issues at our program locations and in the community at large. Community Living Kingston and District is committed to identifying and removing barriers that reduce the ability of persons served to fully access both our programs and the community as a whole. Community Living Kingston and District's Accessibility Plan is designed to summarize the following:

● Those barriers that were removed or otherwise addressed by the agency in the past, specifically over the course of the past year.

● Those items that the organization still intends to address, as well as new items that have been brought to the agency's attention. Some of these items contain firm deadlines for completion, while others do not.

● Those items that were identified, but that the agency does not feel can be addressed at this time for one reason or another.

Identification of Barriers

In preparing this year's Accessibility Plan, Community Living Kingston and District utilized several methods in which to identify accessibility barriers:

● The organization's 2017 Accessibility Plan was used to identify items that were already considered to have been a concern.

● Individual persons served and personnel were consulted by the quality improvement lead and contributed to the identification of issues and potential ideas on how to rectify them.

● The organization's leadership routinely identifies maintenance and property issues throughout the agency. This information was used to identify property issues that negatively impact the accessibility needs of the persons served by the agency.

● The organization's leadership is brought up to speed on accessibility issues by personnel and by persons served on an ongoing basis. The issues anecdotally identified in this manner were also useful in the creation of this plan.

Standing Items of Concern

Throughout this plan, reference is made to 'standing items of concern'. These are items that tend to be fairly broad in nature, and it is unlikely that there is a single strategy that will eliminate the barrier. However, they are items of significant importance to CLKD, and it is imperative that they not be forgotten.

Review of Accessibility Plan

Progress around the plan will be completed regularly. A full review of the organization's Accessibility Plan will be completed at least annually. A member of the Management team will take the lead around updates of the Accessibility Plan.

Communication of Accessibility Plan

The accessibility plan will be posted on the agency website, and will be available to staff via Nucleus.

2018-19 Accessibility Plan

Area(s) of Concern	**Architectural**. An *architectural* barrier is any physical factor that makes accessibility difficult for an individual. This may include narrow doorways, bathrooms that might need to be made more accessible, alarms that are not able to be heard by individuals with hearing impairments, or even something as simple as the location of furniture.
Items Addressed In 2018	-The Options program moved to a new location in June 2018. This program had a number of physical accessibility barriers listed in past reports. - Deck at Aberfoyle was fixed to ensure accessibility and health and safety
Standing Items of Concern/Areas needing improvement	- Slow snow and ice removal can restrict access to and from program locations. The agency continues to utilize snow removal guidelines put in place in 2008, but CLKD must continue to be vigilant. - As the needs of persons served in Family Home arrangements change, CLKD must be prepared to offer assistance to meet accessibility needs. This often requires requests for funding from MCCSS.
Future Goals	**Barrier:** External egress in basement at McMichael is not completely accessible **Strategies to Remove Barrier:** Re-design required. **Potential Obstacles:** Cost, about $40,000 **Persons Responsible:** Mark Vass, Sherrill Boyes **Target Date:** Is targeted for between one and three years for completion **Barrier:** Back ramps at Mowat require rebuild for optimal accessibility **Strategies to Remove Barrier:** Rebuild required. **Potential Obstacles:** Costs, about $10,000 **Persons Responsible:** Mark Vass, Sherrill Boyes **Target Date:** Is targeted for between one and three years for completion **Barrier:** Washroom at Smithfield not optimally accessible—requires rebuild **Strategies to Remove Barrier:** Rebuild required. **Potential Obstacles:** Costs, about $8,000 **Persons Responsible:** Mark Vass, Sherrill Boyes **Target Date:** April 1, 2019 **Barrier:** Families are unaware of availability of elevator at Gardiners location **Strategies to Remove Barrier:** Place signage to indicate elevator locations **Potential Obstacles:** None. **Persons Responsible:** Erin Impola, **Target Date:** April 1, 2019

Area(s) of Concern	**Environmental.** An *environmental* barrier is a characteristic of a setting that compromises service delivery and benefits to be gained. This may include items such as flickering lighting, noise levels, and troublesome fragrances
Items Addressed In 2018	- Options took over new space in June of 2018 and main office moved in August 2018, which eased crowding, noise, etc.

Standing Items of Concern/Areas needing improvement	None
Future Goals	None

Area(s) of Concern	**Attitudinal**. An *attitudinal* barrier is a preconceived (usually negative) attitude that people have towards persons served. Examples of this may include attitudes of neighbours or other community members, or the lack of "person first" language used by agency personnel.
Items Addressed In 2018	None
Standing Items of Concern/Areas needing improvement	-Agency staff are not always mindful of the privacy of persons served, and do not always act sensitively towards them. This is addressed on an ongoing basis through annual training modules, and through the availability of two agency staff to provide specific training in this area. -- Negative attitudes of neighbours and community members can sometimes stigmatize persons served. This is addressed on an ongoing basis through follow-up where such concerns are expressed. Raising the profile of the agency and it's mission is also one way to combat this.
Future Goals	None.

Area(s) of Concern	**Financial**. A *financial* barrier is anything that may mean that a service is restricted because of a lack of sufficient financial resources. Financial barriers may exist at the organizational level, or may be specific to funds possessed by persons served.
Items Addressed In 2018	None in a widespread manner; many instances where issues have been addressed on a case-by-case basis.
Standing Items of Concern/Areas needing improvement	Funding and finances for persons served are not always sufficient, limiting community participation, quality of life, and the ability of families to maintain care. CLKD combats this by being active in provincial organizations that advocate for additional funding, and by petitioning MCSS on a situational basis for funds.
Future Goals	**Barrier:** No resources to expand respite services to meet need on wait list. Physical location where respite is typically provided also booked every weekend with no room to grow. **Strategies to Remove Barrier:** Explore ability to provide fee for service overnight respite **Potential Obstacles:** Time to look into. **Persons Responsible:** Erin Impola, Hailey Latimer **Target Date:** October 1, 2019

Area(s) of Concern	**Employment**. An *employment* barrier is an indication that a workplace does not provide sufficient flexibility or equipment to ensure a productive and satisfying workplace for employees. An employment barrier may also speak to measures that are in place to promote successful employment for persons with disabilities.
Items Addressed In 2018	- A number of positions (some short-term) added to Employment Supports division to address need for helping person served develop and maintain employment. -Plan established to redesign Kwik Shred in light of Bill 148 requirements to pay persons served minimum wage. As of January 2019, all person served working at Kwik Shred receive minimum wage.
Standing Items of Concern/Areas needing improvement	Long-term staffing in employment supports division is not secured, as most positions are grant-based.
Future Goals	**Barrier:** No funding for Direct Support Professional positions in Employment Services past March 2019 **Strategies to Remove Barrier:** See if unused grant funds from 2018 can be transferred to 2019 **Potential Obstacles:** None. **Persons Responsible:** Matt Luck, Colleen Kelly-Jansen

Area(s) of Concern	**Communication.** A *communication* barrier looks at anything that inhibits information being accessible and understandable to all. Examples may include the possible absence of devices available to persons served or personnel to be able to be understood by others, or promotional materials that are not present in formats that are easily understandable.
Items Addressed In 2018	Hiring of a French-language Resource Consultant in CCRCS.
Standing Items of Concern/Areas needing improvement	- Program information is available only in print and assumes a relatively high level of literacy. The organization attempts to combat this via plain-language versions of many documents (rights, complaints procedure). A concerted effort to develop pictorial versions of personal plans has been underway for several years. The organization desires to develop video versions of many documents. - Ongoing need for ASL training for staff throughout agency, especially at CIP. This is addressed by offering/requiring training upgrades as classes become available in community.
Future Goals	**Barrier:** Increase in number of referrals to CCRCS who do not speak English or French. **Strategies to Remove Barrier:** Develop list of possible volunteer interpreters in other languages **Potential Obstacles:** Time to develop.. **Persons Responsible:** Erin Impola, Maria Victoria **Target Date:** October 1, 2019

Area(s) of Concern	**Transportation.** A *transportation* barrier speaks to situations in which service recipients are unable to reach or participate fully in services because of the lack of suitable and available transportation
Items Addressed In 2018	None
Standing Items of Concern/Areas needing improvement	Local accessible bus system has limited availability for bookings for persons served. This is primarily being addressed through a good relationship with the service and distributing information to persons served that promotes good booking habits that allows for maximum service flexibility. The number of agency vehicles, especially accessible ones, can be seen as limited, sometimes limiting community involvement activities of persons served. The organization has a vehicle replacement plan organizing the maintenance of the fleet and keeping it at the current level. However, it is very cost-prohibitive to add additional vehicles (upwards of $60000 per vehicle). A working relationship with an Ontario-based seller has been cultivated over the past few years.
Future Goals	**Barrier:** Lack of reliable accessible vehicles **Strategies to Remove Barrier:** Purchase three new vehicles to replace older part of fleet **Potential Obstacles:** Cost, over $150,000. **Persons Responsible:** Matt Luck **Target Date:** October 1, 2019 **Barrier:** New location of Family Support office in west end limits ability of some to attend drop-in meetings **Strategies to Remove Barrier:** Develop partnerships with other agencies to use space for meetings and monthly drop-ins (currently connected to Molly Brant PS and CLKD's Co2 location) **Potential Obstacles:** Time. **Persons Responsible:** Erin Impola, Diane Stewart **Target Date:** October 1, 2019

Area(s) of Concern	**Community Integration**. A *community integration* barrier is anything that may limit an individual's ability to fully access their community in a way of their choosing
Items Addressed In 2018	Removing community integration barriers are at the core of the organization's everyday work.
Standing Items of Concern/Areas needing improvement	Items listed under *transportation* and *financial* are also related to community integration.
Future Goals	**Barrier:** City of Kingston has requirements that now limit Resource Consultants to only be able to work with licensed child care centres but not playgroups or facilitated drop-ins. This limits ability of children with disabilities to easily access inclusive activities at these types of programs. **Strategies to Remove Barrier:** Advocate to City of Kingston's Special Needs Resourcing department to allow for mandate to include these sites. **Potential Obstacles:** Time.

	Persons Responsible: Erin Impola, Maria Victoria **Target Date:** October 1, 2019

Area(s) of Concern	**Technology.** A *technology* barrier is related to a need of a stakeholder to access technology to ensure communication or inclusion into services.
Items Addressed In 2018	None
Standing Items of Concern/Areas needing improvement	Persons served have limited access to assistance with augmented communication systems. A reduction in community resources in 2011 contributed to this, leaving the organization's two 'communication helpers' without clinical supervision and limiting their ability to expand or maintain their roles.
Future Goals	**Barrier:** Website provider has retired, requiring need for new site. New site will have to be designed to meet OADA requirements. **Strategies to Remove Barrier:** Develop OADA-compliant website. **Potential Obstacles:** Time. **Persons Responsible:** Sheri Scott, Matt Luck, Robyn Ross **Target Date:** October 1, 2019

Area(s) of Concern	**Other.** A barrier that is not easily categorized **Lack of affordable accessible housing**
Items Addressed In 2018	-Half-time position dedicated to researching/developing affordable accessible housing in Kingston. This was done via grant in place through March 2019
Standing Items of Concern/Areas needing improvement	There is increasing concern around 16-18 year olds who can no longer live in their family's home, and for whom school is not a good fit. This concern is amplified because current guidelines do not allow for these individuals to be supported in agency Residential programs or in community participation programs. This is a significant service access gap.
Future Goals	**Barrier:** Need position to continue to be dedicated to accessible housing initiatives. **Strategies to Remove Barrier:** Find avenue to continue Housing Facilitator position on a limited basis of five to ten hours per week.. **Potential Obstacles:** Cost, up to $15,000 with benefits included. **Persons Responsible:** Sheri Scott, Matt Luck, Rob Yeo. **Target Date:** April 1, 2019

Area(s) of Concern	**Other.** A barrier that is not easily categorized **Lack of ability to provide some funded services because of other needed resources**
Items Addressed In 2018	-Updated processes around recruitment and screening for Family Home providers

Standing Items of Concern/Areas needing improvement	None
Future Goals	**Barrier:** Lack of Family Home providers to provide funded services **Strategies to Remove Barrier:** Adopt Life Share brand and supporting materials. **Potential Obstacles:** Waiting for MCCSS to complete improvements to this brand. **Persons Responsible:** Erin Impola, Kelly Agazzi **Target Date:** November 1, 2019 **Barrier:** Accepting new referrals of Family Support wait list due to existing cases **Strategies to Remove Barrier:** Transition a small number of very complex cases to Coordinator to oversee. **Potential Obstacles:** None **Persons Responsible:** Erin Impola, Diane Stewart **Target Date:** November 1, 2019

Requests for Reasonable Accommodations

There were a number of requests for reasonable accommodations by employees or prospective employees in the past year. When applicable, these were documented in *Individual Accommodation Plans*. All requests were able to be accommodated. A summary of the requests follows (note that these do not include short-term accommodations directly related to WSIB claims):

Type of Request	Number of Requests
Schedule request for religious observance	1
Accommodations for documentation/record keeping	2
Requested ergonomics assessment	1
Medical device required in workplace	1
Accommodations for physical nature of work	5
Request assistance with external interview process	1
Request scent reduced workplace	1
Schedule request for medical reason	1

The accessibility plan was reviewed in February 2019. Monitoring of items will continue throughout the year, with a formal update of the plan again being completed no later than March 2020.

Cultural Competence and Diversity Plan

(Updated January 2019)

1. Preamble

Community Living Kingston and District believes that embracing cultural diversity in all aspects of the organization (staffing, service delivery, policy development, volunteer recruitment, etc.) enhances and strengthens the organization and improves service to individuals and families. Community Living Kingston and District is committed to articulating, honouring and upholding principles respecting the culture and diversity of all persons, including the stakeholders of the organization. All procedures and practices within Community Living Kingston and District will consistently reflect support and respect for cultural differences and richness of diversity.

Community Living Kingston and District is committed to enhancing our employees' and other stakeholders' awareness, compassion, and ability to interact with others who are of diverse backgrounds and abilities with dignity, respect, patience, and understanding. We achieve this goal by educating and training our staff members on the dynamics of our growing and culturally diverse community. The Cultural Competency and Diversity Plan addresses cultural competency within CLKD by employing the following guiding elements:

1. Services are delivered with the understanding of, and respect for individuals' cultural beliefs and values.
2. Staff members respect cultural beliefs and values, interpersonal styles, attitudes, and behaviors of the individuals, families, and communities we serve.
3. An organization-wide consciousness of the dynamics of cultural interactions (i.e. – being aware of cultural biases).
4. Administration, management, and service delivery include routine assessments and implementation of processes that respect cultural diversity.
5. A workforce that is culturally and linguistically competent in a system that provides the highest quality of services to all communities served is imperative.

Cultural competency is the self-examination and in-depth exploration of various cultural backgrounds. This includes the recognition of bias, prejudice, and assumptions about individuals from various backgrounds. Community Living Kingston and District will be sensitive to, and respectful of the culture and diversity of individuals (persons served, staff and other stakeholders) in regard to the following:

- Language
- Culture
- Gender
- Sexual Orientation
- Spiritual Beliefs
- Age
- Socio-Economic Status
- Disability

Community Living Kingston and District will not tolerate, under any circumstances, any actions, words, gestures, portrayals or behaviour of any sort that discriminate in any manner or at any level towards a person or persons based on the aspects of diversity listed above. Policies and practices of the organization will consistently reflect this approach.

Area(s) of Concern	**Culture**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions - Numerous agency policies outline principles that promote diversity* - Adherence to provincial French language requirements designed to ensure accommodation of Francophones seeking service in their native tongue. French language designated positions in both Family Support and Child Care Resource Consultant Services.

	- Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	None

Area(s) of Concern	**Age**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions -- Numerous agency policies outline principles that promote diversity* - Training in Surge Learning system for staff around working with different generations in the workforce - Analysis of data each year on ages of persons served in each program - Recruitment of young persons (under 25) to serve as board members - Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	None

Area(s) of Concern	**Gender**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions - Numerous agency policies outline principles that promote diversity* - Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	None

Area(s) of Concern	**Sexual Orientation**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions - Numerous agency policies outline principles that promote diversity* - Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.

Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	None

Area(s) of Concern	**Spiritual Beliefs**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions - Agency accommodates for religious worship per provincial human rights principles and legislation - Numerous agency policies outline principles that promote diversity* - Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	None

Area(s) of Concern	**Socioeconomic Status**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions - Numerous agency policies outline principles that promote diversity* - Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	None

Area(s) of Concern	**Language**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions - Numerous agency policies outline principles that promote diversity* - Adherence to provincial French language requirements designed to ensure promotion of French culture and accommodation for Francophones seeking service in their native tongue. French language designated positions in both Family Support and Child Care Resource Consultant Services. - Collection of data in HRIS about staff able to communicate in French - Completion of personal plans in language of person's choice, where requested - French language website and signage - Accommodation available to all stakeholders as needed in order to better serve

	specific needs in this area.
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	None

Area(s) of Concern	**Disability**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions - Numerous agency policies outline principles that promote diversity* - Completion of personal plans in different formats, where requested - Creation of agency documents (e.g., rights reviews, complaints procedures in plain-language formats, where appropriate) - Annual analysis of data around barriers faced by persons served (encompassing disability). Data also aggregated in Nucleus system. - Self-Advocates included on Board of Directors - Persons served solicit feedback from peers to evaluate satisfaction with services so as to better account for communication needs - Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	None

*Policies that outline principles and practice of cultural diversity include:
- Board Policy BD#12, Rights of Participants
- HR Policy #1.01, Staff Code of Conduct
- HR Policy #1.03, Hiring
- HR Policy #1.08, Harassment/Sexual Harassment and Workplace Violence
-HR Policy #2.06, Cultural Competency

This plan will be monitored/reviewed throughout the 2019 calendar year and will be updated formally no later than March 2020.

Technology Plan

Updated February 2019

Introduction

Community Living Kingston and District relies heavily on the use of computers and electronic information to conduct its everyday business. As such, it is essential that the organization has procedures that ensure its information technology is secure and backed up on a regular basis. It is further necessary that potential threats are minimized such that access to systems is uninterrupted as much as possible, and that all information is protected and secure.

An effective Technology Plan addresses the following areas: Hardware, Software, Security, Confidentiality, Backup Policies, Disaster Recovery Preparedness, Assistive Technology, and Virus Protection. This plan addresses all of those areas of concern. It is updated based on input from person served, personnel and other stakeholders.

Development of the Technology Plan

The technology plan was initiated in 2007 and has been revised at least annually since then. The technology plan will be updated again no later than March 2020.

Plan

Area(s) of Concern	Confidentiality and Security
Current Practices	Personal information is hosted on CLKD servers. The data is secure through the use of passwords, user groups, server directory rights, and limited access points to data CLKD uses a remote desktop server to allow remote users to access the network in a secure manner. Only those staff members with a need to access client and Human Resources data will be permitted access to information All information in the Nucleus Labs Electronic Client Record (ECR) is password protected, with user rights granted to access information on a 'need to know' basis. HR policy 1.19 addresses employee use of the Nucleus ECR system. CLKD's e-mail is contained on an off-site exchange server within the Microsoft Office 365 Cloud and managed by Service First...Total Solutions.
New Items Addressed Since April 2018	Implementation of Network Access documents, requiring all network requests to have sign-off by Coordinator and Manager, prior to submission for processing.

Future Goals and Priorities	**Goal:** Implement policy to restrict employee use of memory sticks as well as personal computers for accessing CLKD's network. **Potential Obstacles:** None **Persons Responsible:** Matt Luck **Target Date:** January 2020 **Goal:** Implement policy for staff use of the new Ceridian electronic payroll system. **Potential Obstacles:** None **Persons Responsible:** Matt Luck, Jeff Harrison **Target Date:** January 2020 **Goal:** Provide "Security training" to staff as recommended by Service First. **Potential Obstacles:** None **Persons Responsible:** Matt Luck, Jeff Harrison **Target Date:** January 2020 **Goal:** Institute mandatory password reset in Nucleus every six months **Potential Obstacles:** None **Persons Responsible:** Sheri Scott **Target Date:** May 2019. COMPLETED February 2019.

Area(s) of Concern	Assistive and Communication Technology
Current Practices	Any agency staff that requires assistive technology is encouraged to bring their need to the attention of their Manager, who will consult with other agency leaders and the IT staff to discuss financial considerations and needed equipment. A staff member with a hearing impairment has an iPhone for assistance with communication issues. SMART Boards, IPads, and touch-screen computers are available for all stakeholders at Community Inclusion program sites.
New Items Addressed Since April 2018	A new SMART Board was purchased to replace the failing unit at the Options program site.
Future Goals and Priorities	**Goal:** iPads will be purchased for the Childcare Resource Consultants team that will support early learning and communication for kids attending licensed childcare centres who are on the spectrum. **Potential Obstacles:** None **Persons Responsible:** Erin Impola**,** Matt Luck **Target Date:** January 2019

Area(s) of Concern	Virus Protection
Current Practices	The off-site email exchange server as well as all network servers and workstations are protected by virus protection software and spyware/anti-spam programs. Services are purchased, monitored and regularly updated by Service First...Total Solutions. Scripts are written to disallow all .zip files, which pose significant risk. Non-networked computers at day program locations are monitored with virus protection managed by Service First.
New Items Addressed Since April 2018	None.
Future Goals and Priorities	**Goal:** Provide "Security training" to staff as recommended by Service First. **Potential Obstacles:** None **Persons Responsible:** Matt Luck, Jeff Harrison **Target Date:** January 2020

Area(s) of Concern	Disaster Recovery Preparedness and Back-Up Policies
Current Practices	All data and operating system software located on the agency file server(s) are backed up daily by Service First both locally onsite and offsite to the cloud—backups are monitored by Service First...Total Solutions. Email Information contained on Microsoft Office 365 servers are spread across 3 Microsoft regional data centers in Canada for redundancy—an additional specific agency backup of email is available for extra cost. Service First...Total Solutions is responsible for recovering data and technology functioning in the event of an emergency. All users are directed to maintain company data on the network in order to ensure that the 'crash' of an individual workstation is insignificant in terms of lost data and workstation replacement time. All data on the ECR system is secured by Nucleus Labs.
New Items Addressed Since April 2018	Recovery plan is in place, in the situation of a catastrophic event that would detail the steps involved to mitigate down-time, including: Rent temporary space, deploy temporary servers, restore servers from back-ups, ensure top 10 most crucial users are up and running immediately then expand to all users. 'Master Install Document' has been created that provides all necessary information to rebuild our network which includes: server details, license numbers, configuration information, router information, passwords etc.
Future Goals and Priorities	None

Area(s) of Concern	Hardware and Software
Current Practices	All servers are located at the main administrative office in a locked, environmentally controlled room Servers and work stations at all administrative offices and program locations are constantly monitored by a third-party professional In the event that a workstation requires attention, is the responsibility of the user to place a work order through a ticketing system that is managed by Service First. Tickets are addressed by Service First in priority sequence. CLKD replaces and upgrades workstation computers, smart phones, and tablets as finances permit. The vast majority of users require only minimal computing speed, power, and storage. Approximately 17 users have higher needs for computing speed/ power and as these "critical" users approach 3-4 years of use, their units are rotated to "non-critical" users with lesser requirements. New computer workstations for critical users are usually purchased every 3-4 years at an approximate cost of $600-$900 per computer. If a unit for a non-critical user is in need of replacement before a critical user's unit is ready to be passed down, a lower cost computer is then purchased to suit their needs. Internal server equipment (3 units — apps, data and remote desktop servers) is replaced every 3-4 years upon recommendation of Service First...Total Solutions. CLKD's Days Rd location internet access is 50Mb/second dedicated true fibre. This ensures the reliability and speed of internet access. CLKD has photocopiers with scanning capabilities, including Optical Character Recognition format that allows for scanned documents to be edited. Residential, Gananoque and Respite House locations are connected through remote network. Days Rd, Bath Rd, Gardiners Rd, CO2 and Milestones connect directly through the network. The Nucleus Labs, Ceridian Dayforce and Surge Leaning systems are monitored by each respective company, with a contract governing the agreement between them and CLKD.
New Items Addressed Since April 2018	25 computers were acquired in total of which 21 replaced aging units and 4 units were added to the fleet to meet growing organizational needs. Also the main server was replaced in accordance with the asset management planning recommendations from Service First…Total Solutions. CLKD introduced an online learning management system which is hosted by Surge Learning.
Future Goals and Priorities	**Goal:** Replace approximately 10-20 computers (10-20% of the overall equipment fleet). **Potential Obstacles:** Cost of at least $13,000 **Persons Responsible:** Matt Luck, Dixie Luck **Target Date:** April 2020

Area(s) of Concern	Other– Oversight
Items Previously Addressed	As previously outlined CLKD has contracted with Service First...Total Solutions to provide fully managed support for daily IT operations. Internal involvement with respect to IT matters is now limited to performance oversight for the third party contract arrangement as well as strategic decisions (mostly related to hardware and software planning), purchasing and policy governance.
Future Goals and Priorities	**Goal:** Explore Microsoft Team's workflow capabilities as a means of advancing the organization's capacity for communications, work flow, projects and general collaboration. **Potential Obstacles:** Time needed to research and logistical complications around training. **Persons responsible:** Sheri Scott, Dixie Luck **Target date:** April 2020

Plan to Secure Input from Stakeholders

The following plan outlines the agency's plan to secure input from it's three groups of stakeholders: Persons Served, Staff, and Other Stakeholders (Community Partners, Family Members, Funders):

Year	Persons Served	Staff	Other Stakeholders
2019 and every third year thereafter	In 2016, a project was led by two occupational therapy students from Queen's University. This project saw a group of four persons served become trained to administer surveys to their peers. This is the desired primary method for persons served to be solicited for feedback. The peer-delivered surveys will be the method used, unless unforeseen circumstances dictate otherwise.	Staff will not be surveyed, unless specific feedback about certain issues is desired.	The agency will design a survey to elicit feedback specifically from family members/advocates.
2020 and every third year thereafter	The peer-delivered surveys will be the method used, unless unforeseen circumstances dictate otherwise.	Staff will be surveyed.	No other stakeholders will be surveyed in 2020.
2021 and every third year thereafter	The peer-delivered surveys will be the method used, unless unforeseen circumstances dictate otherwise.	Staff will not be surveyed, unless specific feedback about certain issues is desired.	The agency will design a survey to elicit feedback specifically from community partners/funders.

Plan to Distribute Performance Improvement Information

Intent

It is imperative that information related to performance improvement is shared with all stakeholders. A fundamental component of the quality improvement cycle is the distribution of such information such that all stakeholders have access to this information and that they have the opportunity to provide feedback on this information.

Procedure

The following guidelines will be followed in order to ensure that performance information is shared on a regular basis and in formats that are useful to all parties. (Note: In the list below, "Other stakeholders" include parents, community partners, and MCSS).

Stakeholder	Method	Ensuring Usefulness	Timelines	Feedback Invitation
Persons Served, Personnel, Other Stakeholders	Annual Quality Improvement Report will provide yearly update of all performance improvement activities. Report is available via combox (for staff), on website, and paper copies are available.	It is recognized that this document may not be the perfect forum for persons served. As such, primary staff persons will be encouraged to ask persons served if they are interested in reviewing the information for programs that are of interest to them and explain this information to them.	Annually	QI Report contains contact information for all Management staff.
Persons Served, Personnel, Other Stakeholders	Agency report card will be used to communicate information in a more understandable and meaningful manner. The report card will be posted on the agency website and posted at program locations.	Report card will utilize simply 'thumbs up' and 'thumbs down' grades.	Annually	All users will be encouraged to provide feedback via phone or email.
Persons Served, Personnel, Other Stakeholders	Agency website will contain up-to-date information related to all performance improvement activities. Updates for all measures will be made as data is available.	Attempts will be made to ensure that information is presented in a very direct, user-friendly manner.	Wherever Possible	All users will be encouraged to provide feedback via phone or email.
Persons Served, Personnel, Other Stakeholders	Agency newsletter will have a Quality Improvement section in each edition in which progress will be updated.	Attempts will be made to ensure that information is presented in a very direct, user-friendly manner.	Twice a year	Telephone and email contact information will be provided in order to encourage feedback.
Personnel	Updates are provided at staff meetings as requested by staff or supervisors.	This format allows for the information to be presented directly to staff in a face-to-face forum.	Wherever Possible	Interactive nature of the forum invites feedback and discussion.
Personnel	Bulletin Boards and combox system in Nucleus Labs will be used to convey information wherever possible.	This will largely be in the same format as information distributed to program locations.	Wherever Possible	Invitation to provide feedback will be included in any such postings

Note

This plan coexists with other documents detailing the Data Collection/QI Process and that may specify the timelines by which to collect data for measures. Such documents include, but are not limited to, the *Overview of the Quality Improvement Process* included in the Quality Improvement Report.

Review

This plan will be reviewed by the Quality Improvement Lead on an ongoing basis. It was last updated in November 2018 will be reviewed in November 2019.

Review of Agency Policies and Procedures

Best practices suggest that a strong organization ensures that the full content of their Policies and Procedures manual are reviewed on an annual basis. This is also required by the agency's CARF accreditation. The following outlines how the practice was completed in 2018-19.

Section 1: Board and General Administration
All policies were reviewed but not updated in 2018-19.

Section 2: Operations
All policies were reviewed but not updated in 2018-19.

Section 3: Human Resources
The policies below were updated in 2018-19 as noted. All others were reviewed but not updated.

Policy Number	Policy Name	Review Date	Reviewed By
1.01	Staff Code of Conduct	Jan 15 2019	HR Director
1.02	Criminal Reference Check	September 4 2018	HR Director
1.03	Hiring	May 1 2018 and September 4 2018	HR Director
1.04	Orientation	May 1 2018	HR Director
1.05	Staff Training	May 1 2018	HR Director
1.06	Performance Appraisals	May 1 2018 and September 4 2018	HR Director
1.09	Smoking, Alcohol and Drug Use	October 17 2018	HR Director
1.11	Benefits While On Leave	August 24 2018	HR Director
1.13	Compensation for Non-Union Employees	March 14 2019	HR Director
1.17	Attendance Management	November 6 2018	HR Director
2.02	Student and Volunteer Placement	May 1 2018	HR Director
3.01	Occupational Health and Safety	July 4 2018	HR Director
3.04	Workplace Safety and Insurance	November 8 2018	HR Director
3.08	Work Refusal	September 4 2018	HR Director/JHSC
3.13	Slips, Trips, and Falls	Jan 15 2019	HR Director
3.14	Respiratory Protection Program	May 3 2018	HR Director
3.16	Scent Reduced Workplace (new policy)	Mar 1 2019	HR Director/JHSC

Section 4: Finance
All policies were reviewed but not updated in 2018-19.

Note: In future reports, this review will not be included. The agency's Surge LMS now prompts applicable Directors to update/review policies on an annual basis and keeps records around these activities.

Review of Complaints Received

Background

Community Living Kingston and District has a complaint procedure that is available for all stakeholders to follow (including staff, where the Collective Agreement with CUPE 2635 may not apply). For the purposes of this report, it is considered to be a formal complaint if the formal intervention of the program Manager has been requested or was required.

Program Area of Complaint:

Program	2015-16	2016-17	2017-18	2018-19
Residential Services	1	2	3	2
CIP	2	0	0	0
CCRCS	0	0	0	0
SIL/ESIL	0	1	0	0
Family Home	3	1	0	0
Respite	0	0	0	0
Family Support	0	0	0	0
Employment Services	n/a	n/a	0	1
Summer Programs	0	0	1	0
Total Complaints	6	4	4	3

Specific complaints for 2017-18:
- There was one complaint related to the living situation of a person served
- There was one complaint about the conduct of a staff member;
- There was one complaint about a program relocation;

Type of Complaint	2015-16	2016-17	2017-18	2018-19
Service Quality	4	2	1	1
About specific staff/individual	2	0	2	1
Possible mistreatment of person served	0	2	0	0
Agency Practices	0	0	1	1

Source of Complaint	2015-16	2016-17	2017-18	2018-19
Family Member	6	3	1	1
Community Member	0	0	2	0
Other Agency	0	0	1	1
Staff Member	0	0	0	1

Trends

In 2016, the threshold for what was considered to be a 'formal' complaint was changed, as for many years the agency had logged no formal complaints but believed that this was misleading. The number of formal complaints has been fairly consistent over the past four years, having decreased slightly.

Areas Requiring Performance Improvement

Complaints are quite varied in nature and do not seem to settle around any single area that can easily be worked on.

Actions to be Taken to Address Areas Needing Improvement

No specific actions are identified because of the variance in the types of complaints

Actions Taken or Changes Made to Improve Performance

Every situation was handled on a case by case basis. No formal investigations were required to handle any of these complaints.

Status of Complaints

All complaints brought forward this year appear to have been resolved to the satisfaction of all parties involved.

Who did we support this year?

		CIP	Residential	Family Home	Respite	SIL/ESIL	Gananoque	CCRCS	Family Support	Employment Supports
Number of Persons Served	2017-18	145	49	25	93	114	26	186	254	43
	2018-19	141	50	23	90	123	26	220	244	46
Gender of Persons Served	2017-18	Male: 62.1% Female: 37.9%	Male: 67.3% Female: 32.7%	Male: 64% Female: 36%%	Male: 65.6% Female: 34.4%	Male: 58.7% Female: 41.3%	Male: 65.4% Female: 34.6%	Male: 74.2% Female: 25.8%	Male: 60.7% Female: 39.3%	Male: 72.1% Female: 27.9%
	2018-19	Male: 61% Female: 29%	Male: 70% Female: 30%	Male: 60.9% Female: 39.1%	Male: 62.2% Female: 37.8%	Male: 58.5% Female: 40.7% Other: 0.8%	Male: 57.6% Female: 42.3%	Male: 73.2% Female: 26.8%	Male: 59.4% Female: 40.6%	Male: 69.5% Female: 30.5%
Age of Persons Served	2017-18	19-29: 20.8% 30-39: 29.8% 40-49: 21.5% 50-59: 7.8% 60-69: 16.7% 70+: 3.5%	19-29: 10.2% 30-39: 6.1% 40-49: 22.4% 50-59: 24.5% 60-69: 24.5% 70+: 12.2%	Under 19: 12% 19-29: 40% 30-39: 24% 40-49: 4% 50-59: 4% 60-69: 16%	Under 19: 36.6% 19-29: 32.3% 30-39: 17.2% 40-49: 7.5% 50-59: 4.3% 60-69: 2.6%	Under 19: 3.5% 19-29: 28.9% 30-39: 18.5% 40-49: 12.3% 50-59: 15.8% 60-69: 21.8%	19-29: 15.4% 30-39: 23.1% 40-49: 11.5% 50-59: 11.5% 60-69: 23.1% 70+: 15.3%	0-2: 0.54% 2-4: 36.6% 4-6: 32.3% 6+: 30.6%	Under 19: 51.2% 19-29: 31.1% 30-39: 8.3% 40-49: 3.9% 50-59: 3.5% 60+ 2.0%	Under 19: 30.2% 19-29: 41.9% 30-39: 9.3% 40-49: 4.7% 50-59: 9.3% 60+: 4.7%
	2018-19	19-29: 15.6% 30-39: 29.8% 40-49: 26.9% 50-59: 9.2% 60-69: 14.9% 70+: 3.5%	19-29: 8% 30-39: 6% 40-49: 26% 50-59: 24% 60-69: 24% 70+: 12%	Under 19: 8.7%% 19-29: 47.8% 30-39: 21.8% 40-49: 4.3% 50-59: 4.3% 60-69: 13%	Under 19: 42.2% 19-29: 32.2% 30-39: 12.2% 40-49: 8.9% 50-59: 3.3% 60-69: 1.1%	Under 19: 5.1% 19-29: 25.5% 30-39: 20.4% 40-49: 14.3% 50-59: 16.3% 60-69: 11.2% 70+: 7.1%	19-29: 23.1% 30-39: 23.1% 40-49: 11.5% 50-59: 11.5% 60-69: 19.2% 70+: 11.5%	0-2: 1.4% 2-4: 36.8% 4-6: 33.6% 6+: 28.2%	Under 19: 52% 19-29: 30.3% 30-39: 8.6% 40-49: 4.1% 50-59: 3.7% 60+ 1.2%	Under 19: 13% 19-29: 50% 30-39: 10.9% 40-49: 8.7% 50-59: 8.7% 60+: 8.7%
Type of Respite Received or Desired*	2017-18				Family Home: 50.5% Group: 62.4%					
	2018-19				Family Home: 46.7% Group: 66.7%					

* Figures may not add up to 100%, as persons served may receive both types of respite.

Who did we support this year?— Barriers

		CIP	Residential	Family Home	SIL/ESIL	Gananoque
Mobility of Persons Served % of persons served who require no mobility assistance	2017-18	69.6%	54.2%	72%	66.7%	69.2%
	2018-19	73.4%	60%	65.2%	83.7%	70.8%
Communication Style of Person Served % of persons served who communicate ver-bally	2017-18	65.3%	51%	68.1%	88%	84.6%
	2018-19	74.4%	64%	56.5%	90.2%	86.9%
Transportation Used By Persons Served*	2017-18	Accessible: 33.1% Public Transit: 24.1% Walk/Bike: 12.2% Provided Rides: 66.9%	Accessible: 24.5% Public Transit: 14.2% Walk/Bike: 2% Provided Rides: 91.8%	Accessible: 20% Public Transit: 28% Walk/Bike: 12% Provided Rides: 56%	Accessible: 13.2% Public Transit: 49.1% Walk/Bike: 49.4% Provided Rides:49.1% Note: There is some reason to think that data is underreported here.	Walk/Bike: 73.1% Provided Rides: 76.9% Drives own car: 15.4%
	2018-19	Accessible: 28.5% Public Transit: 32.6% Walk/Bike: 22.7% Provided Rides: 85.1%	Accessible: 26% Public Transit: 18% Walk/Bike: 6% Provided Rides: 96%	Accessible: 39.1% Public Transit: 43.8% Walk/Bike: 21.8% Provided Rides: 78.3%	Accessible: 13.8% Public Transit: 74% Walk/Bike: 65% Provided Rides: 74.8%	Walk/Bike: 78.2% Provided Rides: 78.3% Drives Own Car: 17.4%

- * indicates that figures may not add up to 100%, as multiple or no categories could be selected in the original data set.
- Family Home, Respite, CCRCS, and Family Support figures may include individuals that have been referred for service, be in the midst of matching pro-cesses and/or had initial intake complete, but are not yet receiving services
- No data included for Respite, CCRCS or Family Support, as these barriers are not germane to the services provided. No data available for Employment Supports

*

Community Inclusion Programs

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
For persons served to be involved in their community (*effectiveness*)	# of new community based resources developed	All persons served, CIP	Program Coordinators	April 1, 2018-March 31, 2019	Annually	At least 15	Between 8 and 14	Less than 8	12

Trends: This is the first year that this has been formally tracked, so no trends are available.

Extenuating Factors/Discussion: Milestones made the most inroads in this area, with seven new community activities developed, including the Portable Music Program at Music Mates, an adapted seated dance class for seniors called Sit n' Dance, Pet Therapy and the VON seated exercise program. Co2 noted two new connections, including volunteer jobs at the Salvation Army, and Options noted three, including a social group at the Canadian Hearing Society.

Follow-up Completed: A new Coordinator at Milestones contributed to the increase in community connections noted there. It is also noted that the program started allowing persons served in one program to connect with activities of interest in other programs, allowing for persons served to have more opportunities for community connections that interest them.

Action Plan: To continue with targets above that have spurred investigating new activities. Planning processes will continue to be used to identify activities of interest to persons served, which will prompt program staff to search out matching opportunities in the community.

Community Inclusion Programs

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff in CIP	Dayforce (HR and Payroll Software)	January 1, 2018 -December 31, 2018	Every Six Months	Less than 4%	Between 4% and 5%	More than 6%	3.25%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018
Sick Rate	5.53%	3.79%	2.98%	3.07%	4.19%	2.22%	3.25%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcomes measures are. There was a brief period in 2018 where the introduction of Bill 148 had placed limits on the employer's ability to manage light absenteeism. However, the repeal of Bill 148 by the new government erased those changes.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, as per the agency's *Attendance Management Program*. This program was update following legal advice in 2018.

Action Plan: To continue to administer the *Attendance Management Program*.

To ensure access to the community for persons served (*service access*)	# staff trained in person-centered planning principles	All Staff in CIP	Training Records	April 1, 2018-March 31, 2019	Annually	8 or more	6 or 7	Less than 6	8

Trends: This is the first year that this was formally measured, so no trends are available.

Extenuating Factors/Discussion: No extenuating factors are noted.

Follow-up Completed: Success in this area was largely the result of increased efforts to use H.S.A planning tools, and the agency has developed an internal committee of experts in these resources. Program staff received training largely through these mechanisms.

Action Plan: Continue to use resources of this planning team to train staff on an ongoing basis.

Residential Services Division

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
For persons served to have 'natural' supports (*effectiveness*)	% of persons served increasing or maintaining amount of non-family/non-staff supports	All Persons Served, Residential Services	Unpaid Supports Tracking Sheets	April 1, 2018-March 31, 2019	Every Three Months	More than 70%	Between 50% and 70%	Less than 50%	41.8%
For persons served to have family supports (*effectiveness)*	% of persons served increasing or maintaining amount of family supports	All Persons Served, Residential Services	Unpaid Supports Tracking Sheets	April 1, 2018-March 31, 2019	Every Three Months	More than 70%	Between 50% and 70%	Less than 50%	37.2%

Trends:

Year	2017-18	2018-19
Natural Supports	40.9%	41.8%

Year	2017-18	2018-19
Family Supports	67.6%	37.2%

Extenuating Factors/Discussion: This measure depends on tracking sheets being filled out by a variety of staff, so the reliability could be somewhat compromised. Staff training and requests for only Facilitators to fill out should manage this concern, however. It is noted that family hours are decreasing for many reasons, including aging parents who are passing away, parents who are retiring and spending more time away from Kingston, illnesses common with aging parents, and siblings who are having children, which has taken away from their ability to spend time with the person served.

Follow-up Completed: More efforts have been made to reach out to volunteers to provide feedback and support in an effort to help them in their role and encourage more time with persons served.

Action Plan: To have more conversations with persons served around people in their lives who they would like to reconnect with. Also, the division will be starting a monthly newsletter that will include novel things that have happened with natural supports, with the goal to spark creativity and an understanding of the importance of natural supports.

Residential Services Division

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	What are we measuring? (Indicator)	Who are we looking at? (Target Population Applied)	Where are we getting the data (Data Source)?	What time period did we look at (Time of Measurement)?	How often are we measuring this (Follow up Interval)?	Awesome This would be a great result that shows all of the hard work we do for persons served	Not too bad We can do better. It shows that we are on the right track but we can improve even more.	We need to work on it We can do much better, and need to really look at improvement strategies	
To reduce medication errors (*supplemental*)	Number of 'Tier 1' medication errors	All persons served, Residential Services	Nucleus Labs Report	April 1, 2018-March 31, 2019	Every Three Months	Less than 60	Between 60 and 80	More than 80	87

Trends:

Year	2016-17	2017-18	2018-19
Number of Tier 1 Errors	95	101	87

Extenuating Factors/Discussion: Data on med errors has been collected since 2006, but were only broken into 'Tier 1' and 'Tier 2' errors starting in 2016. 'Tier 1' errors are serious errors such as non-administration of medication, administering medication at the wrong time or to the wrong person, etc. 'Tier 2' errors are signing errors, errors in written instructions, etc. As noted above, Tier 1 errors were down by a fair amount, though did not meet the target. There were 62 Tier 2 errors this year, up from 50 the previous year. Three locations accounted for 46% of Tier 1 errors this year. Errors appear to be more evenly dispersed across the division this year.

Follow-up Completed: Program Coordinators continue to be supplied with data to share at staff meetings as requested during the year. Staff making errors are followed up with by both the Manager and Coordinator afterwards to discuss how the error could have been avoided, with subsequent training and an on-site medication observation with another Residential Coordinator being completed.

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Action Plan: To continue with the procedures noted above, as they were successful in reducing errors in 2018. The agency has also started a strategy to consider repeated medication errors to be disciplinary. Will also ensure that all medication protocols are not generic and are tailored to the specific needs of persons served. Plan in place to designate the first five minutes of all shifts to a conversation about responsibility for medications on that shift. A visual flow chart to be implemented to guide staff around their medication responsibilities. MTARs to be colour coded to match Dispill packs. Medication times will also be added to task sheets as a prompt.

Residential Services Division

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Residential Services	Nucleus Labs Report	January 1, 2018 -December 31, 2018	Every Six Months	Less than 5%	Between 5% and 6%	More than 6%	5.29%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018
Sick Rate	4.84%	4.99%	5.15%	518%	3.84%	3.67%	5.29%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcomes measures are. There was a brief period in 2018 where the introduction of Bill 148 had placed limits on the employer's ability to manage light absenteeism. However, the repeal of Bill 148 by the new government erased those changes. It is noted that in Residential Services, a number of staff went on short-term leaves due to illness that caused a higher usage of sick time.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, as per the agency's *Attendance Management Program*. This program was update following legal advice in 2018.

Action Plan: To continue to administer the *Attendance Management Program*.

To ensure access to augmentative communication systems (*service access*)	Number of staff taking training in augmented communication systems	All Staff, Residential Services	Training Records	April 1, 2018-March 31, 2019	Once A Year	At least 4	2 or 3	Less than 2	3

Trends: This is the first year that this data has been formally collected.

Extenuating Factors/Discussion: Three staff attended "Bridging The Gap– Communication 101", put on by the Canadian Deaf-Blind Association

Follow-up Completed: None formal

Action Plan: Continue to send training event info to staff. Encourage staff to apply for training through Joint Staff Education Committee.

Community Services Division — Supported Independent Living

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
Ensure that persons served have a chosen, meaningful valued social role (*effectiveness*)	% of persons served with noted social role identified in personal plan	All Persons Served, Community Services	Personal Plans	April 1, 2018-March 31, 2019	Annually	More than 75%	Between 65% and 75%	Less than 65%	60%

Trends:

Year	2017-18	2018-19
Results	28%	60%

Extenuating Factors/Discussion: There was a significant improvement this year. Admittedly, the definition of 'socially valued role' is somewhat interpretive, which may impact reliability. This has been partially addressed by having only one person (the program Manager) examine the data so that it is interpreted fairly consistently.

Follow-up Completed: The action plan from last year was closely followed. This involved:

1. Establishing a time frame for initial personal plans to be completed with new persons served;
2. Establishing expectation for Compass and LTC to complete plans, as they were not being completed consistently. Both of these programs saw significant improvement.
3. A process was established for planning with persons served who were resistant to the process.

Action Plan: To continue to follow the action plan noted above.

Community Services Division — Supported Independent Living

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Community Services	Nucleus Labs Report	January 1, 2018 -December 31, 2018	Every Six Months	Less than 4%	Between 4% and 5%	More than 5%	3.57%

Trends:

Year	2012	2013	2014	20015	2016	2017	2018
Sick Rate	1.87%	2.25%	2.98%	3.75%	2.91%	2.56%	3.57%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcomes measures are. There was a brief period in 2018 where the introduction of Bill 148 had placed limits on the employer's ability to manage light absenteeism. However, the repeal of Bill 148 by the new government erased those changes.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, as per the agency's *Attendance Management Program*. This program was update following legal advice in 2018.

Action Plan: To continue to administer the *Attendance Management Program*.

Community Services Division — Supported Independent Living

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure that persons served enter service as soon as possible after funding is identified (*service access)*	% of persons served in service within 60 days of funding approval	All Persons Served, Community Services	Nucleus Labs Report	April 1, 2018-March 31, 2019	Once A Year	At least 75%	Between 50% and 75%	Less than 50%	80%

Trends:

Year	2016-17	2017-18	2018-19
Sick Rate	100%	100%	80%

Extenuating Factors/Discussion: Figures are based on only five referrals, which may not provide the most reliable data.

Follow-up Completed: None, other than diligence around ensuring people are brought into service quickly.

Action Plan: None formal.

Family Services Division—Family Home

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
Ensure continuity of Family Home living arrangements (*effectiveness*)	% of persons served maintaining family home arrangement for entire year	All Persons Served in a 'Traditional' Family Home arrangement	Program Coordinator	April 1, 2018-March 31, 2019	Once a Year	More than 90%	Between 80% and 90%	Less than 80%	91.7%

Trends:

Year	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Maintenance Rate	100%	95.5%	90%	93%	85%	96%	91.7%

Extenuating Factors/Discussion: There were two discontinuations in 2018-19. One was due to an individual moving to a more independent living environment, which is not included in the data set by definition. The other involved changing needs of a person served. As evident from the trends, success rates have remained very high in the program for many years.

Follow-up Completed: Flexibility around service provision continues to be the main method to ensure stable arrangements. This flexibility includes adequate respite.

Action Plan: To continue with flexibility around the service model.

Family Services Division—Family Home

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Family Home program	Nucleus Labs Report	January 1, 2018 -December 31, 2018	Every Six Months	Less than 4%	Between 4% and 5%	More than 5%	2.10%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018
Sick Rate	2.66%	2.30%	3.54%	4.65%	1.89%	1.45%	2.10%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcomes measures are. There was a brief period in 2018 where the introduction of Bill 148 had placed limits on the employer's ability to manage light absenteeism. However, the repeal of Bill 148 by the new government erased those changes.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, as per the agency's *Attendance Management Program*. This program was update following legal advice in 2018.

Action Plan: To continue to administer the *Attendance Management Program*.

Family Services Division—Family Home

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure that there are family home providers available when vacancies arise (*service access)*	# of new Family Home providers recruited, screened and approved	All Providers, Family Home program	Program Coordinator	April 1, 2018-March 31, 2019	Once A Year	At least 2	At least 1	None	4

Trends: This is the first year this has been formally tracked.

Extenuating Factors/Discussion: Two providers this year were connected through previous service providers, another was a former provider, and one provider came already connected to a person served who was new to CLKD.

Follow-up Completed: Recruitment and screening is now the responsibility of Kelly Agazzi (Family Home Coordinator) and Hailey Latimer (Respite Coordinator) after years of being housed with another position.

Action Plan: Continue to use existing strategies to recruit and screen providers.

Family Services Division—Respite

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	What are we measuring? (Indicator)	Who are we looking at? (Target Population Applied)	Where are we getting the data (Data Source)?	What time period did we look at (Time of Measurement)?	How often are we measuring this (Follow up Interval)?	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
Ensure usage of Respite House (*effectiveness*)	% of days respite house is utilized for funded or private respite	Respite House	Program Coordinator	April 1, 2018-March 31, 2019	Once a Year	More than 80%	Between 65% and 80%	Less than 65%	70.7%

Trends:

Year	2007-08	2008-09	2009-10	2012-13	2013-14	2016-17	2017-18	2018-19
% Usage	78.96%	80%	76.43%	88.35%	93.9%	69%	69.6%	70.7%

Extenuating Factors/Discussion: Trends continue to be fairly steady. As base funding remains stagnant, there is no avenue that way to increase capacity. There have been some attempts to increase consumer direct options, though one individual who used this often has recently passed away.

Follow-up Completed: A person served has starting using the respite house each Tuesday afternoon, and another a few days a week. These sorts of 'one-day' options had not been the house model in the past, but are an excellent use of the house when it is otherwise vacant/unused.

Action Plan: A plan is in place for a person served to start using the location two overnights a week via private respite. In addition, the Manager and Coordinator are looking at avenues to utilize the location on weekends where trip respite is occurring and the house is otherwise vacant.

Family Services Division—Respite

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Respite program	Nucleus Labs Report	January 1, 2018 -December 31, 2018	Every Six Months	Less than 4%	Between 4% and 5%	More than 5%	2.10%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018
Sick Rate	2.86%	2.38%	4.81%	1%	1.9%	1.45%	2.10%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcomes measures are. There was a brief period in 2018 where the introduction of Bill 148 had placed limits on the employer's ability to manage light absenteeism. However, the repeal of Bill 148 by the new government erased those changes.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, as per the agency's *Attendance Management Program*. This program was update following legal advice in 2018.

Action Plan: To continue to administer the *Attendance Management Program*.

Family Services Division—Respite

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure that respite allocations are being effectively used. (*service access)*	% of Family Home respite allocation utilized	All persons served, Respite program	Program Coordinator	April 1, 2018-March 31, 2019	Once A Year	More than 85%	Between 65% and 85%	Less than 65%	77.7%

Trends: This is the first year that this has been formally tracked.

Extenuating Factors/Discussion: Of the six individuals approved for Family Home respite, three had used all of their funding, two used at least half of it and one had used none.

Follow-up Completed: None formal, though the action plan below has been in planning stages.

Action Plan: Provide other respite options , including after school respite and use of the respite house.

Family Services Division— Child Care Resource Consultant Services

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
Ensure maximum usage of enhanced funding (*effectiveness*)	# of children reported as unable to attend child care centres due to lack of enhanced funding	All centres served by CCRCS	Program Co-ordinator	April 1, 2018-March 31, 2019	Once a Year	Less than 2	Between 2 and 5	More than 5	0

Trends:

Year	2014-15	2015-16	2016-17	2017-18	2018-19
Number of Children Unable To Attend Centre	2	0	1	0	0

Extenuating Factors/Discussion: While there were no occasions where children were not able to attend centres because of a lack of enhanced funding, there were two reports of children receiving funding who could not then find workers to support them.

Follow-up Completed: Advocacy efforts were partially responsible for the City allotting an extra $162,000 in annualized funding starting in 2018-19.

Action Plan: None formal.

Family Services Division— Child Care Resource Consultant Services

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Respite program	Nucleus Labs Report	January 1, 2018 -December 31, 2018	Every Six Months	Less than 3%	Between 3% and 4%	More than 4%	2.01%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018
Sick Rate	2.35%	2.74%	2.49%	1.54%	1.63%	1.26%	2.01%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcomes measures are. There was a brief period in 2018 where the introduction of Bill 148 had placed limits on the employer's ability to manage light absenteeism. However, the repeal of Bill 148 by the new government erased those changes.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, as per the agency's *Attendance Management Program*. This program was update following legal advice in 2018.

Action Plan: To continue to administer the *Attendance Management Program*.

Family Services Division— Child Care Resource Consultant Services

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure that families receive service as quickly as possible after referral (*service access)*	% of persons served in service within 60 days of referral	All new referrals, CCRCS program	Nucleus Labs Reports	April 1, 2017-March 31, 2018	Once A Year	More than 67%	Between 50% and 67%	Less than 50%	97.5%

Trends:

Year	2015-16	2016-17	2017-18	2018-19
Success Rate	77%	67%	86.2%	97.5%

Extenuating Factors/Discussion: There were 82 referrals to the program, which his higher than last year (65). The average wait time was 26.5 days (last year: 33.5). The shortest wait time was one day (last year: 1). The longest was 69 days (last year: 154).

Follow-up Completed: An additional resource consultant (designated French Language) was hired in 2018. This was helpful at trimming wait times and allowing the program Coordinator to more quickly complete intakes. The program Coordinator was also removed from an assignment in Sharbot Lake, leaving her three days a month to focus on other duties, including referrals. In addition, coverage was put in place for the Coordinator when she is on vacation so that another party is assigned to ensure timely intakes.

Action Plan: To continue with existing processes, as they seem to be achieving good results.

Family Services Division— Family Support

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
Ensure that families have access to information, outreach and support (*effectiveness*)	# of monthly drop in and parent group meetings attended by at least ten families	All drop ins, Family Support	Program Coordinator	April 1, 2018-March 31, 2019	Once a Year	At least 8	Between 5 and 7	Less than 5	5

Trends:

Year	2016-17	2017-18	2018-19
Result	0	5	5

Extenuating Factors/Discussion: The lowest number of attendees was in April, with zero. The highest was May, where 75 attended parent group, with 41 attending in June and 31 (combined drop in and parent group) in November. The median number was 8, the same as the previous year. The average number was 16.4 (last year: 18). The higher-attended session included presentations about best practices when hiring respite workers, a session on Passport funding, a session on housing and an income tax session.

Follow-up Completed: The program has been operating at a satellite location at Molly Brant Public school in order to try to better meet families at needed locations. Leslie Moore has also been working with a parents group to find new topics of interest (e.g., an upcoming session on internet safety with an office from the local police force).

Action Plan: To continue to offer topics of interest to families to drive attendance, including sending out a survey to try to pinpoint ideas. To continue with the satellite program at Molly Branch.

Family Services Division— Family Support

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Family Support program	Nucleus Labs Report	January 1, 2018 -December 31, 2018	Every Six Months	Less than 3%	Between 3% and 4%	More than 4%	2.07%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018
Sick Rate	1.81%	0.88%	3.47%	1.36%	2.73%	0.19%	2.07%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcomes measures are. There was a brief period in 2018 where the introduction of Bill 148 had placed limits on the employer's ability to manage light absenteeism. However, the repeal of Bill 148 by the new government erased those changes.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, as per the agency's *Attendance Management Program*. This program was update following legal advice in 2018.

Action Plan: To continue to administer the *Attendance Management Program*.

Family Services Division— Family Support

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To ensure that families receive service as quickly as possible after referral (*service access)*	% of persons served in service within 60 days of referral	All new referrals, Family Support program	Nucleus Labs Reports	April 1, 2018-March 31, 2019	Once A Year	More than 67%	Between 50% and 67%	Less than 50%	27.2%

Trends:

Year	2015-16	2016-17	2017-18	2018-19
Success Rate	74%	84.8%	91.36%	27.2%

Extenuating Factors/Discussion: The average length of time was 134 days. The longest was 273, while the shortest was seven. There were a number of factors that contributed to this reduction in referral speed that were unusual in 2019: A change in Coordinators, a Family Support Worker who had just started and then left the program, two new Family Support Workers needing to be trained and orientated. All of this transition time took significant time away from addressing new referrals. n addition, an influx of children with complex special needs resulted in caseload responsibilities having to be reorganized, which again took time.

Follow-up Completed: The program now appears to have its personnel stabilized (this was the only year in memory where there was this sort of upheaval). In addition, the program had initiated a new intake and orientation process, but subsequently found that it seems to cause more work than it does benefit. As such, this new process has been scrapped.

Action Plan: To revert back to old intake and orientation process.

Employment Services Division— Organization Employment Supports/Kwik Shred

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
For persons served to work frequently at Kwik Shred for minimum wage *(effectiveness)*	% of 'regular' persons served staff working at least two shifts per week.	All persons served working at Kwik Shred	Employee time sheets	January 1, 2019 -March 31, 2019	Once A Year	100%	Between 80% and 100%	Less than 80%	100%
Trends: This is the first year that this has been formally tracked, so no trends are able to be examined. **Extenuating Factors/Discussion:** Kwik Shred exceeded production rates from 2017 by the third quarter of 2018, which led to ensuring ample hours for all regular workers. **Follow-up Completed:** Implementation of a business plan to raise business volume. **Action Plan:** Continue with business plan that was successful in raising volume.									
To ensure that the newly redesigned Kwik Shred is financially viable *(efficiency)*.	Amount of revenue generated above basic operating costs	All expenses and revenues at Kwik Shred	Finance records	April 1, 2018-March 31, 2019	Once a year	At least $80,000	Between $70,000 and $80,000	Less than $75,000	$70,000
Trends: This is the first year that this has been tracked since the implementation of a new business model at Kwik Shred, which included paying all worker persons served minimum wage rather than a training wage. **Extenuating Factors/Discussion:** The prices of scrap metal are volatile, but remained fairly high this year. Excess moneys were put towards replacing a metal shredder and a forklift that had reached the end of their useful life. **Follow-up Completed:** An aggressive re-organization of Kwik Shred was put in place over the past two years as the business model was shifted, as noted above. **Action Plan:** To continue to seek out new community customers so that the business is not dependent on a single large contract. To continue to sell paper rather than disposing of it in order to have additional revenue.									

Employment Services Division— Organization Employment Supports/Kwik Shred

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To generate additional work opportunities at Kwik Shred *(Service Access)*	Number of 'casual' positions created at Kwik Shred	All persons served working at Kwik Shred	Employee HR Records	January 1, 2019 -March 31, 2019	Once A Year	At least 3	At least two	Two or less	4

Trends: This is the first year that this has been formally tracked, so no trends are able to be examined.

Extenuating Factors/Discussion: Kwik Shred exceeded production rates from 2017 by the third quarter of 2018, which led to being able to create casual positions.

Follow-up Completed: Implementation of a business plan to raise business volume.

Action Plan: Continue with business plan that was successful in raising volume.

Employment Services Division— Employment Supports

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To create employment opportunities for persons served (*Effectiveness)*	Number of individuals served securing paid employment of three months or longer	All persons served, Employment Supports	Nucleus	April 1, 2018-March 31, 2019	Once A Year	At least 6	Between 3 and 5	Less than 3	1
To ensure that jobs are secured in a fiscally responsible manner *(efficiency)*.	% of persons served who secured employment with less than four weeks of job training	All persons served who secured paid employment	Nucleus	April 1, 2018-March 31, 2019	Once a year	At least 75%	Between 50% and 75%	Less than 50%	100%

Trends: This is the first year that either of these have been formally tracked, so no trends are able to be examined.

Extenuating Factors/Discussion: None.

Follow-up Completed: None formal

Action Plan: To develop a position that would be paired with CIP that would allow for more employment opportunities for persons served in that program. To secure funding for Laurie McShane's position past March 2020. Such security of positions would allow for more formal plans to ensure that the efficiency measure is met.

Employment Services Division— Employment Supports

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To ensure that referrals are suitable (*Service Access)*	% of referrals that result in a written employment plan	All referrals to Employment Supports	Nucleus	April 1, 2018-March 31, 2019	Once A Year	At least 60%	Between 40% and 60%	Less than 40%	100%

Trends: This is the first year that this has been formally tracked, so no trends are able to be examined.

Extenuating Factors/Discussion: This year, referrals to the program were largely in-house came from individuals who were already working in worker cooperatives or at Kwik Shred. Therefore, it was somewhat expected that these referrals might be suitable. As such, it might be expected that this level of success will be hard to achieve again in the future. The Employment Facilitator, Laurie McShane, completed thirty-five employment plans in a six month period.

Follow-up Completed: None formal

Action Plan: To develop a position that would be paired with CIP that would allow for more employment opportunities for persons served in that program. These would likely be suitable referrals, given that these persons served are well-known to the agency.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	What are we measuring? (Indicator)	Who are we looking at? (Target Population Applied)	Where are we getting the data (Data Source)?	What time period did we look at (Time of Measurement)?	How often are we measuring this (Follow up Interval)?	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure staff health and safety	OSHA Recordable Injury Rate	All Staff	WSIB Reports, Dayforce reports	April 1, 2018-March 31, 2019	Every Six Months	0 per 100 FTE	Between 0 and 3 per 100 FTE	More than 3 per FTE	6.66
To ensure staff health and safety	OSHA Lost Time Case Rate	All Staff	WSIB Reports, Dayforce reports	April 1, 2018-March 31, 2019	Every Six Months	0 per 100 FTE	Between 0 and 1 per 100 FTE	More than 1 per FTE	0.83

Trends:

Year	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Recordable Injury Rate	**2.03**	2.49	2.38	3.58	2.95	5.99	6.66

Year	2014-15	2015-16	2016-17	2017-18	2018-19
Lost Time Case Rate	0.95	2.24	0.42	0.86	0.83

Extenuating Factors/Discussion: There were sixteen injuries reported to WSIB this year, up from fourteen the year before. Two of the injuries resulted in lost time. One was the result of a slip, trip and fall where inappropriate footwear was a factor. The other injury involved a staff member falling off a truck at Kwik-Shred. It does appear likely that injuries have been more rigorously reported to WSIB in the past two years with changes in the HR department.

Follow-up Completed: A footwear policy was put in place to attempt to minimize slip, trip and fall concerns. Training around truck safety was given to all staff at Kwik Shred.

Action Plan: Continue new training units in Surge. All Coordinators are being trained in supervisor health and safety in December 2019.

Business Function Measures— Supplemental Information

The following is a summary of staff injuries in the 2018-19 fiscal year. No targets are associated with this data at this point, and this information should be considered supplemental to the agency's other health and safety business targets.

Category	2017-18	2018-19)
Number of Fatalities	0	0
Number of WSIB-reportable injuries	14	16
Number of Lost-Time Injuries	2	2
Total Number of Hours Lost	228	210
Number of non-WSIB reportable injuries	20	23
Types of Injuries	Lift/Transfer/Physical Support with Person Served: 9 Slip, Trip or Fall 10 Bumped Head 4 Aggression by Person Served 4 Cut Caused by Object 2	Lift/Transfer/Physical Support with Person Served: 11 Slip, Trip or Fall 14 Bumped Head 2 Aggression by Person Served 4 Cut Caused by Object 0 Other lifting (items) 4 Other 4

Note: Of Slips, Trips Falls so far this year:
- 21.4% happened inside a CLKD location
- 35.7% happened at a CLKD location, exterior
- 14.2% happened in a CLKD vehicle
- 42.9% were related to slips on ice
- 25% appear to be directly relatable to inappropriate footwear, while footwear may have been a contributing factor in several others. Please note that CLKD put footwear provisions in place as of December 2018 to help address this situation.

Based upon this information, CLKD will put in place a target for 2019-20 related to the number of slips ,trips and falls in the hopes that it's new footwear practices will reduce injuries.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	What are we measuring? (Indicator)	Who are we looking at? (Target Population Applied)	Where are we getting the data (Data Source)?	What time period did we look at (Time of Measurement)?	How often are we measuring this (Follow up Interval)?	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To manage long-term costs	Unfunded Liabilities (in dollars) in Excess of 30 Days	All Staff	Finance Reports	April 1, 2018-March 31, 2019	Every Six Months	Less than $85,000	Between $85,000 and $100,000	More than $100,000	$50,582

Trends:

Year	2016-17	2017-18	2018-19
Amount	$89, 523	$89, 662	$50, 582

Extenuating Factors/Discussion: The agency had the ability to pay a significant amount of excess time out at the end of the 2018 fiscal year, paying out 1824 hours, which accounts for approximately $40,000 of the reduction. Staff who did not wish to be paid out were also given the option to aggressively use time off before the end of the fiscal year in order to ensure that their accruals were brought down.

Follow-up Completed: As noted, there was a payout at the end of the fiscal year. The Scheduling department has also been managing time off much more carefully, ensuring that staff do not carry excess accruals. The agency has also changed it's practice around overtime, preferring to pay it out rather than have it converted to lieu time.

Action Plan: Program Managers and the scheduling team will continue to require staff to take time off when accruals reach 30 vacation days or 40 lieu hours. Overtime to continue to be paid out as accrued.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	What are we measuring? (Indicator)	Who are we looking at? (Target Population Applied)	Where are we getting the data (Data Source)?	What time period did we look at (Time of Measurement)?	How often are we measuring this (Follow up Interval)?	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure responsive on-call systems	% of calls responded to in six minutes or less	All Calls to Manager On-Call System	Alliance Wireless Reports	April 1, 2018-March 31, 2019	Every Six Months	More than 80%	Between 65% and 80%	Less than 65%	70.1%

Trends:

Year	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Result	44%	65.6%	84.6%	86.2%	53.2%	69.8%	69.4%	70.1%

Extenuating Factors/Discussion:

- Of those calls that did not meet the target, 40% of them had an extended period before the answering service made the first call.
- There were 66 calls to the system (last year: 72).
- 44.7% of calls were related to medical issues with persons served (last year: 45.8%), 32.8% were due to a property issue (last year: 12.5%), 13.4 were related to a person served showing challenging behavior (last year: 12.5%).
- The shortest response time was 1 minute; the longest was 31 minutes; the average was 6.1 minutes (last year: 6.5 minutes)

Follow-up Completed:

- The organization sends a prioritized list of available Managers to the service on a weekly basis;
- The organization again followed up with the service to ensure their understanding that the service must call Managers immediately upon receiving a call from staff.

Action Plan:

- To continue with approaches already in place.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To ensure consistent staffing	Part-Time Turnover Rate	All Part-Time Staff	Dayforce and Other HR Records	April 1, 2018-March 31, 2019	Once A Year	Less than 15%	Between 15% and 25%	More than 25%	38.7%

Trends:

Year	2017-18	2018-19
Amount	25.2%	38.7%

Extenuating Factors/Discussion:

- The turnover rate for full-time staff was 4.78% (last year: 1.7%). The turnover rate for part-time staff was 38.7% (Last year: 25.2%) The overall turnover rate was 22.8% (Last year: 14.1%)
- Of the departing part-time staff, 29.8% left for full-time work (last year: 40.5%), 21% left because they left Kingston (which may also include for work out of town) (last year: 27%). Probation terminations were the reason for 14% of departures, which is anecdotally much more than in the past. Other reasons included part time work elsewhere, return to school, not wanting to be trained in multiple programs and disliking personal care as part of the duties.
- Full-time staff who left do not include Management staff. Reasons for leaving included a retirement, the opportunity to work as a police officer, and returning to school.

Follow-up Completed:

- A new exit survey process was put in place that is much more detailed. It is estimated that 54% of departing staff completed the survey.
- A *Staff Retention Task Force* was put in place in 2019 to look at possible ways to increase staff retention. This committee includes four Management staff (Jeff Harrison, Sherrill Boyes, Jeanette Beaubien and Rob Yeo) and five front-line staff (Stephen Machan, Samantha Hunter, Kaitlyn Ferguson, Ryan Wood and Lisa MacIntosh) and has the support of CUPE 2635.

Action Plan:

- To do a complete review of the exit surveys to examine reasons for leaving and opportunities for improvement.
- To develop an action plan from the task force. Ideas at current time are ways to reduce short shifts, ways to create full time work and ways to reduce Required To Stay.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To ensure consistent staffing	% of Part-Time Vacancies Filled Within 14 Days	All Staff	HR Records	April 1, 2018-March 31, 2019	Every Six Months	More than 75%	Between 60% and 75%	Less than 60%	77.4%

Trends:

Year	2017-18	2018-19
Amount	63.6%	77.4%

Extenuating Factors/Discussion: The average replacement time was 10.7 days (last year: 12.2)

Follow-up Completed: The strategy from 2018, was continued. This involved, instead of 'crisis hiring' when a vacancy came up, having strong applicants interviewed upon receipt of a resume, allowing for there to be pre-screened candidates available to offer positions.

Action Plan: Continue with approach noted.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To ensure regular feedback to staff	% of Staff Who Have Had A Performance Appraisal Within the Past Two Years	All Staff	Dayforce Records	Measured as of April 1, 2019	Every Six Months	More than 75%	Between 60% and 75%	Less than 60%	73.5%

Trends:

Year	2017-18	2018-19
Amount	32%	73.5%

Extenuating Factors/Discussion: The improvement is largely attributable to the fact that the agency changed it's policy such that appraisals are now due every two years rather than annually. However, there has been more diligence on the part of supervisors around completing appraisals, though a handful of supervisors are still behind. Management appraisals are quite overdue at this juncture.

Follow-up Completed:

- A new database was put in place to allow easier reporting to ensure that Coordinators receive monthly updates around appraisal status
- The appraisal forms themselves were edited in 2018 such that they are less time consuming for Coordinators to complete

Action Plan:

- Continue with new database to allow supervisors to see appraisal status more regularly.

Surveys— All Programs

What Question Did We Ask?	How are we hoping to do (target)?			How did we actually do? (Results)
All Questions Were Asked on a 'Mostly Yes' or 'Mostly No' Basis, unless otherwise noted. **We Want As Many 'Mostly Yes' Answers as Possible in the Results.**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
Does CLKD listen to your ideas?	90% or better	Between 80% and 90%	Less than 80%	80.6%
Do you have enough freedom at CLKD?	90% or better	Between 80% and 90%	Less than 80%	85.7%
Do the staff at CLKD treat you right?	90% or better	Between 80% and 90%	Less than 80%	89.3%.
Do you know what staff to talk to at CLKD if you were mad or sad?	90% or better	Between 80% and 90%	Less than 80%	89.3%
Does CLKD let you be with your friends?	90% or better	Between 80% and 90%	Less than 80%	94.5%

Who Took the Survey?

Residential 28.5% CIP 48% Family Home/Respite 3.6% SIL 19.6% Employment 7.1%

* Respondents may be a part of multiple programs, so figures will add up to greater than 100%

Trends: These are lower satisfaction levels than in previous years, but this is the first year where this survey format has generated a significant number of respondents. The survey format used was a follow-up to a program originally designed in 2015 by two Queen's OT students, who developed a training program allowing a group of persons served to administer surveys to their peers. This was done on a small-scale basis from 2015 to 2017. This is the first year where a significant number of responses was generated. It was hoped that this format would give a truer reflection of satisfaction than paper or other survey formats where staff or families may be able to influence answers. As such, it is not surprising that satisfaction rates are slightly lower than in the past. There were no significant differences in satisfaction rates across programs, with the exception to one question 'Does CLKD listen to your ideas', where only 63% of respondents indicated had a favourable response.

Extenuating Factors/Discussion: It is likely that they survey group was more likely to meet with respondents who were able to answer verbally, though the anonymous nature of the survey makes it impossible to determine this.

Follow-up Completed: None formal.

Action Plan: A meeting will be held with the survey administrators in the spring of 2019 to look for further insight into the relatively low satisfaction rate for the first item.

Surveys— Child Care Resource Consultant Services

What Question Did We Ask?	How are we hoping to do (target)?			How did we actually do? (Results)
All Questions Were Asked on a Yes or No Basis, unless otherwise noted. **We Want As Many 'Yes' Answers as Possible in the Results.**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
When you first started services, was your intake completed in a timely manner?	90% or better	Between 80% and 90%	Less than 80%	100% (Last Year: 96.4%)
The Resource Consultant is flexible in meeting our communication needs (meetings, phone calls, emails,)	90% or better	Between 80% and 90%	Less than 80%	100% (Last Year: 100%)
The information shared with me by the Resource Consultant is useful.	90% or better	Between 80% and 90%	Less than 80%	100% (Last Year: 100%)
The Resource Consultant treats our family with respect and dignity	90% or better	Between 80% and 90%	Less than 80%	100% (Last Year: 100%)
I am aware that my child has an Individual Program Plan and/or a One Page Profile	90% or better	Between 80% and 90%	Less than 80%	100% (Last Year: 100%)
The Resource Consultant makes us aware of other services in the community as necessary	90% or better	Between 80% and 90%	Less than 80%	100% (Last Year: 100%)
The Resource Consultant was helpful in assisting us with our child's transition to school	90% or better	Between 80% and 90%	Less than 80%	94.4% (Last Year: 95.2%)
Please rate your overall satisfaction with the services offered by Child Care Resource Consultant Services (Outstanding, Above Average, Satisfactory or Unsatisfactory)	At least 90% Outstanding or Above Average	Between 80% and 90% Outstanding or Above Average	Less than 80% Outstanding or Above Average	86.9% (Last Year: 89.2%) (78% said 'outstanding')

Who Took the Survey?

By Area:

City of Kingston	91.3%
Other	8.7%
Frontenac Township	8.7%

By Age of Child:

0 to 2	4.4%
2-6	65.2%
6-12	30.4%

By Time In Service:

Under 6 months	4.4%	1 to 2 years	39.1%
6 to 12 months	21.7%	2+ years	34.8%

Surveys— Family/Advocates

What Question Did We Ask?	How are we hoping to do (target)?			How did we actually do? (Results)
All Question Were Asked With 'Mostly Yes' or 'Mostly No' as the options. **We Want as Many 'Mostly Yes' Responses As Possible— Those are Considered Positive Responses in the Results Below**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
I am treated with dignity and respect by staff members of CLKD	90% or better	Between 80% and 90%	Less than 80%	100%
My input and opinion is valued by CLKD and I have the opportunity to express opinions	90% or better	Between 80% and 90%	Less than 80%	97.1%
CLKD addresses my questions or concerns quickly	90% or better	Between 80% and 90%	Less than 80%	97.1%
The services offered by CLKD promote independence	90% or better	Between 80% and 90%	Less than 80%	96.7%
The services offered by CLKD allow my family member/friend to be move included in the community	90% or better	Between 80% and 90%	Less than 80%	96.9%
I understand and am included in the planning process that happens with my family member/ friend every year	90% or better	Between 80% and 90%	Less than 80%	97.1%
The planning process that happens every year with my family member/friend is valuable and important	90% or better	Between 80% and 90%	Less than 80%	96.9%
The program location and/or offices that I have visited are clean and welcoming	90% or better	Between 80% and 90%	Less than 80%	100%
Newsletters, pamphlets and the website are informative and easy to read	90% or better	Between 80% and 90%	Less than 80%	100%

Response Distribution:

Family Member 94.1%
Friend/Advocate 5.9%

Response Distribution (Can Select Multiple, Will Add Up To More Than 100%)

Residential Services 15.2% SIL 21.2% Community Inclusion 45.5% Family Home 12.2% Respite 15.2%
Employment Services 12.1% Family Support 15.2% Gananoque 21.2%

Surveys— Staff Retention Task Force

In early 2019, CLKD assembled a staff retention task force designed to look further into increasing turnover rates amongst part time staff. While this is a significant problem across the provincial sector, CLKD felt it imperative to look further into this issue to see if there were any improvements that could be made that might ameliorate this issue. The first order of business of the task force was to put together a survey to solicit feedback. The results from that survey are presented here (some questions are condensed for brevity). The task force will further examine these results and put forward recommendations later in 2019.

Response Breakdown:

Division of Service

Residential Services	78.6%
Community Services	20.6%
Family Services	6.4%
CIP	1.59%
Employment Services	1.59%

Note: Respondents could choose multiple Divisions of Service, so percentages will add up to more than 100%

Employment Status

Full Time	42.4%
Part Time	57.6%

The Following Questions Were Asked of Part-Time Staff Only

As a part-time staff, I would be more likely to stay with the agency if I were able to be trained in more programs/locations, even if it meant having shifts moved often or increasing the chance of being Required to Stay.

Response	Result	
Completely Agree	20.29%	Positive Responses: 47.83%
Somewhat Agree	27.54%	
Somewhat Disagree	27.54%	Negative Responses: 52.18%
Completely Disagree	24.64%	

Surveys— Staff Retention Task Force

As a part-time staff, which of these is most important to you in considering your future at the agency? (Respondents were asked to rank order. In the chart below, the 'score' is the weighted score of the rank ordering, with higher numbers meaning more important).

Consideration	Score	Comments
Rate of Pay	5.66	65% of applicants had this in top two. Only three rated it in the bottom two.
Number of Scheduled Hours	4.89	66% rated in top three.
Opportunities for full-time work/ advancement	4.25	
Flexibility of Shifts (working around other commitments)	3.85	
Type of shifts (day vs. evening)	3.42	
Length of shifts	3.2	
Too much Required to Stay	3.1	Was least important for 29% of respondents, and was in bottom two for 48%

As a part-time staff, I would be interested in more full-time work being available:

I would be interested if there were positions that were less than 40 hours a week, but higher than part-time minimums (e.g., a 70% position that worked 28 hours a week)

Response	Result	
Absolutely, no doubt	40%	Positive Responses: 88.57%
I'd agree with this, with some reservations	48.57%	
I'd tend to disagree with this	8.57%	Negative Responses: 11.43%
I would be completely against this	2.86%	

Surveys— Staff Retention Task Force

These questions were asked of all employees

I would be in favour of more full-time jobs even if it made it more likely that Required to Stay would have to be absorbed by full-time employees

Response	Overall Result	Full-Time Staff Only		Part-Time Staff Only	
Absolutely, no doubt	27.97%	18%	Positive: 82%	35.3%	Positive: 70.6%
I'd agree with this, with some reservations	47.46%	64%		35.3%	
I'd tend to disagree with this	17.8%	8%	Negative: 18%	25%	Negative: 29.4%
I would be completely against this	6.78%	10%		4.4%	

I would be in favour of more full-time jobs even if the majority of the work were on weekends

Response	Overall Result	Full-Time Staff Only		Part-Time Staff Only	
Absolutely, no doubt	18.8%	8.2%	Positive: 61.3%	26.5%	Positive: 63.3%
I'd agree with this, with some reservations	43.59%	53.1%		36.8%	
I'd tend to disagree with this	28.21%	34.7%	Negative: 38.8%	23.5%	Negative: 36.7%
I would be completely against this	9.4%	4.1%		13.2%	

I would be in favour of more full-time jobs even if it made it more difficult to get time off on short notice

Response	Overall Result	Full-Time Staff Only		Part-Time Staff Only	
Absolutely, no doubt	16.95%	4%	Positive: 48%	27.6%	Positive: 78.3%
I'd agree with this, with some reservations	48.31%	44%		50.7%	
I'd tend to disagree with this	27.12%	8%	Negative: 52%	14.5%	Negative: 21.7%
I would be completely against this	7.63%	44%		7.2%	

Surveys— Staff Retention Task Force

I would be in favour of more full-time jobs even if it meant that preferred vacation time was less easily accommodated and had to be decided by seniority

Response	Overall Result	Full-Time Staff Only		Part-Time Staff Only	
Absolutely, no doubt	24.58%	15.7%	Positive: 45.1%	30.9%	Positive: 67.7%
I'd agree with this, with some reservations	33.05%	29.4%		36.8%	
I'd tend to disagree with this	31.36%	45.1%	Negative: 54.9%	20.6%	Negative: 31.3%
I would be completely against this	11.02%	9.8%		11.7%	

I would be in favour of more full-time jobs even if it meant it was more likely that full-timers had to work on statutory holidays

Response	Overall Result	Full-Time Staff Only		Part-Time Staff Only	
Absolutely, no doubt	30.77%	10.2%	Positive: 36.7%	45.6%	Positive: 79.4%
I'd agree with this, with some reservations	30.77%	26.5%		33.8%	
I'd tend to disagree with this	24.79%	34.7%	Negative: 63.3%	17.7%	Negative: 20.6%
I would be completely against this	13.68%	28.6%		2.9%	

I would be in favour of more full-time jobs even if it meant that schedules may not be as individualized and tailored to the community inclusion activities of persons served.

Response	Overall Result	Full-Time Staff Only		Part-Time Staff Only	
Absolutely, no doubt	20.51%	10.2%	Positive: 49%	28.3%	Positive: 77.5%
I'd agree with this, with some reservations	44.44%	38.8%		49.2%	
I'd tend to disagree with this	29.91%	44.8%	Negative: 51%	17.7%	Negative: 22.7%
I would be completely against this	5.13%	6.2%		4.8%	

Surveys— Staff Retention Task Force

I would be in favour of more full-time jobs even if it meant that split shifts were a regular part of the work.

Response	Overall Result	Full-Time Staff Only		Part-Time Staff Only	
Absolutely, no doubt	13.68%	8%	Positive: 24%	17.6%	Positive: 39.7%
I'd agree with this, with some reservations	18.8%	16%		22.1%	
I'd tend to disagree with this	26.5%	22%	Negative: 76%	29.4%	Negative: 60.3%
I would be completely against this	41.03%	54%		30.9%	

I would be more likely to stay with the agency if I could work in more than one division of service.

Response	Overall Result	Full-Time Staff Only	Part-Time Staff Only
I would be more likely to stay	40.52%	26%	50.8%
It wouldn't impact me one way or the other	43.1%	52%	36.9%
I would be less likely to stay- I wouldn't want to work in multiple service divisions	16.38%	22%	12.3%

I would be more likely to stay with the agency if there were fewer short shifts.

Response	Overall Result	Full-Time Staff Only	Part-Time Staff Only
I would be more likely to stay	33.91%	28.3%	36.9%
It wouldn't impact me one way or the other	62.61%	69.8%	58.5%
I would be less likely to stay- I wouldn't want to work in multiple service divisions	3.48%	1.9%	4.6%

Surveys— Staff Retention Task Force

I would appreciate staff recognition in the following ways (Respondents were asked to rank order. In the chart below, the 'score' is the weighted score of the rank ordering, with higher numbers meaning more important).

Consideration	Score	Comments
Letter/Card	4.17	Part-time staff rated 'private conversation highest', followed by 'letter/card'. Full-time staff had these two the other way. The order of all other choices was the same.
Private Conversation with Supervisor	4.16	
Combox Message	4.12	
Personal Call from Supervisor	3.67	
Recognition at a Staff Meeting	3.49	
Public Event	1.89	

I would be less likely to call in sick if the sick bonus was significantly higher.

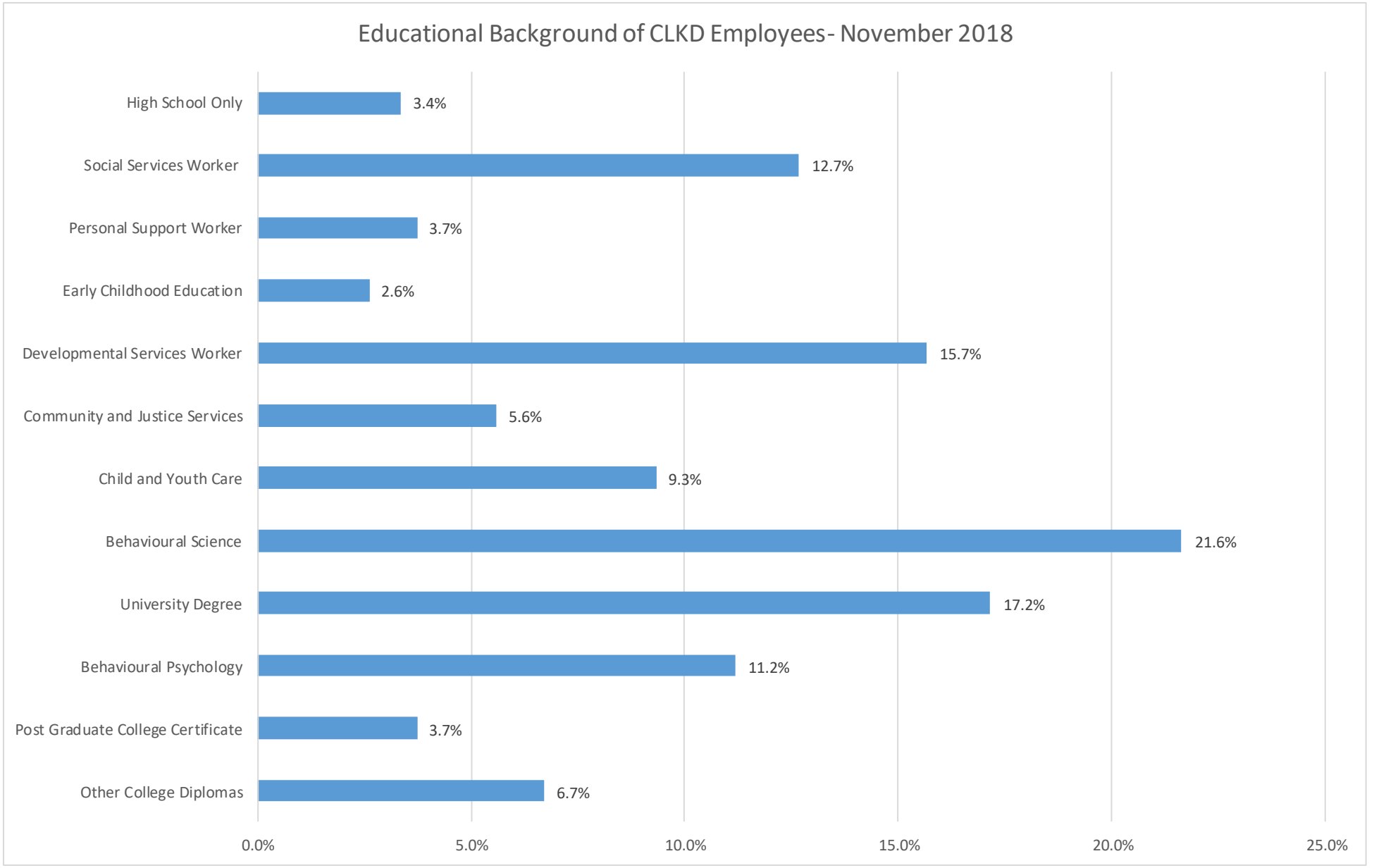
Response	Result	Full Time Only		Part-Time Staff Only	
Completely Agree	23.01%	16%	Positive Response: 52%	28.1%	Positive: 54.7%
Somewhat Agree	30.97%	36%		26.6%	
Somewhat Disagree	16.81%	14%	Negative Response: 48%	20.3%	Negative: 45.3%
Completely Disagree	29.2%	34%		25%	

Common themes on how to make staff more comfortable with personal care:

Time/Mentoring: More time with senior staff on how to do personal care routines with persons served. Observed that this is an intimidating part of the work for many and that proper mentoring is needed. Also observed that this would allow the person served to become more comfortable with the new staff member.

Training: Maybe some more 'dedicated' training around personal care principles, the philosophy behind it, etc.

Colleges: Increase efforts to get into classrooms to discuss personal care as a reality of the work.



Notes

- Many staff have multiple credentials. As such, totals will add up to more than 100%
- *Post-Graduate College Diploma* includes Autism and Behavioural Science and Early Childhood Resource Consultant
- Among the *Other College Diplomas* noted: Community Support Worker, Creative Arts, Health Care Aid, Mechanical Engineering Tech, Police Foundations

Comparison to 2017

- SSW down 2.7%, DSW down 1.7%, CJS up .0.7%, CYC up 1.0%, Behaviour Science up 2.8%, Behavioural Psychology up 2.6%, University Degree up 0.7%, PSW up 0.3%

Data Integrity Assurance

A great deal of time and effort goes into collecting the data that is summarized in the preceding pages. However, the collection and summarizing of the data is meaningless if the collected data lacks integrity. A strong agency uses its data to assist in organizational decision-making. Simply put, data that is not accurate or consistent means that this decision making is being done with bad information. As a result, the right decisions cannot be made. Fortunately, some simple processes can ensure the integrity of the organization's data. *Some* of Community Living Kingston and District's processes are noted below.

Reliability is meant to ensure that data is collected consistently and in a way that could be reproduced at another time and by other people. Because the organization does not use standardized tests or measures that can ensure reliability, other steps have been taken:

- Very few personnel are entrusted to tracking data. This tighter circle of staff limits misinterpretation.
- For all self-reporting measures with some amount of subjectivity, discussions with the team have occurred as to how to ensure that data is coded properly.
- Most data is gleaned directly from reporting functions in the organization's payroll or client records software, virtually eliminating any danger of the data not being collected the same way on another occasion.
- Unless otherwise noted, data measures all persons served, not just a sample. This means that reliability issues related to data sampling are not a factor.

Validity simply suggests that the your data measures what it intends to measure.

- The organization's data is reflective of the needs of stakeholders as gleaned from ISAs and plans, and is reflective of the agency's mission and values.
- The organization's focus is not clinical in nature. It depends on the face validity of it's measure— that is, does common sense indicate that the measure makes sense to address the area of concern? This face validity is achieved by having various parties from outside the program review measures to determine if they seem to make sense.

Completeness means that the data is as complete as possible and that obtainable data is not missing, be it intentionally or unintentionally. Incomplete data has little value, as it may exclude entire groups of persons served or may be missing data that will greatly influence success towards missing a target.

- The number of client records in all spreadsheets is routinely checked against the overall list of persons served to ensure that data is complete.
- All programs have an indicator and no groups are missing from data collection or analysis.
- All attempts are made to find any missing data. Any data that continues to be missing is properly coded in Excel (using the #n/a function, where Excel is still used) so that the program can process the available data properly.

Accuracy simply means that all data is recorded properly and that any errors are caught and corrected.

- Spot checks are completed by the Quality Improvement Lead to ensure accuracy. This includes a review of distribution of values (when Excel is used)
- Where Excel is used, a frequency distribution of values is run in Excel to look for any values suspected of being inaccurate or outside of normal distribution.

Note about trends in this report: For several measures, it is noted in this report that no trends were available because it was the first year that the measure was in place. This is the result of a review of measures in 2018 that was completed with program Managers so as to ensure that many of the older measures that had been in place for some time were still relevant. In many cases, new measures that were reflective of current needs were implemented and old ones discarded.

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Visit our website: www.communitylivingkingston.org

If you have questions about this report, or if you would like this information in an alternate format, please contact Jeff Harrison (jeffrey.harrison@clkingston.ca). You may also wish to review our Outcomes Report Card, which presents this information in a simplified manner. The Outcomes Report Card can be found on the agency's website.