COMMUNITY LIVING
Kingston and District
Inspiring Possibilities

Quality Improvement Report 2017

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Community Living Kingston and District is a CARF-accredited organization

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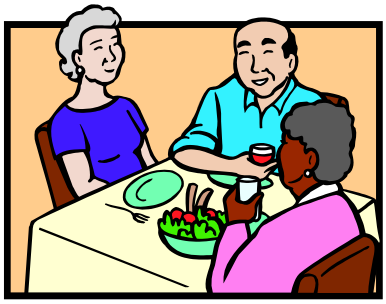
Alternate Format Availability

Understanding This Report

It is the goal of Community Living Kingston and District to ensure that everyone can access this report in a way that meets their needs. If you require this information in an alternate format, please contact Community Living Kingston and District and we will provide the information in a way that suits your needs.

This report is like a report card. It says what we do and how we do it. It tells you what we think we do well and what we want to do better.



If this report is hard to understand

- Call Community Living Kingston and District and ask for the information in a different format.
- Ask a support worker, friend, or a family member for help if you want to know more about what this report says.

If you would like a simpler overview of what is in this report, you may want to look at the Quality Improvement Report Card, which can be found on our website at www.communitylivingkingston.org.

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.

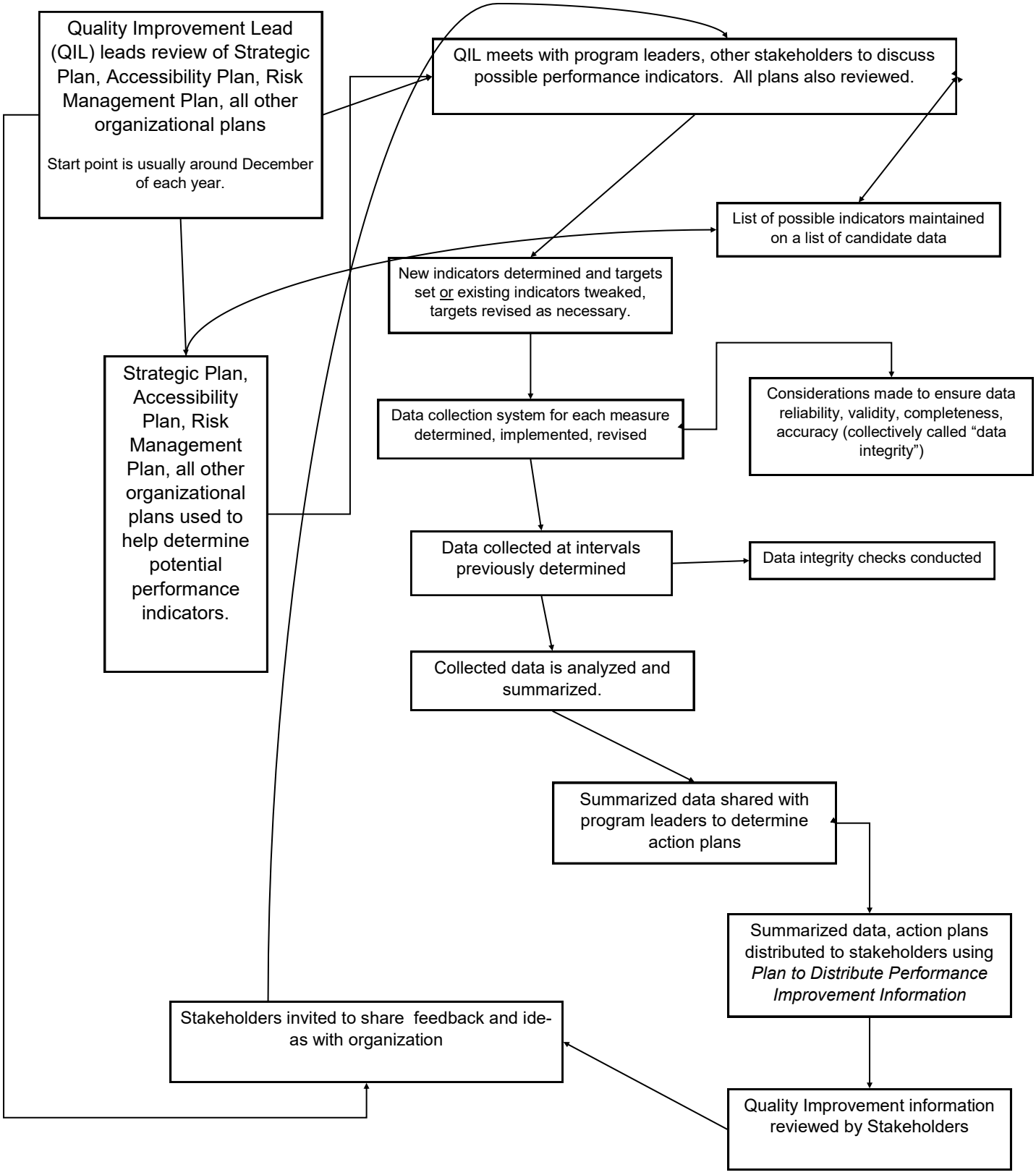
The mission of Community Living Kingston and District is to ensure that people with intellectual disabilities have every opportunity to participate fully in our community with dignity and independence.

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.	
Supported Independent Living	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.	
Gananoque Services	A variety of services, primary among them being to promote community inclusion and to support people to live as independently as possible.	

Overview of Quality Improvement Process

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



Strategic Plan

Note: This Strategic Plan was developed in 2015 with a number of key stakeholders. Over the course of the 2015 and 2016 calendar years, and into 2017, significant items are being addressed by Strategic Planning Implementation Teams, headed by a member of the Board of Directors and a member of the Management team. Updates have been provided to the Board on a regular basis accordingly.

Renewing Our Strategic Plan

Introduction

In January 2014, the Board of Directors at Community Living Kingston and District initiated a process to renew the association's strategic plan. The goal of the process is not simply to generate a "Plan" with strategies, tactics, and timelines. Rather, the core objective is to engage a broad range of board members, managers, staff, and people supported, families and other stakeholders in strategic thinking, strategic actions, and strategic learning. Specifically, we launched this initiative with four key objectives in mind:

-Support proactive and innovative activities by Community Living Kingston and District in partnership with key stakeholders.

-Engage families, staff, and people supported in a process of organizational renewal.

-Clarify the nature of the challenges and opportunities facing the organization and the broader community living movement.

-Renew the "Strategic Directions" of the organizations and chart priority areas for the next three years.

Our Goal

That people with intellectual disabilities have every opportunity to participate fully in our community with dignity and independence.

Value-based Objectives

1. Children have the opportunity to grow up in a safe and nurturing family.
2. Children are able to live in their own neighborhood, attend local schools with their peers, and participate in all aspects of school life in a meaningful way.
3. Every person has an opportunity for meaningful work and fair compensation.
4. Every person is able to live in a safe and secure home with others of their choosing without interference or prejudice.
5. Individuals have full access to any organized supports and services from which they might benefit and control over the manner in which they are provided.
6. Every person institutionalized because of an intellectual disability will return to community life.
7. Human, organizational and material resources are secured to achieve the objectives of the Association.
8. The objectives of the Association be made visible, understood and accepted within the general community.

Mandate

Community Living Kingston and District is contractually mandated to provide a range of services and programs funded by the provincial and municipal governments. However, Community Living Kingston & District has a much broader mandate than to simply provide government funded services – our mandate calls us to develop inclusive communities, create opportunities for people with intellectual disabilities, and support families.

Stakeholder Participation

To begin the process, a series of consultation meetings have been held with a variety of stakeholder groups. The consultation meetings have generally lasted an hour on average. The conversations focus on three questions: 1) what's working? Sharing stories of accomplishments, motivations for the work and strengths of the organization; 2) what's not working? Key challenges faced individually and organizationally; and 3) Priority areas for action – what is to be done? To date, the consultations have been held with the following stakeholder groups:

Stakeholder consultations

Bayswater Program

Gananoque board of directors and staff

Board finance committee

Board education committee

Residential coordinators, facilitators & part-time staff

Community Inclusion Program

Family Home program

Child care resource

Supported Independent Living

Y.W.C. Coop & KWIK Shred

People First

Families

Volunteer services

People supported in residences

Family support

Management team members

CUPE Local officers

DSO

Building on our Strengths

Living the vision and values

There is a tremendous sense of pride in the organization expressed across all the stakeholder groups. As expressed by several employee groups, Community Living "walks the talk" and "lives by its values." Such common core values builds commitment to the organization and remains the foundational cornerstone. The organization works in the best interest of families and the people supported. There is a tangible sense among stakeholders that the organization is person-centred and family / community focused. The culture and living philosophy of Community Living Kingston and District is recognized as a vital asset.

Personal and community growth

Supporting the growth of the people supported, seeing their smiles, and supporting them to make their own decisions was consistently described as what is working best at Community Living. Growth is not a one-way experience and direct support professionals discussed the growth they have experienced. The variety in the work done and the trust from management to try things outside of the box was consistently a highly valued aspect of what is working well. People share tremendous sense of pride of accomplishments. Accomplishments what they are able to do, what the organization does, but most of all, what people supported accomplish in their lives. Sharing these stories happens informally, but not systematically across the organization.

Flexibility

There is a strong sense that flexibility is a key driver of success in the organization. Flexibility applies to a variety of different situations and practices. Flexibility around funding envelops, flexibility in plans, flexibility in support plans and work processes, etc. The ability to "work outside the box" is a core competency of staff and supporting such a creative, "can do" approach is a critical strength in the management team. Another cultural asset of the organization is management's demonstrated commitment to the "can do" motivation that makes the organization agile and flexible.

Organizational support

Staff and families both expressed a strong sense of feeling supported by the organization. There is loyalty that flows in both directions throughout much of the organization. Such feelings of organizational support are a significant source of strength for the organization. Management is nearly universally recognized for the tremendous sense of support they convey to staff and have built into the culture of the organization. The culture has been one of an open door policy and very approachable management team. Where such feelings breakdown, and stakeholders do not feel like they are part of the team, presents an important strategic challenge as discussed below. Communication is at the heart of these challenges, but strategically, as the organization has grown, an open door policy will increasingly need to be replaced with a conscious, proactive strategy to protect and build on this cultural asset.

Trust and integrity

At the foundation of the feelings of organizational support were expressions of trust and integrity. "Managers trust us to make good decisions…" Most striking were multiple examples of the trust that families had for the individual staff in the organization. The ability to respond and support families in a non-bureaucratic way; a relationship-building approach that gets to know individual people supported and the complex and sometimes chaotic lives that families lead is essential to living the vision of the organization. Relationships with other agencies are both a critical strength and a significant challenge for stakeholders in the organization. There have been many excellent examples of high-trust partnerships with other stakeholders.

Addressing Our Challenges

Workload

The feeling of being stretched thin was nearly universal across all stakeholders. The primary driver identified has been the increased requirements around documentation and reporting. (Nucleus has made a significant difference, but workload remains a critical concern.) A second challenge in this regard concerns staffing levels and staffing ratios. The chronic underfunding and financial constraints have clearly impacted the organization in this regard. Many people expressed the feeling of compromising quality time and individualization to manage the increased workload. The organization has made many strategic adjustments in policies and procedures, but resource limits have impacted the quality of services and relationships throughout the organization.

Communication

Investment in Nucleus has resulted in tremendous improvements in the efficiency and effectiveness of information exchange. However, communication remained a key challenge expressed by many stakeholders. Communication has strategic implications for working effectively as a team. Communication strategies and practices are central to building trust and maintaining relationships with families and people supported. Direct support professionals with part-time schedules may feel excluded from this sense of teamwork. Communication challenges across programs also pose significant risks to a sense of teamwork as a person-centred, rather than a program boundary-based, organization. Sharing stories of success and challenge internally is also a challenge, again, particularly as the organization has grown. External communication is also a strategic concern. First, communicating organizational decisions with key stakeholders is a challenge given workload pressures but essential to maintain trust. Second, communicating our stories to the broader community and enhancing our relationships with families not receiving services and other external stakeholders emerged as a key strategic issue.

Planning processes

Challenges were expressed around the life planning process in terms of the time, skills, and mechanics of developing the plans (not in all cases). In the most challenging examples, there were feelings that planning was a barrier to living and the rigidity of goals setting worked at cross purposes with the flexibility of creativity and innovation. Communicating changes in services were raised as a challenge from both the staff and family perspectives. Communicating how to implement activities in pursuit of goals or other initiative arising from life plans were identified as a challenge, (e.g. a facilitator may become frustrated that certain plans are not carried out while part-time staff may feel frustrated that the reasons for doing certain things are not clearly explained).

Clinical needs

There is a wide-spread feeling that support needs, especially in relation to an aging population, are increasing the clinical challenges on staff and space. The organization (and the service system) is not well positioned to support an aging population and there were strong feelings expressed that seeing people supported go into a long-term care facility sometimes felt like a failure on behalf of the organization and the entire system of services. At the same time, aging is a natural part of the life cycle and the challenges of supporting aging adults is not unique to CLK&D. Indeed the people we support in LTC facilities have better support than the general population. Challenging the institutional framework for LTC is a natural and healthy feeling for our organization. Exploring how we can best support people, especially those with age-related health needs, will be an increasing challenge for the organization.

Space

Program and residential space needs were raised in a number of consultations. The challenge of affordable housing is not unique to CLK&D, however, there was a broader sense that the limited number of current models for residential supports is a major barrier to advancing the organization's mission. Cost constraints and concerns over pressures for more congregate settings were voiced by a number of key stakeholders across the organization and beyond.

Information & technology

Nucleus has made a significant improvement to communication and information management, but challenges still exist that may be addressed by further exploiting the use of technology. First, documentation workloads were generally reported to exceed the allocated time, resulting in bringing work home or working off the clock. Second, there is still room for improving proficiency in the use of Nucleus, especially in identifying ways to leverage how this technology can improve communication, relationship management and workflow.

Succession planning, professional development and a sustainable career

The high level of organizational commitment and long tenure of many employees is a clear indicator of strength. At the same time these characteristics highlight several important challenges, succession planning and professional development. These challenges are well-known to the organization and management is constantly exploring ways to support professional development and opportunities for growth. More generally from employee surveys in the sector, we know that from the perspective of direct support professionals, opportunities for advancement generally appear very limited and job satisfaction tends to be lowest in this area. There are several key challenges which are not unique to CLK&K. How might the organization better support a comprehensive succession planning and professional development program. A wide range of challenges are associated with this strategic issue including:

Professional growth in the current role (not just advancement up the supervisory hierarchy)

Systemic and organization-wide program for succession planning

Greater stability and predictability of work hours among pert-time employees

Fair compensation practices at all levels of the organization

Accessible and flexible supports and services

Over 200 individuals and families have urgent and unmet needs according to the regional DSO. Over 400 are on the waitlist for services and this number includes only those who have completed the DSO process. Many stakeholders discussed the challenges related to the lack of accessibility (mostly due to cost) and flexibility in the supports and services offered by CLK&D. There is a trade-off between stretching resources to support more families and the individualization and quality of services. The challenge is to expand capacity through multiple strategies: agitating for more resources from government, generating alternate sources of revenue for greater capacity, and developing greater community capacity through natural support and social capital.

More generally, the long waitlists and number of families without a service connection with CLK&D creates challenges for the relevance of CLK&D to these primary stakeholders. The organization is incredibly skilled and dedicated to finding and advocating for services these families, especially those in crisis. But we run the risk of being seen as solely as a service provider, an extension of government with little relevance to families if we do not have the capacity to offer accessible services. This sense of grassroots purpose is a strong part of the CLK&D culture but the pressures from limited capacity and long waitlists means we must constantly nurture the community organizing culture within the association.

Moving Forward– Identifying Key Strategic Issues

Based on the consultations, the Planning and Priorities Committee worked to identify a number of key strategic issues. The strategic issues were framed as questions and organized into a number of categories building off the existing strategic directions of the organization:

Services and supports

Strategic partnerships

Human Resource Management

Information and Communication Technologies

Financial Management

The Board of Directors, managers and coordinators at CLK & D provided feedback on the draft list of individual strategic issues. These groups conducted an exercise to identify the particular issue that they felt was the most important. Board members and managers had an opportunity to state why that issue was important. (It is recommended that this exercise be conducted more broadly throughout the organization.) The comments and priorities are recorded below each strategic issue listed below. Comments in bold reflected a "top priority" issue for that participant.

Services and supports

Can CLK&D create employment and volunteer opportunities through social enterprise or similar initiatives?

Board priority (1)

Management priority (1)

Create more job opportunities or "small business" ventures. Perhaps consider how to support individuals in a home based business.

Important because this is part of what we should do to further our mission and we are doing less of this in some areas than we used to and there is a lack of support for this in the community or a one size fits all approach.

How can CLK&D foster and support alternative housing options.

Board priority (2)

Management priority (2)

Assistance to find / build "affordable" apartments in the community for people we support. Perhaps building such an apartment complex with supports?

We do not have enough housing options both in terms of / of spaces and a range of options to meet a variety of individual / family needs & desires. I would add respite option to this question recognizing that "a quality break" can influence longer term planning.

We must be proactive in creating more affordable housing or lobby strongly for an increase to rental subsidies thru ODSP. If people do not have a safe, affordable nurturing home "space" they will not be as able to integrate successfully in the community. Quality of life issue.

Funding restrictions necessitate the need to creative alternatives.

To be able to offer more housing opportunities to people served.

How can we enhance information management practices through Nucleus?

How could we meet the demand for more flexible and alternative services and supports?

Board priority (5)

Management priority (6)

Continue strength of providing choice to individuals, especially in dealing with changing needs.

Walking the talk – no cookie cutter solutions. Person-centred, addresses the need while also potentially building skills and independence. Broaden thinking as more opportunities are tried and tested.

We need to be responsive to a growing diversity of needs. Individual funding will require us to be increasingly flexible about how we provide supports.

Family want support to coordinate services / supports. Worry of informal and unregulated services being ineffective, a care model or worse (people will be vulnerable). Families and people who receive support need services when and how they want.

Each person is an individual with different needs and we should be open to how services are delivered taking into account funding restrictions, therefore "thinking outside the box" on service delivery.

Because this is what we should always be about – shaping our service to meet the diverse needs of people rather than trying to shape people to fit into the service we currently offer.

People don't want or need traditional supports, we need to respond individually every time – not compromise on what's important for someone to have a good life. Each person, each family has different values, priorities and has to be met "where they are at"

We need to be able to respond to more diverse needs and do things differently. Go after more / different dollars and don't give up.

What do people want? How do we deliver it? Will this create jobs / professional development?

To address current and changing needs in the community and to be prepared with creative support plans.

Because families want choice and should have options.

How to respond to the sudden influx of SSAH and Passport dollars?

Management priority (3)

Advertise more on the CHAP program. A lot of families still don't' know about the program. Also, inform staff to this working opportunity.

Key to future supports. Have had to dilute service quality somewhat to respond to limited passport allocations already – fresh ideas would be great. Infrastructure will be needed to deal with this, supervisors, facilitators, space, etc.

This is huge. We need to inform families of our culture & values @ CLK & D ("sell our services and supports" or why they should purchase services from us!. The huge concerns is can we deliver – our costs to provide service are high – families can purchase services elsewhere for a lower cost and will this decrease professionalism in the field – cheaper costs lead to more hours of service but at what cost or is it?

Strategic Partnerships

How can we better manage community assets, opportunities, and allies?

There are a lot of community assets & allies that need to be identified and pursued.

Mapping of community assets, opportunities & allies. We will accomplish more through collaboration and building solid working relationships with community partners. That includes knowing who they are, what they offer, how they can / can't stretch / be flexible. It is important to understand "systems" in order to access the most effective / responsive services for families & individuals.

If we have a better way of tracking this, we can be more efficient rather than having several people researching the same thing. Will increase opportunities for people supported by staff that maybe aren't so good at this. Will help identify where we need to work harder.

How can we improve our relationship management practices with external stakeholders?

Leverage what we have in Nucleus.

How can CLK&D support and nurture the development of a family network in our community?

Board priority (2)

Management priority (1)

Need to think about what is the value proposition for CLK&D membership.

Support and create more independent living situations for individuals who wish to live on their own (not in a group situation). Apartments or "in-law" suites in people's homes that are safe.

Families will focus the direction of the agency and take ownership. Agency needs to have separate identity from Ministry. Families need to keep their voice about issues that are important.

Families / individuals need to be invested in outcomes. Once need identified then can attach $ supports – allow for creativity to come with solutions.

To solidify and maintain family connections.

So that families don't fall through the cracks. So they have an agency to turn to when emerging needs arise.

Strength from each other, complimentary strengths/skills; stronger voice to inform, advocate to government; less professionalization in people's lives; to lead and direct professional supports

How can CLK&D enhance the role of support for the local People First chapter?

Board priority (1)

Human Resource Management

How might core competencies training support our organizational mission and culture?

How can we develop more formal succession planning/talent management practices?

Manager priority (2)

We will lose a lot of history, knowledge, skills if we don't take this issue seriously. Perhaps see if some people will self-identify and then match with mentors.

We will have a number of key employees leaving the organization in the next 5 – 15 years. Succession planning / talent development is critical to ensure continuity of mission and purpose.

Strong commitment of long-term staff is wonderful, but also an area of vulnerability & longevity of this great organization.

We need to ensure that the organization continues to be person-centred and that the leadership has a socialistic base.

Can be done well. We have good staff who can be in new positions.

As an organization, we must invest in the development of our younger staff by building their skills and providing them with opportunities for growth. This will allow the organization to continue to grow and it will give our staff the opportunities they want – to use their full potential to develop themselves professionally and to find their own professional self-worth.

Cannot deliver high-level support without having the right people at the helm.

Will have mass exodus from key positions in next 5 – 10 years.

Sustainable careers for DSPs very important.

How Can We Improve Our Professional Development Programs?

We need to maintain skills and knowledge that keeps pace with our changing times; evidence based practices and societal trends (family expectations, needs, desires). We need to be able to communicate and plan effectively and one way of enhancing this is through understanding the issues and developing a professional skill set.

How can we better support a sense of cohesive teamwork across the organization?

Manager priority (1)

Need to increase team building within the association as a whole.

Need team building within our staff teams.

Impacts the quality of support. Broader appreciation of what agency does well. Job satisfaction and employee retention. Creates inclusive environment for all.

Departments are silos; would contribute to better info about internal and community assets. People we serve do not live in silos, e.g. 9-3 community options, 3 – 9 residential.

How can CLK&D support and enhance the person-centred culture of the organization?

Manager priority (2)

Person-centred must be the theme across all strategic points – this should not have to be seen as an added responsibility

"Keep it simple" - personal so that everyone will know each person's goals – which usually are not huge!

Communication and Information Strategies

How can we improve our internal communication practices?

More sideways info to staff about the different programs / successes we have.

More info to staff re:

-Board of directors & what it does

-How does non-profit agency define us

-Distribute Peter's ED report to the board throughout the organization for "best practice communication to all.

We need all employees, persons served and families to operate from the same level of information

-Helps people feel included and understand rationale better when decisions are made

Leaves room for more feedback and exploration of ideas (many minds think better than one)

We need to excel in this area to be able to move forward, expressing our needs wants and thoughts in a clear professional and reliable manner.

Develop more ways of communicating with families of individuals, especially those who are new to Community Living.

How can we improve our external communication strategies?

To support #1 priority of flexible and alternate services.

To "sell" our organization as being a person-centred organization

To enhance the community's capacity to be better at inclusivity for all.

Membership awareness as well as community visibility

Need dedicated staff member to lead communications as core responsibility no add on role.

So the public knows who we are and out mission.

So families have info to make decisions about community supports.

How can we improve the efficiency and effectiveness of our Information management practices?

More / better IT support for the office and front line staff at the homes.

We currently collect a lot of info, we need to make sure that we collect the right info and use it strategically,

More support awareness

Continue to be marketable in service, become preferred service

Have an obligation to keep families informed of services so choices can be made

Prevent abuse / neglect

Financial Management

How can we diversify our revenue?

Board priority (2)

Management priority (1)

MCSS and City of Kingston funding has guidelines for how to spend the monies provided. May need new money to fund initiatives outside of eligible activities.

Cost out services and run trials.

Allows organization ability to put funds where needed. Flow with individuals as their needs change.

We are beyond capacity. Extends across many of the other areas of need. Allows us to meet other organizational priorities. Provides room for more flexible, person-centred supports, staff development diversification of services, etc.

This has to be carried across all sectors of the organization. Fee for service / passport. How can we be competitive? Perhaps we need to stress why CLK&D rather than some other.

What Capital Strategies are Needed to Best Address Changing Space and Program Needs?

Management priority (1)

What is our vision re how, where and when to serve people. What are our capacities? What are tactics? What are goals? What will the growth be?

How are we spending our money? We need to review all areas to see where we can improve (save money) be able to use dollars in the needed areas.

Forward thinking approaches to current, emergent needs but with an eye to the future. Invest all stakeholders in the process. Avoid silo approaches in specific pro0gram needs, creates dialogue that extends ideas.

How can we develop more strategic fundraising capacity?

How can CLK&D offer high quality and accessible fee for service programs?

We are now a business. Recognize this and understand this while at the same time we develop relationships and trust.

Next Steps— Implementation Teams and Action Plans

Implementing and sustaining the strategic plan builds on the continuous process of strategic thinking, strategic learning and strategic action.

Select limited number of key strategic issues (priority areas)

Based on the consultations, several issues were identified as strategic priorities by the stakeholders. Some important areas, such as fundraising, were not identified as a strategic priority. Successful implementation is most likely if we "go where the energy is," or pursue strategies that a seen as most salient to families, staff, and people supported.

As a first step, we should identify a limited number of key strategic issues and recruit at least two "champions" to co-lead on the issue. For example, a board member and manager could co-lead

An initial list of priority areas will likely include some of the following key issues:

Alternative residential supports and innovative housing strategies

Flexible and alternative services and supports (We may want to create sub-units for this issue)

Social enterprise strategies for employment and volunteer opportunities

Diversifying community options (participating in community nights and weekends)

Becoming the provider of choice for people and families receiving passport dollars

Financial strategies to support our mission – diversifying our revenue

Succession planning and talent management

Becoming a hub for families – supporting a local family network

Recruit implementation team members as working task group

Not every issue identified as a priority for advancing the organization's mission will require a full team of stakeholders to work on the task, but this approach is recommended for most issues. There are several core principles which should guide the formation and functioning of these working task groups:

Diverse membership – By including direct support professionals, people supported, board members families, community allies and managers, we are more likely to achieve positive outcomes.

Action oriented – The task groups should be action focused, creative, and willing to try new ways of doing things.

Externally focused – An external focus does not mean that we are not concerned about improving current practice, rather most of the initiatives must draw inspiration from families not currently receiving supports, allies with who we may become more deeply engaged with, and ensuring that we advance our mission in ways that brings real value to our community.

Fully discuss & explore nature of the challenge / strategic issue

Defining the problem / challenge will be the first critical step for all of the working groups. While some problems may seem self-evident (lack of alternative housing options), ensuring a full discussion of the nature of the issue among task group members other external allies and stakeholders is still critical. Each task group should consider some of the following actions as part of this important step:

Consultation with subject matter experts and key stakeholders

Explore current practices at other agencies

Survey stakeholders / conduct needs assessment

Articulate vision for success – goals and objectives

What is the vision for success? Thus far in the process of renewing our strategic plan we have identified the key issues, but we have not yet articulated a vision for success. As a second step in the implementation process, each task group should develop a vision for success. While the statement does not need to be lengthy, such a statement should include the following components:

Long term goals

Intermediate objectives

Potential spillover effects, including unintended consequences

Indicators of success

Select strategy & outline activity timeline

Action plans might outline a small pilot project (a small social enterprise initiative) or reflect a larger organizational initiative (a comprehensive succession planning and talent management program). Large or limited action plans, task groups should be action oriented and taking action on good ideas should not wait until the "end" of the group's work, but be an integral part of the process. We will develop an "Action plan template" to make it easy for each task group to be action oriented.

Monitoring, reporting and reviewing activities

Communication was an important theme raised throughout the consultation process. Sharing our plans, celebrating our success and analyzing our shortfalls should be included as a natural and integral part of developing and implementing action plans. This should start with the recruitment of participants, right through the various milestones achieved by the different task groups. The co-champions should share responsibility for managing and monitoring the work of the task groups, but everyone should participate in communicating our work.

Risk Management Plan

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 December 2016. It will be reviewed again in December 2017.

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.

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, Q-Straint) • 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 BT 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.
Results of Actions Used to Manage Risk	• There was one significant injury due to a slip, resulting in a person served suffering a broken collarbone. There were no other major injuries.
New Strategies to be Adopted This Year	• An undefined focus on slips, trips and falls following the completion of this year's trend analysis.

People	
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	• None

People	
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. This was completed with the Smithfield team in November.
Results of Actions to Manage Risk	• There were no major issues related to violence/trauma this year..
New Strategies to be Adopted This Year	None

People	
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.
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.

People	
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
Results of Actions to Manage Risk	• There were no major issues related to abuse/neglect this year..
New Strategies to be Adopted This Year	None

People	
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	• 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) • Injuries 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 receive annual training 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.
Results of Actions Used to Manage Risk	• Bump caps were instituted in 2016 as a direct result of another concussion related to use of accessible vehicles.
New Strategies to be Adopted This Year	Both MSD prevention and safe driving training (via video) will be introduced to staff.

People	
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 for all employees • Policies elated to infection control and pandemic preparedness
Results of Actions Used to Manage Risk	• There were no illness issues of significance this year. However, it did anecdotally appear that mental health leaves increased.
New Strategies to be Adopted This Year	None at this time, though a strategies to help employees manage mental health/stress may need to be developed.

People	
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 • Regular updates from Health Unit provided to employees • Employees informed of persons served that may have communicable diseases • Flu shot clinic held annually
Results of Actions Used to Manage Risk	• There were no issues related to communicable diseases this year.
New Strategies to be Adopted This Year	None

People	
Area of Risk	Employees
Type of Potential Risk	Staff Turnover
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	• Competitive wage and 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.
Results of Actions Used to Manage Risk	• Staff turnover was much higher than usual this year.
New Strategies to be Adopted This Year	None

People	
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

People	
Area of Risk	Employees
Type of Potential Risk	Workplace Violence
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
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 training around workplace violence prevention
Results of Actions Used to Manage Risk	• There were no significant reports of issues related to workplace violence this year..
New Strategies to be Adopted This Year	None

People	
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	None

People	
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 Review of Complaints elsewhere 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 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

Property and Assets	
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.
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	Options to offer employees defensive driving instruction are being explored.

Property and Assets	
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

Property and Assets	
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
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

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
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

Organization	
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 (Likelihood)	Moderate
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

Organization	
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.
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	• Increased coordinated training efforts • Increased requests for clinical supports

Organization	
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 has met with a consultant to look at options to increase membership, or to restructure membership options.
Results of Actions Used to Manage Risk	Low membership continues to be an issue.
New Strategies to be Adopted This Year	Board of Directors currently reviewing membership strategies so as to increase number of members.

Organization	
Area of Risk	Logistical
Type of Potential Risk	Main office location at 1412 Princess (including Options) is slated to move to a new location in 2018. There is a risk that our current landlord could give us notice to move earlier than our new locations are available. There is also a risk of having technical, administrative, and service disruptions that occur over the course of a move.
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	None (newly identified)
Results of Actions Used to Manage Risk	None (newly identified)
New Strategies to be Adopted This Year	• Steering committee to oversee details of a move to be established • Emergency alternate space for Options in case of such a disruption to be discussed with new landlord.

Organization	
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)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	Current invoice form for private work contains language that indicates that CLKD is not the employer.
Results of Actions Used to Manage Risk	None (newly identified)
New Strategies to be Adopted This Year	Legal advice has been solicited. CLKD will adopt some new procedures in order to mitigate the risk.

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

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.

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 2016 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 in six month intervals, with a progress report being posted on the agency website and/or in the agency newsletter. 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. Paper copies will be made available to all those who request the plan (an ad in the newsletter will alert people to this option).

2017 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 2016	- New spaces for the main administrative sites, as well as the Options program, have been identified and will be moved into in the fall of 2018. As such, some issues from the 2016 that are specific to these locations will be removed from the plan, as they will be addressed with the relocation. - At Roosevelt, a ramp was re-built, and side and patio doors were made accessible, at a cost of about $40,000. - Much of the upper floor at Splinter was renovated in part to work towards it being a more accessible home.
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 new 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 MCSS.
Future Goals	**Barrier:** External egress in basement at McMichael is not accessible **Strategies to Remove Barrier:** Re-design required. Drawings have been submitted accordingly. **Potential Obstacles:** Cost, about $80,000 **Persons Responsible:** Wade Wright, Sheri Scott **Target Date:** As funds become available **Barrier:** New locations (main offices, Options) will need accessibility issues previously identified to be addressed. These include: power doors at all entrances, and a light alarm for those that are hearing impaired. **Strategies to Remove Barrier:** Issues will be worked into the redesign **Potential Obstacles:** Unknown costs. **Persons Responsible:** Peter Sproul **Target Date:** September 2018

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 2016	- Co2 location was doubled in size, easing crowding, noise issues.
Standing Items of Concern/Areas needing improvement	None
Future Goals	**Barrier:** General congestion at Options creates an unwelcoming environment for persons served (crowding, noise, etc.) **Strategies to Remove Barrier:** Move scheduled in 2018 **Potential Obstacles:** None **Persons Responsible:** Jeff Harrison **Target Date:** September 2018

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 2016	-Core competencies training completed with all existing staff in 2016
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 2016	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	None

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 work-place 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 2016	-Job postings now reference accommodation requests - Submission for funds from Employment Modernization Fund for increased part-nerships and to dedicate resources to supported employment.
Standing Items of Con-cern/Areas needing improvement	Kwik Shred model requires review in light of MCSS announcement related to shel-tered workshops in December 2015.
Future Goals	**Barrier:** Community employment services are not a fit for individuals with intellectual disabilities. **Strategies to Remove Barriers:** Upcoming agency reorganization will include development of employment program **Potential Barriers:** None **Person(s) Responsible:** Erin Impola **Target Date:** July 2017

Area(s) of Concern	**Communication.** A *communication* barrier looks at anything that inhibits in-formation 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 2016	More Family Support and CCRCS documents converted to French. Lunch and learns for French-speaking staff. Promotional video being designed for CIP to augment written promotional materi-als.
Standing Items of Con-cern/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 or-ganization 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:** Ability to communicate with French-language families seeking service would be somewhat limited. **Strategies to Remove Barrier:** Upgrade French language abilities of targeted staff **Potential Obstacles:** Cost, time **Persons Responsible:** Danielle Carnegie **Target Date:** Ongoing

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 2016	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	None

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 2016	None in a 'broad' way. 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	None

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 2016	Accessibility of website improved, and accessibility section added to site that shows agency efforts to meet OADA requirements. OT assessment completed with a staff member who requires accommodation, and assistive technology purchased based on OT recommendations.
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	None

Area(s) of Concern	**Other.** A barrier that is not easily categorized
Items Addressed In 2016	None completed though implementation team noted in the future goals below was active.
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:** There is a significant lack of affordable housing in Kingston, which impacts persons served tremendously. Moreover, there is a lack of affordable *accessible* housing in Kingston. **Strategies to Remove Barrier:** Implementation team (see Strategic Plan) developed to help address issues. Implementation team is led by Sheri Scott and has ample Board representation. Contacts have been made with City of Kingston, Township of Gananoque, and Frontenac County. Goal is to develop strategic partnerships to help address housing issues. [Note: Sheri Scott has joined the City's accessibility committee]. **Potential Obstacles:** Cost, time, ability to develop partnerships **Persons Responsible:** Implementation Team **Target Date:** Ongoing

Requests for Reasonable Accommodations

There were no requests for reasonable accommodations by stakeholders in the past year. Future requests will be identified, noted and responded to.

Follow-Up

The Accessibility Plan will be reviewed by the Management team at least twice a year.

Technology Plan

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 that 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.

Development of the Technology Plan

The technology plan was developed by Rob Christian in 2007 and has been revised at least annually since then. The technology plan will be updated again no later than March 2018.

Technology Plan for 2017-18

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 that is hosted by a reputable third party and managed by Service First...Total Solutions.
New Items Addressed Since April 2016	None
Future Goals	**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 2018 **Goal:** Implement policy for staff use of the new Ceridian electronic payroll system that will be implemented during spring 2017. **Potential Obstacles:** None **Persons Responsible:** Matt Luck, Jeff Harrison **Target Date:** April 2017 **Goal:** Provide "Security training" to staff as recommended by Service First. **Potential Obstacles:** None **Persons Responsible:** Matt Luck, Jeff Harrison **Target Date:** January 2018

Area(s) of Concern	Assistive 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 CIP sites.
New Items Addressed Since April 2016	None
Future Goals	None

Area(s) of Concern	Virus Protection
Current Practices	The off-site e-mail 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. Staff are restricted (by administrator password) from installing new programs onto CLKD computers. Non-networked computers at CIP are monitored with virus protection managed by Service First.
New Items Addressed Since April 2015	None.
Future Goals	**Goal:** Provide "Security training" to staff as recommended by Service First. **Potential Obstacles:** None **Persons Responsible:** Matt Luck, Jeff Harrison **Target Date:** January 2018

Area(s) of Concern	Disaster Recovery Preparedness and Back-Up Policies
Current Practices	All data and operating system software located on the off-site e-mail exchange server and agency servers are backed up daily using a cloud system that is monitored by Service First...Total Solutions. Information contained on agency servers is also backed up on a daily basis to an imaging device which is monitored by Service First. 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 2016	None
Future Goals	None

Area(s) of Concern	Hardware and Software
Current Practices	All servers are located in a locked, environmentally controlled room All servers and work stations at 1412 Princess 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 3-5 years of use, their units are rotated to “non-critical” users with lesser requirements. New computer workstations for critical users are usually purchased every 3-5 years at an approximate cost of $500-$600 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 3-5 years upon recommendation of Service First...Total Solutions. CLKD's internet access is 20Mb/second dedicated wireless. The upload and download speeds are both 20Mb/second. 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. SQL Database supports performance improvements to Attendance Enterprise software Residential locations and remote CIP sites connected to remote network. Nucleus Labs system is monitored by that company, with a contract governing the agreement between them and CLKD.
New Items Addressed Since April 2016	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 remote desktop server was expanded to address existing operational deficiencies. CLKD has worked throughout the year to implement an all in one online HR solution hosted by Ceridian. The transition was expected to take place by spring of 2016 however the project timeline was extended as a result of unexpected resourcing issues that Ceridian encountered with its software development team. Final configuration and testing work is being completed from Jan2017-Mar2017 and the system is now expected to be rolled out during the spring of 2017.
Future Goals	**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 **Target Date:** April 2017

Area(s) of Concern	Other– Oversight
Items Previously Addressed	As previously outlined CLKD has now contracts 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) and policy governance.
Future Goals	**Goal:** Form an internal IT Committee to assess the ongoing performance of the third part service provider as well as collaborate with Service First to make strategic decisions surrounding IT operations and policy governance. **Potential Obstacles:** Recruitment of committee members could be difficult due to limited resources (i.e. available staff hours/expertise) **Persons Responsible:** Peter Sproul, Matt Luck **Target Date:** May 2018, to be assessed on an ongoing basis.

Cultural Competence and Diversity Plan

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 is committed to articulating, honouring and upholding principles respecting the culture and diversity of all persons, including the stakeholders (eg persons served, staff, the community, families) 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 will be sensitive and respectful to the culture and diversity of individuals in regard to the following:

- Language
- Ethnicity/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 or behaviour of any sort that discriminates 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.

2. Overall Approach to Culture and Diversity

Policy Development: Community Living Kingston and District maintains, and will continue to develop policy that clearly outlines the principles and practices of cultural diversity. These include:

- Board Policy #16, Rights of Participants
- HR Policy #1.01, Staff Code of Conduct
- HR Policy #1.03, Hiring
- HR Policy #1.08, Harassment/Sexual Harassment
- HR Policy #2.06, Cultural Competency

This plan was first developed in 2014. It is reviewed and updated annually by Peter Sproul, Executive Director

3. Specific Strategies Related to Cultural Diversity

Issue Specific Initiatives: Initiatives that ensure full inclusion of cultural groups into the activities of the organization will be conducted as appropriate, warranted and necessary. An illustration of this is the initiative that focuses on French Language Services and the goals therein.

Workplace and Service Delivery Accommodations: Community Living Kingston and District will, where reasonable and appropriate, make accommodations to the workplace and within service delivery to enable individuals from particular cultural backgrounds to participate fully in the activities of the organization.

Demographic Data: As a means of understanding and appreciating cultural diversity on a local level, Community Living Kingston and District will routinely collect and analyze data on stakeholder diversity. This will be reported in the Quality Improvement Report to illustrate the importance of diversity in the organization.

Agency Leadership: Community Living Kingston and District will strive to have at least one consumer on the Board of Directors at all times. Consumer representation at the volunteer leadership level of the organization will remain a priority for the organization.

Performance Objectives: Where appropriate, Community Living Kingston and District will set performance targets related to cultural diversity. This will enable the organization to have measurable objectives related to diversity. This will be reported in the Quality Improvement Report along with other performance measures.

Hiring Practices: Community Living Kingston and District will endeavour to hire staff members from various cultural backgrounds. Diversity among the staff will strengthen the organization within the human services sector and will position the Association to offer valued and individually tailored services to a diverse group of stakeholders over time.

Communications: Community Living Kingston and District will work to ensure that internal and external communications (newsletters, Quality Improvement Report, phone system, website) will remain sensitive to issues of language and presented in understandable formats. This will include developing communications in both official languages and offering written material in a manner that is sensitive to the needs and cultural background of stakeholders.

Rights of Participants: Persons served by programs of Community Living Kingston and District will continue to have their rights shared with them prior to the delivery of services and annually thereafter. An annual review of the organization's performance with respect to upholding the rights of the individual will also be conducted. This will include the assurance that rights related to diversity are honoured and respected at all times.

Code of Conduct: The Code of Conduct for all staff members and volunteers will specifically address respect for cultural diversity.

Plan to Secure Input from Stakeholders

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

Year	Persons Served	Staff	Other Stakeholders
2017 and every third year thereafter	In 2016, a project was led by two occupational therapy students from Queen's University, Adrienne Mann and Gemma Pollock. This project saw a group of four persons served become trained to administer surveys to their peers. This is the primary method for persons served to be solicited for feedback.	Staff were not due to be surveyed in 2017. However, given the large amount of turnover in staffing in 2016-17, it was decided that it was an opportune time to solicit feedback related to orientation practices for new staff. A survey was developed for this purpose.	No other stakeholders will be surveyed in 2017.
2018 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. . .
2019 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 family members/advocates.

This plan was reviewed by Jeff Harrison in December 2016 and will be reviewed again no later than December 2017

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	

<u>Note</u>
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 2016 and will be reviewed in November 2017

Review of Organization's Policies and Procedures

Best practices suggest that strong organizations ensure that the full content of their Policies and Procedures manual is reviewed on an annual basis. This is also required by the organization's CARF accreditation. The following document outlines how this practice was completed in 2016-17.

Section 1- General

Policy Number	Policy Name	Review Date	Action Taken (Updated or Remained As Is)	Reviewed By
Resolution 01	Mission Statement	1-Mar-17	Remained As Is	Executive Director
Resolution 02	Membership	1-Mar-17	Remained As Is	Executive Director
Board 01	Board Mandate	1-Mar-17	Remained As Is	Executive Director
Board 02	Role and Responsibilities of the Board	1-Mar-17	Remained As Is	Executive Director
Board 03	Individual Responsibilities of Directors	1-Mar-17	Remained As Is	Executive Director
Board 04	Director's Code of Conduct	1-Mar-17	Remained As Is	Executive Director
Board 05	Education	1-Mar-17	Remained As Is	Executive Director
Board 06	Child Care Resource Consultant Services	1-Mar-17	Remained As Is	Executive Director
Board 07	Finance	1-Mar-17	Remained As Is	Executive Director
Board 08	Policy Governance Model	1-Mar-17	Remained As Is	Executive Director
Board 09	ODSP Trusteeship	1-Mar-17	Remained As Is	Executive Director
Board 10	Financial Requests	1-Mar-17	Remained As Is	Executive Director
Board 11	Leadership Development Bursary	1-Mar-17	Remained As Is	Executive Director
Board 12	Investments	1-Mar-17	Remained As Is	Executive Director
Board 13	Residential Services	1-Mar-17	Remained As Is	Executive Director
Board 14	Volunteer Involvement	1-Mar-17	Remained As Is	Executive Director
Board 15	Family Involvement	1-Mar-17	Remained As Is	Executive Director
Board 16	Rights of Participants	1-Mar-17	Remained As Is	Executive Director
Board 17	Succession Planning	1-Mar-17	Remained As Is	Executive Director
Board 18	Ethical Code of Corporate Responsibility	31-May-16	Updated	Executive Director
Board 19	Executive Director Role and Compensation	1-Mar-17	Remained As Is	Executive Director
Board 20	Board Orientation, Education and Development	1-Mar-17	Remained As Is	Executive Director
Board 21	Supply Chain Board of Ethics	1-Mar-17	Remained As Is	Executive Director
GA 01	Privacy	1-Mar-17	Remained As Is	Executive Director
GA 02	Search Warrant, Summons, Subpoena, and Investigations	1-Mar-17	Remained As Is	Executive Director
GA 03	Prevention of Waste, Fraud, Abuse, and Wrongdoing	1-Mar-17	Remained As Is	Executive Director
GA 04	Computer and Network Use	1-Mar-17	Remained As Is	Executive Director
GA 05	Organizational Mentoring	1-Mar-17	Remained As Is	Executive Director
GA 06	Logo and Trademarks	1-Mar-17	Remained As Is	Executive Director
GA 07	Media Relations	21-Oct-16	New Policy	Executive Director

Section 2– Operations

Policy Number	Policy Name	Review Date	Action Taken (Updated or Remained As Is)	Reviewed By
1.01	Confidentiality	1-Mar-17	Remained As Is	Operations Team
1.02	Fire Safety	1-Mar-17	Remained As Is	Operations Team
1.03	Home and Property of Persons Served	1-Mar-17	Remained As Is	Operations Team
1.04	Medication Monitoring and Management	May 6 2016 and February 22 2017	Updated	Operations Team
1.05	Finance of Persons Served	1-Mar-17	Remained As Is	Operations Team
1.06	Eligibility, Service Provision and Discharge	July 6 2016	Updated	Operations Team
1.07	Use of Pornography by Persons Served	1-Mar-17	Remained As Is	Operations Team
1.08	Sexuality	1-Mar-17	Remained As Is	Operations Team
1.09	Visitors and Guests	1-Mar-17	Remained As Is	Operations Team
1.10	Pets and Service Animals	1-Mar-17	Remained As Is	Operations Team
1.11	Nutrition	1-Mar-17	Remained As Is	Operations Team
1.12	Values and Attitudes	1-Mar-17	Remained As Is	Operations Team
2.01	Individualized Planning	1-Mar-17	Remained As Is	Operations Team
2.02	French Language Services	1-Mar-17	Remained As Is	Operations Team
2.03	Service Quality	1-Mar-17	Remained As Is	Operations Team
2.04	Family Home-- Full Time and Respite	August 16 2016 & February 15 2017	Updated	Operations Team
2.05	Abuse of Persons Served	1-Mar-17	Remained As Is	Operations Team
2.06	Safety and Challenging Behaviour	April 12 2016	Updated	Operations Team
2.07	Positive Behaviour Support Plans	April 12 2016	Updated	Operations Team
2.08	Use of Physical Restraint or Intervention	1-Mar-17	Remained As Is	Operations Team
2.09	Safe Lifting and MSD Prevention	1-Mar-17	Remained As Is	Operations Team
2.1	Handling of Persons Served	1-Mar-17	Remained As Is	Operations Team
2.11	Bathing	1-Mar-17	Remained As Is	Operations Team
2.12	Medical Information, Decisions, and Support	1-Mar-17	Remained As Is	Operations Team
3.01	Standard Administrative Practices	September 16 2016	Updated	Director of Finance
3.02	Reporting and Follow-up of Serious Incidents	1-Mar-17	Remained As Is	Operations Team
3.03	Internal Investigation Process	1-Mar-17	Remained As Is	Operations Team
3.04	Records of Persons Served	1-Mar-17	Remained As Is	Operations Team
3.05	Conflict of Interest	April 12 2016	Updated	Operations Team
3.06	Standards for Home Cleanliness	1-Mar-17	Remained As Is	Operations Team
3.07	Smoking	1-Mar-17	Remained As Is	Operations Team
3.08	Complaint Resolution	April 12 2016	Updated	Operations Team
3.09	Purchased Service Arrangements	April 6 2016	Updated	Operations Team
3.10	Enhanced Support Requests-- CCRCS	1-Mar-17	Remained As Is	Operations Team
3.11	Equipment Maintenance	1-Mar-17	Remained As Is	Operations Team
4.01	Emergency Response Process	1-Mar-17	Remained As Is	Operations Team
4.02	Evacuation	1-Mar-17	Remained As Is	Operations Team
4.03	Telephone, Bomb, and Personal Threats	1-Mar-17	Remained As Is	Operations Team
4.04	Natural Disasters and Utility Failures	1-Mar-17	Remained As Is	Operations Team
4.05	Medical Emergencies or Client Distress	May 6 2016 & December 14 2016	Updated	Operations Team
4.06	Violent and Threatening Situations	1-Mar-17	Remained As Is	Operations Team

Section 3– Human Resources

Policy Number	Policy Name	Review Date	Action Taken (Updated or Remained As Is)	Reviewed By
1.01	Staff Code of Conduct	August 16 2016	Updated	HR Director
1.02	Criminal Reference Check	February 15 2017	Updated	HR Director
1.03	Hiring	1-Mar-17	Remained As Is	HR Director
1.04	Orientation	1-Mar-17	Remained As Is	HR Director
1.05	Staff Training	1-Mar-17	Remained As Is	HR Director
1.06	Performance Appraisals	1-Mar-17	Remained As Is	HR Director
1.07	Scheduling Hours of Work	1-Mar-17	Remained As Is	HR Director
1.08	Harassment	September 19 2016	Updated	HR Director
1.09	Alcohol and Drug Use	1-Mar-17	Remained As Is	HR Director
1.1	Vehicles, Transportation and Licensing	June 12 2016	Updated	HR Director
1.11	Benefits While On Leave	1-Mar-17	Remained As Is	HR Director
1.12	Salary Advances	1-Mar-17	Remained As Is	HR Director
1.13	Compensation for Non-Union Employees	1-Mar-17	Remained As Is	HR Director
1.14	Privacy Protection for Employees	1-Mar-17	Remained As Is	HR Director
1.15	Workplace Violence Prevention	September 19 2016	Updated	HR Director
1.16	Discipline	1-Mar-17	Remained As Is	HR Director
1.17	Attendance Management	1-Mar-17	Remained As Is	HR Director
1.18	Use of Social Media	1-Mar-17	Remained As Is	HR Director
1.19	Use of Electronic Records System for Persons Served	1-Mar-17	Remained As Is	HR Director
2.01	Employee Assistance Program	1-Mar-17	Remained As Is	HR Director
2.02	Student and Volunteer Placement	1-Mar-17	Remained As Is	HR Director
2.03	Staff Recognition	1-Mar-17	Remained As Is	HR Director
2.04	Leave for External Work	1-Mar-17	Remained As Is	HR Director
2.05	Self-Funded Leave	1-Mar-17	Remained As Is	HR Director
2.06	Cultural Competency	1-Mar-17	Remained As Is	HR Director
2.07	Personnel Files	1-Mar-17	Remained As Is	HR Director
2.08	Meeting Accessibility Needs of Stakeholders	February 15 2017	Updated and Renamed	CIP Manager
2.09	Talent Management and Succession Planning	January 27 2017	New Policy	HR Director
3.01	Occupational Health and Safety	1-Mar-17	Remained As Is	HR Director
3.02	Joint Health and Safety Committee	1-Mar-17	Remained As Is	HR Director
3.03	Duties and Responsibilities	1-Mar-17	Remained As Is	HR Director
3.04	Workplace Safety and Insurance	1-Mar-17	Remained As Is	HR Director
3.05	Early and Safe Return To Work	1-Mar-17	Remained As Is	HR Director
3.06	Workplace Inspections	1-Mar-17	Remained As Is	HR Director
3.07	Accident Investigations	1-Mar-17	Remained As Is	HR Director
3.08	Work Refusal	1-Mar-17	Remained As Is	HR Director
3.09	Communicable Diseases	1-Mar-17	Remained As Is	HR Director
3.1	Infection Control	1-Mar-17	Remained As Is	HR Director
3.11	WHMIS	1-Mar-17	Remained As Is	HR Director
3.12	Cell Phones and Driving	1-Mar-17	Remained As Is	HR Director
3.13	Slips, Trips, and Falls	1-Mar-17	Remained As Is	HR Director
3.14	Respiratory Protection Program	1-Mar-17	Remained As Is	HR Director
3.15	Pandemic Preparedness and Response Plan	1-Mar-17	Remained As Is	HR Director

Note: All employee job descriptions were also reviewed in 2016

Section 4– Finance

Policy Number	Policy Name	Review Date	Action Taken (Updated or Remained As Is)	Reviewed By
1.01	Distribution of Financial Information	March 1 2017	Remained As Is	Director of Finance
1.02	Conflict of Interest	March 1 2017	Remained As Is	Director of Finance
1.03	Financial Reporting	March 1 2017	Remained As Is	Director of Finance
1.04	Contracts	March 1 2017	Remained As Is	Director of Finance
1.05	Officers and Signing Officers	March 1 2017	Remained As Is	Director of Finance
1.06	Insurance Coverage	March 1 2017	Remained As Is	Director of Finance
1.07	Capital Assets	March 1 2017	Remained As Is	Director of Finance
1.08	Risk Management	March 1 2017	Remained As Is	Director of Finance
2.01	Banking	March 1 2017	Remained As Is	Director of Finance
2.02	Electronic Banking	March 1 2017	Remained As Is	Director of Finance
2.03	Cheque Signing Authority	March 1 2017	Remained As Is	Director of Finance
2.04	Borrowing	March 1 2017	Remained As Is	Director of Finance
2.05	Investments	March 1 2017	Remained As Is	Director of Finance
2.06	Trusts and Specific Purpose Funds	March 1 2017	Remained As Is	Director of Finance
3.01	Budgets	March 1 2017	Remained As Is	Director of Finance
3.02	Authorization to Commit Resources	March 1 2017	Remained As Is	Director of Finance
3.03	Accounts Receivable and Invoicing	March 1 2017	Remained As Is	Director of Finance
3.04	Cash Receipts	March 1 2017	Remained As Is	Director of Finance
3.05	Accounts Payable and Payment Processing	March 1 2017	Remained As Is	Director of Finance
3.06	Travel Expenses	March 1 2017	Remained As Is	Director of Finance
3.07	Petty Cash	March 1 2017	Remained As Is	Director of Finance
3.08	Consumer Directed Funds	March 1 2017	Remained As Is	Director of Finance
3.09	Family Home Program	March 1 2017	Remained As Is	Director of Finance
3.1	Payroll Processing	March 1 2017	Remained As Is	Director of Finance
3.11	Time Sheets	March 1 2017	Remained As Is	Director of Finance
3.12	Fundraising	March 1 2017	Remained As Is	Director of Finance
3.13	Donations	March 1 2017	Remained As Is	Director of Finance
3.14	Donations in Kind	March 1 2017	Remained As Is	Director of Finance
3.15	Capital Donations Terms and Conditions	March 1 2017	Remained As Is	Director of Finance
3.16	Hospitality	March 1 2017	Remained As Is	Director of Finance
3.17	Purchasing and Procurement	March 1 2017	Remained As Is	Director of Finance
3.18	Road Transportation	March 1 2017	Remained As Is	Director of Finance
3.19	Child Care Wage Subsidy Distribution	March 1 2017	Remained As Is	Director of Finance
3.2	CIP Transportation Fee	March 1 2017	Remained As Is	Director of Finance
3.21	Use of Facilities by Outside Organizations	March 1 2017	Remained As Is	Director of Finance
3.22	Purchasing Card Program-US Bank	March 1 2017	Remained As Is	Director of Finance
3.23	Expenses and Perquisites	March 1 2017	Remained As Is	Director of Finance

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 intervention of the program Manager has been requested or required.

Overview

CLKD had three formal complaints in 2016-17, broken down as follows:

Program	Number of Complaints This Year	Number of Complaints Previous Year
Residential Services	2	1
CIP	0	2
CCRCS	0	0
SIL/ESIL	1	0
Family Home	1	3
Respite	0	0
Family Support	0	0
Gananoque	0	0

Total complaints last year: 6
Total complaints this year: 3

Type of Complaint	Number of Complaints This Year	Number of Complaints Last Year
Service Quality	2	4
Complaints about specific staff/individual	0	2
Possible mistreatment or exploitation	2	0

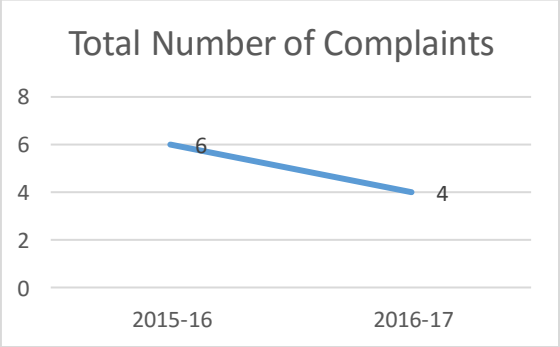
Source of Complaint	Number of Complaints This Year	Number of Complaints Last Year
Family Member	3	6
Staff Member	1	0

Review of Complaints Received

Trends

For many years, CLKD had not logged a formal complaint. However, the threshold for what was considered to be a 'formal' complaint was lowered in 2016 in order to better capture the true quality of our services.

The number of complaints on a year-by-year basis since the definition of what is considered a 'formal' complaint is noted in the chart, right.



Areas Requiring Performance Improvement

Complaints were quite varied and did not settle around any single area that can be easily worked on. Complaints were related to a behaviour support plan, a home layout, possible financial exploitation, and possible mistreatment of a person served.

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

Each situation was handled on a case by case basis. In one case, a formal investigation was launched to examine possible mistreatment, but found none.

Status of Complaints

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

Satisfaction Surveys—Persons Served *(CIP, Family Home, Residential Services, Supported Independent Living, Family Support, Gananoque, Respite)*

Survey Method

In late 2015, CLKD submitted a proposal to Queen's University to secure an Occupational Therapy student who might be able to design a training program whereby a number of persons served could be trained to administer surveys to their peers without staff involvement. This approach was desired by CLKD to minimize response bias, to combat 'survey fatigue' that was building up with respondents, and also because it would be much more empowering for persons served. In early January, two students, Adrienne Mann and Gemma Pollock, started work on the project. By the end of April 2016, four persons served had been trained to administer surveys to their peers. These four persons served continue as peer administrators, with minimal staff support from Laurie McShane to organize times to meet with respondents. Persons served were contacted throughout the year to respond to surveys accordingly.

Target

Questions were framed with three responses: 'Yes', 'No' or 'Maybe'. For each question, the organization sought a positive response rate of at least 80% (a 'positive' response would be 'yes' for all questions except for Question 2, which, because of the way that it is worded, would consider 'no' a positive response). This target was chosen based on responses from the previous year during the survey's pilot period.

Outcome

The charts below outline the responses in each program:

Community Inclusion Programs	Positive	Target Met?
Does CLKD listen to your ideas?	82.4%	Yes
Do you want more freedom at CLKD? ('no' response desired)	13.5%	No
Do the staff at CLKD treat you right?	92.5%	Yes
Do you know what staff to talk to at CLKD if you were mad or sad?	85.2%	Yes
Does CLKD let you be with your friends?	90.6%	Yes

Residential Services	Positive	Target Met?
Does CLKD listen to your ideas?	80.0%	Yes
Do you want more freedom at CLKD? ('no' response desired)	10.0%	No
Do the staff at CLKD treat you right?	75.0%	No
Do you know what staff to talk to at CLKD if you were mad or sad?	80.0%	Yes
Does CLKD let you be with your friends?	85.0%	Yes

Family Home/Respite	Positive	Target Met?
Does CLKD listen to your ideas?	80.0%	Yes
Do you want more freedom at CLKD? ('no' response desired)	14.3%	No
Do the staff at CLKD treat you right?	100.0%	Yes
Do you know what staff to talk to at CLKD if you were mad or sad?	100.0%	Yes
Does CLKD let you be with your friends?	100.0%	Yes

The organization's Board of Directors will review all survey results in September 2017 as part of it's cyclical tasks.

Satisfaction Surveys— Persons Served (CIP, Residential Services, SIL, Family Support, Family Home, Gananoque, Respite)

SIL/ESIL	Positive	Target Met?
Does CLKD listen to your ideas?	100.0%	Yes
Do you want more freedom at CLKD? ('no' response desired)	40.0%	No
Do the staff at CLKD treat you right?	90.0%	Yes
Do you know what staff to talk to at CLKD if you were mad or sad?	90.0%	Yes
Does CLKD let you be with your friends?	100.0%	Yes

Family Support	Positive	Target Met?
Does CLKD listen to your ideas?	83.3%	Yes
Do you want more freedom at CLKD? ('no' response desired)	14.3%	No
Do the staff at CLKD treat you right?	85.7%	Yes
Do you know what staff to talk to at CLKD if you were mad or sad?	85.7%	Yes
Does CLKD let you be with your friends?	100.0%	Yes

- Family Home and Respite results were combined, as there is tremendous overlap between the two services.
- No results were obtained for the Gananoque programs this year. This is largely due to logistical reasons, as survey administration requires a face-to-face meeting that was difficult to set up due to distance.

Limitations

There are a handful of considerations when looking at the data. First, respondent answers are included in each program that they are connected to (i.e, if someone was supported in both Residential and CIP, they were administered only one survey, but their answers are included in each program). Because of the way that data is pulled from Nucleus, it then makes it impossible to complete an agency-wide analysis, as it would include respondent data more than once. It should be noted that data sets for Family Support and SIL are fairly small (n=8 and n=10, respectively).

Key Findings/Trends/Analysis

Across the board, responses are very with the exception of the question "Do you want more freedom at CLKD?". The target connected to this was not met in any of the programs. This was followed up with the four peer administrators. Based on their interviews with persons served, it was their impression that persons served often feel as though they are over-controlled by agency staff, and not given sufficient room to make choices about their lives. [There probably is the possibility that this being the only question requiring a 'no' response as a positive option is slightly confusing to respondents. However, the results will be taken at face value].

A comparison to previous years data is not possible, as this is the first year that this survey format was attempted on a wide-scale basis.

Follow-Up Completed

None formal

Proposed Action Plan

Agency leadership will reinforce the Dignity of Risk with staff members in sharing these results with staff teams, and will use this as a springboard for deeper discussions about respecting the choices and desires of persons served.

Two CIP staff, Alexa Kirkland and Ashley Kelly, are designing a training unit related to age appropriate supports and the importance of allowing choice and freedom for persons served.

Future Monitoring

This survey format will continue in 2017-18.

Satisfaction Surveys— Persons Served— Child Care Resource Consultant Services

Survey Method

Families were provided with the opportunity to complete the survey at the time of their IPP meeting in 2016. A full-scale reminder was distributed in November. While most families were provided with a link to the survey at surveymonkey.com, some were provided paper copies, based on preference.

Response Distribution

Geographic Distribution:	City of Kingston	91.67%
	Township of Frontenac	0%
	Other	8.33%
Length of Time In Service:	Less than six months	12.50%
	Six to twelve months	4.17%
	One to two years	33.33%
	Two or more years	50.00%
Age of Child In Service:	Birth to two years	0.33%
	Two to six years	58.33%
	Older than six years	33.33%

Target

For more than 90% of respondents to indicate an overall satisfaction level of at least above average.

Outcome/Results

Question: Please rate your overall satisfaction with services received through CCRCS:

Outstanding	79.17%
Above Average	16.67%
Satisfactory	4.17%
Unsatisfactory	0.00%

A total of 95.84% of respondents indicated that their satisfaction level was at least above average. Therefore, the target was met.

Limitations

Survey results should be interpreted with caution, as the response rate was only around 12% this year.

The organization's Board of Directors will review all survey results in September 2017 as part of it's cyclical tasks.

Satisfaction Surveys— Persons Served– Child Care Resource Consultant Services

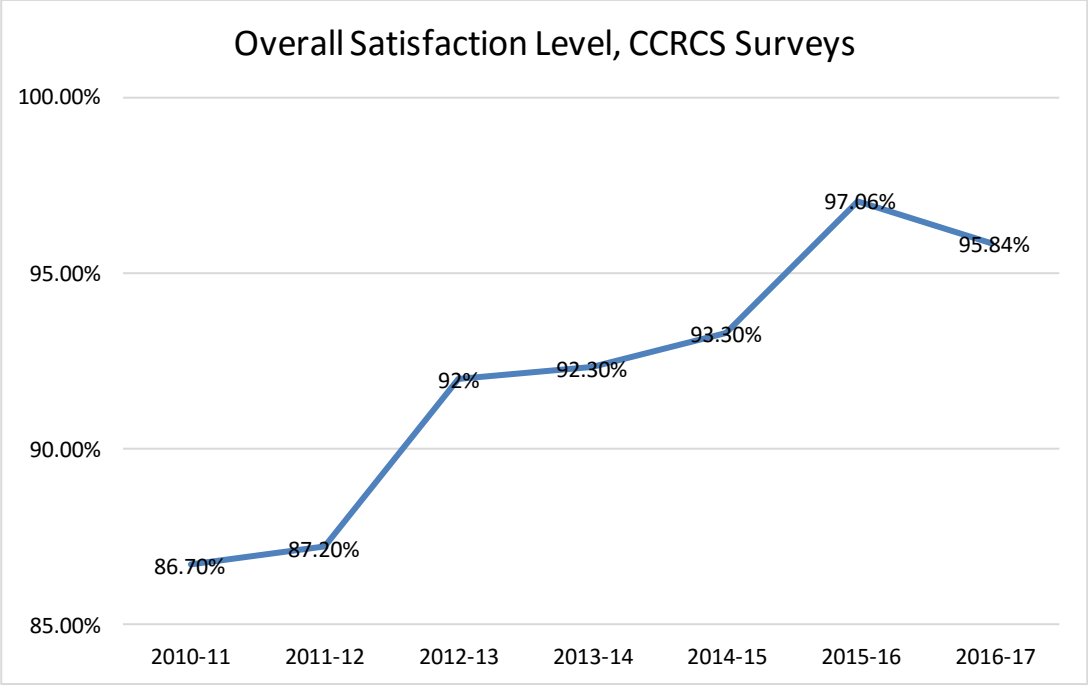
Other Results

Respondents were asked a number of other questions, with the following results showing a comparison to previous years. Percentages indicated 'positive' ratings. (Questions were asked on a yes/no basis).

Question	2013-14	2014-15	2015-16	2016-17
When you first started services, was your intake completed in a timely manner?	96.2%	100.0%	100.0%	100.0%
The Resource Consultant is flexible in meeting our communication needs.	100.0%	100.0%	100.0%	100.0%
The information shared with me by the Resource Consultant is useful.	100.0%	100.0%	100.0%	95.66%
The Resource Consultant treats our family with respect and dignity	100.0%	100.0%	100.0%	100.0%
I am aware the my child has an Individual Program Plan	100.0%	100.0%	91.43%	95.83%
The Resource Consultant was helpful in assisting with our child's transition to school (if applicable)	94.1%	100.00%	100%	94.7%
The Resource Consultant makes us aware of other services in the community as needed.	84.6%	93.30%	100%	87.5%

Key Findings/Trends

Overall satisfaction levels were very similar to last year, and continue to reach the agency goal, as evidenced in the graph below:



Satisfaction Surveys— Persons Served– Child Care Resource Consultant Services

Discussion:
The percentage of families served that rated services as outstanding by increased by 14.6% this year.

Overall satisfaction levels (rating services as 'outstanding' or 'above average' dropped slightly (just over 1.2% this year) after five years of steady escalation. Given the high level of satisfaction, however, this does not cause reason for concern.

As has been the case for several consecutive years, no families reported that service was unsatisfactory.

There was no noticeable variation in satisfaction levels based on demographic factors.

Satisfaction levels were high for all individual questions, though one ("The RC makes us aware of other services in the community as needed") dipped below 90%. There were no comments attached to any responses to this question to give more detail about this.

Follow-Up Completed:
None formal, other than to be vigilant in promoting best practices and to be as responsive as possible to families.

Proposed Action Plan:
Given the high levels of satisfaction, there are no specific areas that require an action plan.

Future Monitoring:
Consumer satisfaction will again be measured in late 2017, with an overall satisfaction level of at least 90%.

Satisfaction Surveys— Staff

Survey Method/Rationale

Staff are identified as stakeholders to be surveyed at least every three years. Because of the larger than usual number of new staff that were hired in 2016, it was decided to develop a survey specific to the orientation practices used with new staff.

Targeted staff were sent a link to a survey at surveymonkey.com.

Response Rate

The survey was sent to 44 staff hired in 2016. There were 22 responses, for a response rate of 50%.

Response Distribution

Residential Services	81.8%
Community Inclusion Programs	22.7%
Community Services	0%

** Note: Staff could select more than one program. Therefore, totals may add up to more than 100%*

Target

For all items to have a positive response rating of at least 85% ('positive rating' meaning a response of either 'Strongly Agree' or 'Mostly Agree').

Outcomes/Result

The results of the survey are noted on the next page.

The target was met in twelve out of nineteen categories.

The organization's Board of Directors will review all survey results in September 2017 as part of it's cyclical tasks.

Question	Strongly Agree	Mostly Agree	Mostly Disagree	Strongly Disagree	Target Met?
The pace of the orientation was appropriate	50%	36.36%	13.64%	0%	Yes
The amount of reading/videos that went with orientation was manageable	66.67%	28.57%	0%	4.76%	Yes
I felt supported by my Coordinator during the orientation process	54.55%	27.27%	13.64%	4.55%	No
I felt supported by my colleagues during the orientation process	68.18%	22.73%	9.09%	0%	Yes
I was provided time to review the personal plans of individuals that I support.	68.18%	27.27%	4.55%	0%	Yes
After the orientation process, I adequately understood the organization's policies and procedures	54.55%	36.36%	9.09%	0%	Yes
After the orientation process, I adequately understood how to administer medications	59.09%	40.91%	0%	0%	Yes
After the orientation process, I adequately understood how to safely lift/re-position persons served.	52.38%	28.57%	19.05%	0%	No
After the orientation process, I adequately understood how to secure persons served in accessible vans (Q-Straints)	61.90%	19.05%	19.05%	0%	No
After the orientation process, I felt comfortable driving the accessible vans	38.10%	33.33%	14.29%	14.29%	No
After the orientation process, I adequately understood how to use Nucleus.	54.55%	40.91%	4.55%	0%	Yes
After the orientation process, I understood expectations around completing daily notes.	72.73%	13.64%	13.64%	0%	Yes
After the orientation process, I adequately understood the purpose of the personal planning process for persons served.	71.43%	14.29%	9.52%	4.76%	Yes
After the orientation process, I felt like I understood how to report suspected abuse of a person served.	50%	31.82%	18.18%	0%	No
After the orientation, I understood the fire safety and evacuation procedures for my location(s)	50%	31.82%	13.64%	4.55%	No
After the orientation, I understood the values of CLKD.	90.91%	9.09%	0%	0%	Yes
After the orientation, I understood the Positive Behaviour Support Plans of individuals I would be supporting	68.18%	18.18%	9.09%	4.55%	Yes
After the orientation process, I felt like I understood the overall needs of the individuals I would be supporting	68.18%	27.27%	4.55%	0%	Yes
After the orientation process, I understood how I would be evaluated by my supervisor in the future	40.91%	27.27%	13.64%	18.18%	No

Selected Comments

Staff were asked to comment on ways to improve the orientation process:

My programs didn't require how to lift people or Q-straints however I began a program that does and haven't gotten those trainings. It may be useful to have a supervisor come with you on one of the first shifts to your location to go over site specific information such as fire and evacuation plans.

Even if all the team members have been helping, I would appreciate to have one worker to refer when I had questions.

The orientation session could occur in a more timely manner. I also felt it was difficult to get the Qstraint training scheduled. I was sent back and forth between my coordinator and the person in charge of Qstraint and felt like a burden when trying to gain access to the video. It has also been very difficult for myself and others to get the appropriate training around blood sugar monitoring which is an essential task we are required to complete in order to ensure individuals we support are healthy.

I feel that for new employees who have never seen an MTAR or administered medication before would benefit from having a training session specifically on medication administration. It can sometimes be overwhelming when you are responsible for something so important, and if the first time you are learning about MTARs and medication administration is in a busy house, that can be quite difficult.

Scheduled time specifically to complete controlled acts training videos. For example, the inhaler training is more than 1.5 hours to complete. This is hard to find time for. I realize the training can be paused, but I don't believe it is as effective if I were to try and rush through a few pages here and there when I could sit down and do it all at once without feeling like I should be doing something with persons served or for the house.

I was not shown the van or any of the locations that people went for programming during orientation so I had to learn these on the fly. The amount of documents and forms that were needed was somewhat overwhelming and hard to keep track of. It would be helpful to have a list of necessary documents and forms on the first day (e.g. drivers abstract, certificates, police check, pay stub, etc.)

Discussion/Action Plan

Overall, the organization was pleased with the results. The organization has decided to zero in on specific areas that the survey results suggested could be improved upon:

- Staff report that they do not feel comfortable driving the accessible vehicles. Subsequent discussions suggest that this is because the vehicles are large and unwieldy and few new staff have experience with this. Going forward, staff will receive a one-hour orientation to the vehicles, including being given the opportunity to drive them without passengers.
- Some staff reported not being sure about the abuse reporting procedures. This will be given increased focus in new staff orientation.
- Some staff reported not being sure how they would be evaluated going forward by their supervisor. The HR Director will spend additional time explaining evaluation processes with new staff.
- The Community Services Division has added training around Q-Straint tie-downs that are specific to one person served in the program.
- The Community Inclusion Programs have started assigning new staff with a mentor staff who can be a single point of contact as they learn about their new job.

Future Monitoring

As set out in the *Plan to Secure Input from Stakeholders*, staff are not due to be surveyed again until 2019.

Characteristics of Persons Served

Demographic Information

		CIP	Residential	Family Home	Respite	SIL/ESIL	Gananoque	CCRCS	Family Support
Number of Persons	2015-16	140	60	27	78	78	26	206	302
	2016-17	152	64	28	95	79	27	197	283
Gender of Persons Served	2015-16	Male: 60.7% Female: 39.3%	Male: 73.3% Female: 26.7%	Male: 59.3% Female: 40.7%	Male: 52.7% Female: 42.3%	Male: 53.8% Female: 46.2%	Male: 61.5% Female: 38.5%	Male: 73.8% Female: 26.2%	Male: 58.3% Female: 41.7%
	2016-17	Male: 64.9% Female: 35.1%	Male: 75% Female: 25%	Male: 60.7% Female: 39.3%	Male: 64.2% Female: 35.8%	Male: 53.2% Female: 46.8%	Male: 62.9% Female: 37.1%	Male: 72.1% Female: 27.9%	Male: 59.7% Female: 40.3%
Age of Persons Served	2015-16	19-29: 21.4% 30-39: 32.1% 40-49: 17.1% 50-59: 10.7% 60-69: 15.0% 70+: 3.5%	19-29: 10% 30-39: 15% 40-49: 16.7% 50-59: 28.3% 60-69: 21.6% 70+: 8.3%	Under 19: 15.4% 19-29: 34.6% 30-39: 23.1% 40-49: 3.9% 50-59: 11.5% 60-69: 11.5% 70+: 3.9%	Under 19: 35.9% 19-29: 32.1% 30-39: 13.8% 40-49: 10.2% 50-59: 7.7% 60-69: 1.3% 70+: 0%	Under 19: 2.6% 19-29: 30.9% 30-39: 19.2% 40-49: 11.5% 50-59: 19.2% 60-69: 7.7% 70+: 8.9%	19-29: 19.2% 30-39 19.2% 40-49: 11.5% 50-59: 15.3% 60-69: 19.2% 70+: 15.3%	0-2: 4.3% 2-4: 27.2% 4-6: 40.1% 6+: 28.2%	Under 19: 47% 19-29: 33.4% 30-39: 10.9% 40-49: 5% 50-59: 2% 60+ 2%
	2016-17	19-29: 19.5% 30-39: 28.6% 40-49: 22.7% 50-59: 11.7% 60-69: 14.3% 70+: 3.2%	Under 19: 7.8% 19-29: 9.4% 30-39: 9.4% 40-49: 18.8% 50-59: 25% 60-69: 21.9% 70+: 7.8%	Under 19: 14.3% 19-29: 39.3% 30-39: 17.9% 40-49: 3.6% 50-59: 10.7% 60-69: 10.7% 70+: 3.6%	Under 19: 32.6% 19-29: 32.6% 30-39: 16.8% 40-49: 8.4% 50-59: 7.4% 60-69: 1.1% 70+: 1.1%	Under 19: 5.1% 19-29: 22.8% 30-39: 19.0% 40-49: 11.4% 50-59: 19.0% 60-69: 13.9% 70+: 8.9%	19-29: 18.5% 30-39: 22.2% 40-49: 11.1% 50-59: 14.8% 60-69: 18.5% 70+: 14.8%	0-2: 1.5% 2-4: 32.5% 4-6: 37.6% 6+: 28.4%	Under 19: 45.2% 19-29: 33.6% 30-39: 12.0% 40-49: 4.2% 50-59: 3.2% 60+ 1.8%
Type of Respite Received or Desired*	2015-16				Family Home: 67.9% Group: 53.8%				
	2016-17				Family Home: 51.8% Group: 64.2%				

* indicates that figures may not add up to 100%, as multiple or no categories could be selected in the original data set.

Characteristics of Persons Served (continued)

Barriers

		CIP	Residential	Family Home	Respite	SIL/ESIL	Gananoque	CCRCS	Family Support
Mobility of Persons Served	2015-16	N/A	N/A	N/A		N/A	N/A		
	2016-17	Require No Assistance: 59.1%	Require No Assistance: 67.2%	Require No Assistance: 63%		Require No Assistance: 70.6%	Require No Assistance: 70.4%		
Communication Style of Person Served	2015-16	Communicates Verbally: 79.3%	Communicates Verbally: 61.6%	Communicates Verbally: 76.9%		Communicates Verbally: 84.5%	Communicates Verbally: 88.5%		
	2016-17	Communicates Verbally: 73.4%	Communicates Verbally: 46.7%	Communicates Verbally: 71.4%		Communicates Verbally: 78.5%	Communicates Verbally: 85.2%		
Transportation Used By Persons Served*	2015-16	Accessible: 37.1% Public Transit: 24.3% Walk/Bike: 10.7% Provided Rides: 67.8%	Accessible: 23.8% Public Transit: 20% Walk/Bike: 3.3% Provided Rides: 85%	Accessible: 25.9% Public Transit: 25.9% Provided Rides: 44.1%		Accessible: 14.1% Public Transit: 56.4% Walk/Bike: 58.9% Provided Rides: 50%	Public Transit: 15.4% Walk/Bike: 73.1% Provided Rides: 73.1% Drives own car: 15.38%		
	2016-17	Accessible: 37.7% Public Transit: 22.7% Walk/Bike: 11.7% Provided Rides: 68.2%	Accessible: 20.3% Public Transit: 25% Walk/Bike: 6.3% Provided Rides: 82.8%	Accessible: 21.4% Public Transit: 32.1% Walk/Bike: 14.3% Provided Rides: 50%		Accessible: 19% Public Transit: 50.6% Walk/Bike: 58.2% Provided Rides: 55.7%	Public Transit: 14.8% Walk/Bike: 74.1% Provided Rides: 74.1% Drives own car: 14.8%		

- * 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 processes and/or had initial intake complete, but are not yet receiving services
- Number of persons served in CIP may be slightly higher than actual, as some unique persons served may be counted more than once due to configuration of data set.

Characteristics of Persons Served (continued)

Barriers (continued)

		CIP	Residential	Family Home	Respite	SIL/ESIL	Gananoque	CCRCS	Family Support
Family Involvement with Persons Served	2015-16	High Level: 29.3% Moderate: 33.1% Limited: 15% None: 22.5%	High Level: 34.5% Moderate: 32.7% Limited: 21.8% None: 10%	High Level: 65% Moderate: 10% Limited: 5% None: 20%		High Level: 36.3% Moderate: 28.7% Limited: 24.2% None: 10.6%	High Level: 61.5% Moderate: 15.4% Limited: 23.08% None: 0%		
	2016-17	High Level: 28.9% Moderate: 30.9% Limited: 15.4% None: 24.8%	High Level: 35.1% Moderate: 31.6% Limited: 22.8% None: 10.5%	High Level: 61.9% Moderate: 9.5% Limited: 14.3% None: 14.2%		High Level: 36.6% Moderate: 28.2% Limited: 25.4% None: 9.9%	High Level: 59.3% Moderate: 25.9% Limited: 14.8% None: 0%		
Age of Primary Caregiver	2015-16						N/A		20s: 0.4% 30s: 14.2% 40s: 37.2% 50s: 28.4% 60s: 8.9% 70s+: 10.9%
	2016-17						50s: 24% 60s: 36% 70s: 12% Not Applicable: 28%		20s: 1.3% 30s: 15.2% 40s: 36.8% 50s: 28.2% 60s: 9.3% 70s+ 9.3%

- * 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 processes and/or had initial intake complete, but are not yet receiving services
- Number of persons served in CIP may be slightly higher than actual, as some unique persons served may be counted more than once due to configuration of data set.

Community Inclusion Programs—Effectiveness Measures

Objective:
To increase the extent to which persons served are involved in their community through work.

Rationale:
The foundation of CIP involves ensuring that person served have access to work that is meaningful to them, whether volunteer or paid. This is a key component of community involvement.

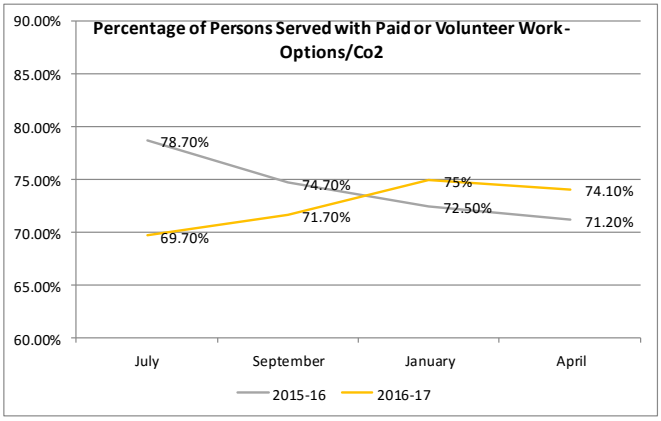
Indicator	Applied To	Time of Measurement	Follow-Up Intervals	Data Source	Obtained By	Target
Percentage of Persons Served with Active, Ongoing Volunteer Work	All Persons Served, CIP	April 1, 2016–March 31, 2017	Every three months	Nucleus Labs ECR	Quality Improvement Lead	Options and Co2: More than 75% Milestones: More than 50%

Outcome (Results):
Options and Co2: Averaged over the four measurement periods, 72.6% of persons served had active, ongoing volunteer (or paid) work. Therefore, the target was not reached.

Milestones: Averaged over the four measurement periods, 51.3% of persons served had active, ongoing volunteer (or paid work). Therefore, the target was reached.

Limitations:
None.

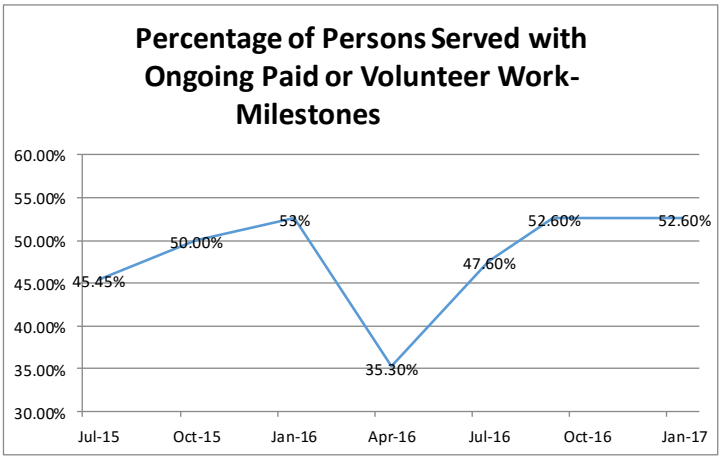
Key Findings/Trends:
As noted in the graph at right, the percentage of persons served in the Co2/Options programs who volunteer increased slightly over the course of the year, which is the opposite of the trend from 2015-16. An analysis of the past five years shows that there is no steady trend as to when persons served might be more likely to volunteer.



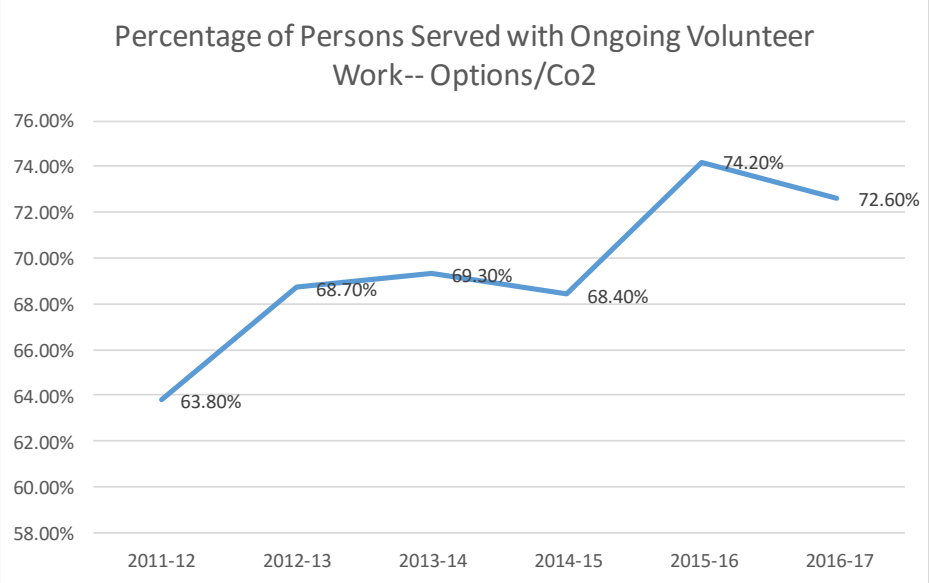
This item has linkages to the organization's Strategic Plan. One of the plan's strategic directions is related to ensuring that CIP is the provider of choice in the community. One aspect of the services that is somewhat unique is the focus that is placed on community presence, which includes volunteer work.

Key Findings/Trends (continued):

In the Milestones program, the percentage of persons served who volunteered increased slightly as the year went on. This is noted in the graph at right.



While work can be an important component to the lives of persons served at Milestones, those individuals are senior-aged, and have expressed interest in a slower pace of life. As such, volunteer work is much more of a focus in the Co2 and Options programs. As noted in the graph below, volunteer rates are higher than they were several years ago, although this must be interpreted somewhat cautiously, as the small number of individuals in what is now the Milestones program are included in the data up until 2014.



Discussion:

There has not been significant change since 2015-16. The improvement at Milestones is likely due to an increased focus on including persons served in volunteer activities to which the program was already connected. The 1.6% decrease at Options and Co2 equates to one less person served having volunteer work. There were few new admissions to the program in 2016-17, which means that the persons served themselves were fairly stable. As has been the case in the past, limited funds for more support-intensive volunteer work impacts the extent to which persons served can purchase this work. Placement students, who can be useful to provide these supports on a short-term basis, were not as plentiful this year.

Follow-Up Completed:

None formal. Persons served continued to be encouraged to pursue volunteer opportunities as part of their involvement with CIP, and several new partnerships with volunteer sites were developed. However, this did not translate into a higher percentage of persons served having volunteer work.

Proposed Action Plan:

To continue to encourage participants to pursue volunteer opportunities.

As noted in last year's report, a promotional video for CIP was being considered. An agency staff, Megan Coleman, has taken the lead on this project and there is an anticipated completion date of June 2017.

Future Monitoring:

This will continue to be monitored, with the same targets.

Residential Services Division— Effectiveness Measures

Objective:
To ensure relationships with non-familial unpaid supports.

Rationale:
It is an integral component of the philosophy of CLKD that individuals served benefit from the development of natural supports that are beyond the more artificial supports provided by paid agency staff.

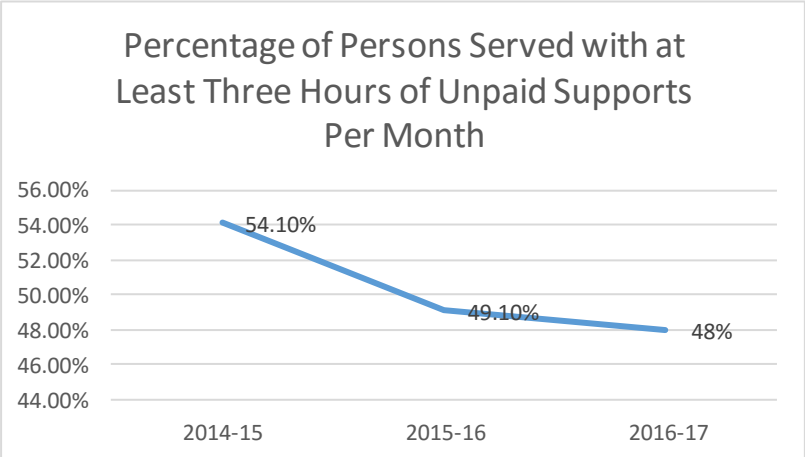
Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Percentage of Persons Served who receive more than three hours a month of unpaid supports (non-family)	All Persons Served in Residential Services Division	April 1, 2016–March 31, 2017	Every Six Months	Hours as tracked by staff at individual program locations	Quality Improvement Lead	More than 50%

Outcome (Results):
Overall, 48% of persons served averaged three hours per month of unpaid supports. Therefore, the target was not met.

Limitations:
None.

Key Findings/Trends:
In 2015-16, 49.1% of persons served averaged at least three hours of unpaid supports each month.

Unpaid supports were highest during the period between October and December (54.7%). They were lowest during the period between April and June (39.3%).



Key Findings/Trends:
An analysis of the data reveals that the age of the person served is not a large barrier to whether or not they met the target, with older persons served meeting the target at a similar pace to younger persons served.

Communication barriers continue to be the biggest obstacle to meeting the target. Only 36% of those with a communication barrier met the target, while 51% of those without a communication barrier met the target.

Of the individuals that did not meet the target, only 7% finished within a half-hour of reaching it, indicating that those that did not reach the target were largely not 'close'.

By location, the following results were noted:

Location Code	Percentage of Persons Served Meeting Target 2015-16	Percentage of Persons Served Meeting Target 2016-17
Aberfoyle	50%	50%
Arbour	40%	40%
Dolshire	100%	100%
McMichael	0%	33%
Melanie	25%	25%
Mowat	80%	20%
Parkway	100%	86%
Ringstead	0%	0%
Roosevelt	50%	75%
Smithfield	66.70%	50%
Davis	75%	50%
Splinter	N/A	0%

Discussion:
In previous years, the target was for persons served to reach an average of five hours of unpaid supports each month. This was lowered to three hours in 2016-17. The chart above notes target rates based on the three hour per month target.

Starting in 2017-18, the Parkway program and one individual at Mowat will be begin to be supported by the Community Services Division. As such, they will no longer be accounted for in this data. If these individuals were removed from the data set this year, only 41% of persons served would have met the target.

Follow-Up Completed:

Monthly graphs continue to be provided program locations to provide a visual update and reminder to the support team

Unpaid supports has been discussed at each Residential staff team meeting and is part of quarterly updates for each person served

Continued coordination with Volunteer Coordinator about Best Buddy and Volunteer matches. There has been some creativity put into volunteer roles that may work for people that are not interested or too risky to support in the community with volunteers

Each Residential team has chosen one person served in the home they work in who has traditionally been someone difficult to find unpaid support opportunities for. At winter round of team meetings, the team completed a brainstorming exercise where they focused on the persons interests and current connections that can be tapped into to help them develop unpaid relationships.

Supporting and Developing Natural Supports training was provided as a session in the Residential Facilitator/Coordinator training day at the end of March (This training was provided by Eleonor Egidio and Meagan Rogers).

Nucleus notes are being cross referenced with the unpaid supports tracking to ensure accuracy of the recordings and that nothing is missed.

Proposed Action Plan:

Graphing and providing a visual update monthly per person served will continue. Additionally, Coordinators will be providing regular feedback and messaging around the data provided to support and encourage team efforts. Incremental improvements will be celebrated.

Summer team meetings will feature a follow up to the exercise completed earlier in the year to ensure an action plan is being developed and reported on. Steps will be documented so they can be referenced and supported by the entire team.

Additional time will be added to staff team meetings as needed to ensure there is time for discussion, training and planning so that the team can continue to build on their skill around developing natural supports with persons served.

Consideration will be given to providing the Developing Natural Supports seminar to teams who seem to be struggling with this area of support.

Future Monitoring:

This will continued to be measured, with the same targets.

Respite Services— Effectiveness Measures

Objective:
To increase usage of the respite house. ["In Use" means any instance in which the respite house is occupied for Respite purposes. This includes any instances in which the house is occupied by using funds budgeted to Community Living Kingston and District and instances in which the house is occupied for use under private arrangement.]

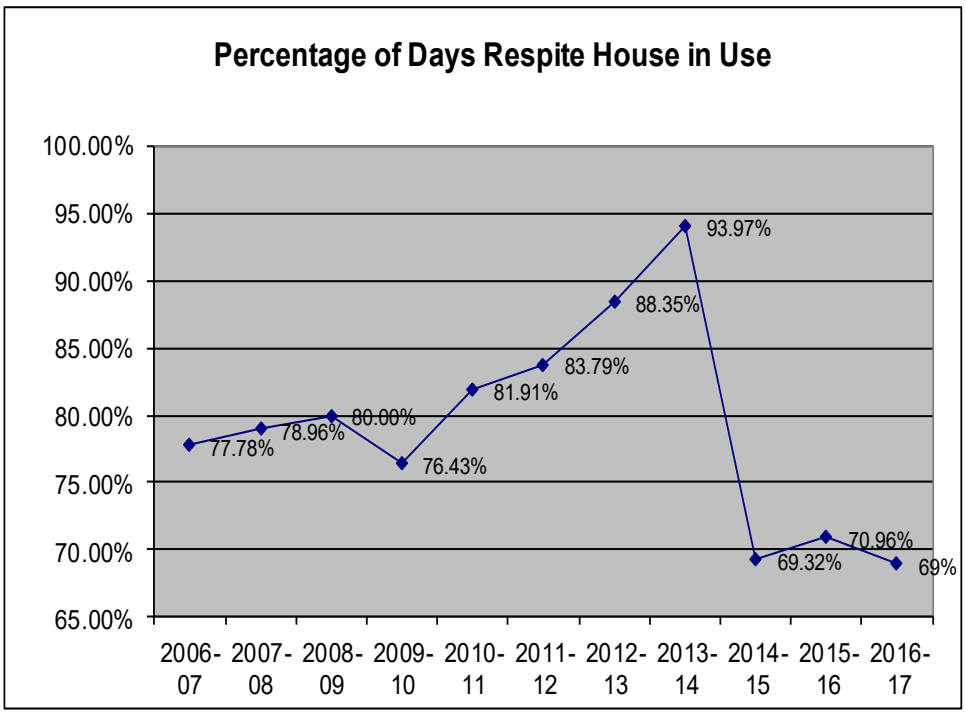
Rationale:
The respite house was designed to provide much needed respite for individuals and their families. A goal of the program is to optimize the use of this location such that these respite needs are met. Staff in Respite Services are encouraged to be creative in facilitating ways in which to ensure that the house can be used so as to achieve this goal.

Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Percentage of Overnights that the Respite House is Utilized.	Respite House	April 1, 2016– March 31, 2017	Annually	Data Provided By Coordinator of Respite Services	Quality Improvement Lead	More than 80%

Outcome (Results):
The respite house was used 69% of the time in 2016-17. Therefore, the target was not met.

Limitations:
None.

Key Findings/Trends:



As noted in the graph at left, the use of the house decreased slightly last year.

Levels of use have not rebounded from their decline following the 2013-14 year.

Usage rates were lowest in December (58%). In all other months, they held between 68% and 74%.

The usage rate was highest by one private user, who accounted for 41.2% of use. The four scheduled agency weekends—youth, coed, women's and men's— all accounted for between 13.1% and 15.4% each. These weekends are typically scheduled in four week cycles.

Discussion:
Usage rates were significantly higher prior to 2014. Prior to 2014, a pair of siblings utilized the house for up to two weeks each month. However, they stopped using the house in the summer of that year, and usage rates dipped accordingly. The introduction of a coed weekend in 2015-16 did put more of a variety of users in place, but did not necessarily increase overall usage rates.

While use of the house is still an important issue, it is noted that recent focus within the program has been to develop new types of respite. This has led to 'vacation respite', where persons served go out of town for a weekend rather than using the respite house.

Follow-Up Completed:
The Coordinator of the Respite program has continued to try to offer private and emergency respite to those in need. However, this does come with support costs attached (to either hire private workers or agency staff), which can be cost prohibitive in the current funding environment.

Proposed Action Plan:
To continue to look for private service users for when the location is not occupied by funded group respite.

Future Monitoring:
The agency will continue to monitor this, with a continued target of 80%. However, the focus of the Respite program is increasingly on offering a wider variety of respite and offering formal respite options to a larger number of individuals. A measure will be developed to track this accordingly.

Child Care Resource Consultant Services—Effectiveness Measures

Objective
To ensure that all children have the ability to access child care centres of their choosing, even where additional funding is required.

Rationale
The CCRCS program is dedicated to ensuring that children with disabilities have the opportunity be fully included in their chosen child care centres. One of the other functions of the CCRCS program is to administer city-allotted enhanced support funding to centres that require additional assistance to include children whose needs may be greater. Funding is at a premium, and careful administration is warranted in order to ensure that it can be efficiently used to benefit as many as possible.

Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Number of children reported as unable to attend child care centre due to lack of available enhanced funding	All Centres serviced by the program	April 1, 2016–March 31, 2017	Annually	Coordinator, CCRCS program	Quality Improvement Lead.	Less than four.

Results:
One child was unable to attend centres during this period due to lack of additional resources required. Therefore, the target was met.

Limitations:
This measure does require self-reporting on the part of the centres, which may result in unreported cases.

Key Findings/Trends/Discussion
In 2014-15, two cases were reported. This was reduced to zero in 2015-16.

Follow-Up Completed
None formal at this time. The program has simply continued to try to responsibly manage the allotted money as effectively as possible, and endeavours to be responsive accordingly.

Action Plan
The program will continue to advocate for additional resources from the funder.

The program will continue to carefully administer enhanced funds.

Future Monitoring
The program will continue with this measure, with a reduced target from last year.

Target for 2017-18: Fewer than four children will be unable to access centres due to lack of available resources through enhanced funding.

Supported Independent Living and Gananoque Programs— Effectiveness Measures

Objective:
To assist persons served to increase their independence.

Rationale:
A key component of the SIL programs is centered around providing support that assist individuals to be more independent in their daily lives.

Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Percentage of persons served working on a life skill on a weekly basis.	All persons served, SIL and Gananoque programs.	October 1 2015 to March 31 2016	Every three months	Data sheets supplied by program Facilitators	Quality Improvement Lead.	At least 90%

Summary:
This measure proved to be challenging to collect data on. While data collection systems were put in place, they were not reliable in the sense that there were wide variances in what individual staff considered to be 'working on a life skill'— in some cases, staff considered virtually everything to be a life skill, while in others, the window was quite narrow. Ultimately, the measure was poorly designed by the Quality Improvement Lead.

Future Direction:
Persons served by these programs have expressed a desire to access more 'special' recreational activities that are outside of what they might usually do. As such, a measure is being designed to track this going forward.

Evidence gathered in the first few months of 2017 suggest that only 25% of persons served in SIL access an average of one 'special' recreational activity per month. A preliminary goal is to raise this to 50% in 2017-18.

Family Support Program— Effectiveness Measures

Objective:
To ensure that families have access to information, outreach and support.

Rationale:
The Family Support program strives to maintain the integrity of families caring for an individual with an intellectual disability. Supports are tailored to each family and will vary according to the specific needs. A key component of this goal is to assist families to be knowledgeable about and to access resources that will assist them to be self-reliant. The Family Support drop-ins and information sessions are useful tools to contribute to this.

Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Average number of families attending drop-ins and information sessions each month.	Families Served.	April 1, 2016 to March 31, 2017	Annually	Coordinator, Family Support Program	Quality Improvement Lead	At least ten.

Outcome:
The program averaged exactly ten families attending drop-ins or information sessions each month. Therefore, the target was met.

Limitations:
None

Key Findings/Trends/Discussion:

Three of the nine sessions saw turnout of more than ten families. The highest number of families was in November 2016, where twenty-four families attended. There were other sessions where eighteen and fourteen families attended.

Some momentum seemed to build over the course of the year, as three of the highest attended sessions were in the last four offerings.

Follow-Up Completed:

The sessions were publicized via Facebook, paper and electronic flyers, the Family Support Newsletter, the agency website, and through sharing with community partners.

Proposed Action Plan:
The strategies noted above will continue to be used.

Future Monitoring:
This will continue to be measured, with a slight modification. The target will be that ten families be in attendance for 75% of sessions/drop ins. This was chosen simply to get rid of any variances that may come with averaging across the year.

Family Home Program— Effectiveness Measures

Objective:
To ensure continuity of Family Home living arrangements.

Definitions:
A "discontinuation" is defined as any Family Home living arrangement that is ended. A discontinuation can be initiated by the Family Home provider, by the person being supported by the Family Home Program, or by Community Living Kingston and District. An occurrence in which an arrangement is discontinued as a result of relocation to another community on the part of the Family Home provider or the person being supported is not considered a discontinuation. A discontinuation is also not deemed to have occurred if the person being supported "graduates" from the Family Home arrangement to a more independent living situation or if they move to live with natural family by mutual choice.

Rationale:
It is a fundamental assumption of the Family Home program that individuals being supported by the program benefit from long-term, stable living environments. As such, the agency goes to great lengths to recruit and train new families and to support all parties during the course of the arrangement in order to further this stability.

Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Percentage of Persons Served Who Do Not Have a Discontinued Family Home Arrangement	All Persons Served in a Family Home Arrangement.	April 1, 2016 to March 31, 2017	Annually	Coordinator, Family Home Program	Quality Improvement Lead	At least 90%

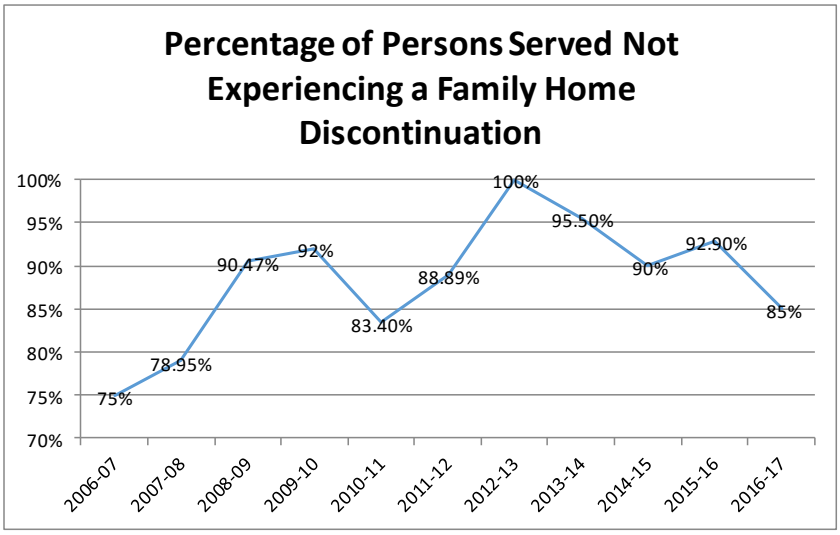
Outcome:
In 2016-17, 85% of persons served had no discontinued Family Home arrangements. Therefore, the target was not met.

Limitations:
None.

Key Findings/Trends:

As noted in the graph at right, the success rate was lower this year than in previous years. This is the first year since 2011 in which the target was not met.

It should be noted that because of the relatively small number of individuals supported in the program, each person served who suffers a discontinuation can impact percentage totals significantly.



Discussion:

There were three discontinuations this year. Two occurred because individuals needed to move to long-term care, as their needs could no longer be met in a Family Home arrangement. One other discontinuation was prompted by the desire of the individual's natural family. There was also one death of a person supported, which is not reflected in the data as a discontinuation.

Follow-Up Completed:

Flexibility around service provision continues to be the main method to ensure stable arrangements. This flexibility includes adequate respite.

Proposed Action Plan:

Continued flexibility with the service model is the main plan of action.

Future Monitoring:

This will continue to be monitored in 2017-18.

Target for 2017-18: More than 90% of persons served will not experience a discontinued Family Home arrangement.

Efficiency Measures— *Community Inclusion, Residential Services, Respite Services, Supported Independent Living, Child Care Resource Consultant Services, Family Home, Family Support, Gananoque Services*

Objective:
To decrease staff absenteeism. "Staff absenteeism" includes any hours in which an employee utilizes sick or family sick time as defined within the Collective Agreement.

Rationale:
Staff absenteeism presents a tremendous financial cost to the agency both by requiring staffing to cover the abandoned shift and by utilizing resources to make sure that the shift is covered. Staff absenteeism has a negative impact on staff teams and on support provision. Reducing staff absenteeism allows for funds to be freed up for a variety of other functions.

Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Percentage of total payroll assigned to sick pay.	All Employees	January 1, 2016-December 31, 2016	Every Six Months	Attendance Enterprise	Quality Improvement Lead.	Is program specific. See chart below**

** Targets for 24-hour programs are set at less than 5%, though results as high as 6% will be considered in an acceptable range. Targets for all other direct-service programs will be set at 4%, with results as high as 5% being considered an acceptable range. Targets for departments with limited direct support will be set at 3%, with results as high as 4% being considered to be in an acceptable range. These different targets are meant to reflect the different demands of each department.

Outcome:
As noted in the table (right), the target was met in all departments except the Community Inclusion Programs, which still maintained levels considered within an acceptable range.

Department	Target	Result	Target Met?
Residential Services	5%	3.84%	Target Met
Community Inclusion	4%	4.19%	Not met, but in acceptable range
SIL/Enhanced SIL	4%	2.91%	Target Met
Family Support	3%	2.73%	Target Met
Respite	4%	1.90%	Target Met
Family Home	4%	1.89%	Target Met
CCRCS	3%	1.63%	Target Met
Gananoque	4%	2.02%	Target Met

Limitations:
Data is based on the 2016 calendar year rather than the fiscal year, unlike other measures in this report.

While some staff work in multiple departments, sick data is assigned only to their 'home' program. As such, there will be some slight inaccuracies in terms of which division actual sick time occurred in. However, staff sharing across departments is limited, so any inaccuracies should be very minor.

Because of the reports available, only those staff who worked for the organization as of December 31, 2016 are recorded here. Any staff who may have resigned during the 2016 calendar year are not included. It might be expected that the results above may be lower than actual.

Efficiency Measures— Community Inclusion, Residential Services, Respite Services, Supported Independent Living, Child Care Resource Consultant Services, Family Home, Family Support, Gananoque Services

Key Findings/Trends:
Sick levels were lower from 2015, with the notable exception of the Community Inclusion Programs, which saw a rise due to six staff taking extended sick leaves due to unusual circumstances. The largest budget centre is Residential Services, which saw a decrease in sick time use. Besides Residential Services, the Community Inclusion Programs and the SIL/ESIL programs, all other programs have fairly small staffing complements and budget centres. The graph below further illustrates year-to-year results.

The overall percentage of sick time used in the agency (including administration and other programs not included in this analysis) was 3.41%, which is up from 3.21% in 2015. Despite this, the organization is very pleased with the overall results.

Follow-Up Completed:
The organization has continued to utilize the attendance management program developed in 2011. This program includes monitoring of sick time, twice a year reporting of sick usage to HR and program managers, and twice a year follow-up with employees whose attendance is a concern.

Department	2012	2013	2014	2015	2016
Residential Services	4.84%	4.99%	5.15%	5.18%	3.84%
Community Inclusion	5.53%	3.79%	2.98%	3.07%	4.19%
SIL/Enhanced SIL	1.87%	2.25%	2.98%	3.75%	2.91%
Family Support	1.81%	0.88%	3.47%	1.36%	2.73%
Respite	2.86%	2.38%	4.81%	1%	1.90%
Family Home	2.66%	2.30%	3.54%	4.65%	1.89%
CCRCS	2.35%	2.74%	2.49%	1.54%	1.63%
Gananoque	n/a	n/a	2.72%	2.35%	2.02%

Proposed Action Plan:
Continued use of the attendance management program.

Additional monitoring of sick rates may be possible with new scheduling/HR/payroll software that is due to be implemented in 2017.

Future Monitoring:
This measure will continue, utilizing the same targets for each department noted previously.

Supplemental Measure—Residential Services Division

Objective:
To decrease medication errors.

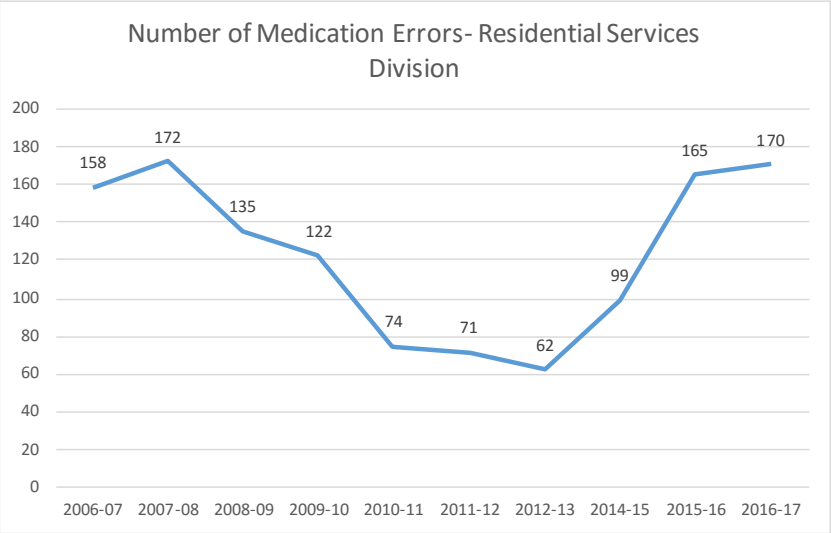
Rationale:
Medication administration is a vital clinical and organizational responsibility of the agency. It has a profound impact on the continued good health and quality of life of persons served by the agency. Medication errors have a negative impact on the health and quality of life so mentioned. Similarly, medication errors have a negative impact on the use of the agency's resources, including the time and expense involved in following up on errors, reporting errors, and providing proper training to prevent future errors. For this myriad of reasons, it is a fundamental area of continued concern for the agency.

Indicator	Applied To	Time of Measurement	Follow-up Interval	Data Source	Obtained By	Target
Number of Medication Errors Committed	All Persons Served, Residential Services Division	April 1, 2016-March 31, 2017	Every Six Months	Nucleus Labs summary report	Quality Improvement Lead	Fewer than 90.

Outcome (Results):
A total of 170 medication errors were committed. Therefore, the target was not reached.

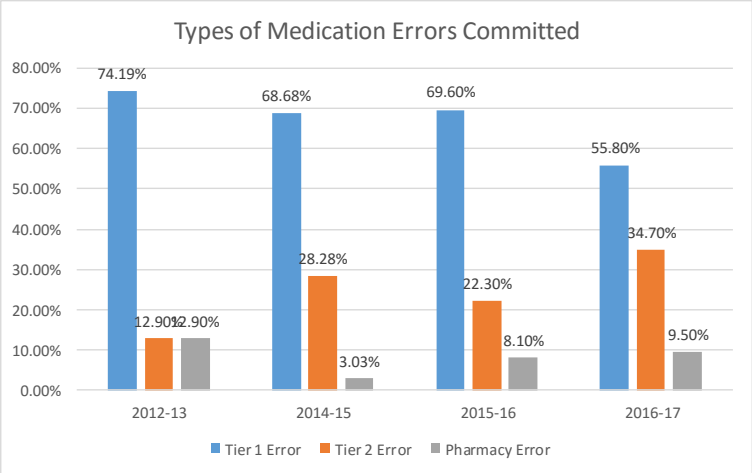
Limitations:
Using whole numbers to measure results can be misleading, as it does not allow for easy comparisons of data given that the size of the agency has grown over the years.

Key Findings/Trends:
There was another increase in the number of errors committed this year, as evidenced in the graph at right. There continues to be an upward trend in the number of errors committed.



Key Findings/Trends (continued):

In previous years, data was broken down into several sub-categories of medication errors. This year, errors have been grouped into Tier 1 errors (non-administration of medications, medication given at wrong time or to wrong person, etc.), and Tier 2 errors (not signing off on administration, failure to count meds at end of shift, etc.). As noted in the graph at right, the percentage of errors that were the more serious Tier 1 errors was lower than in previous years, though the whole number of such errors is still too high.



The table below summarizes the medication errors at each program location.

Location	**Total Number of Errors**	**Tier 1 Errors** (e.g., Non-Administrations, Wrong Person, Wrong Med, Wrong Time, etc.)	**Tier 2 Errors** (Wrong MTAR Instructions, Failure to Count Meds, Failure to Sign off on Meds, etc.)	**Number of Non-Attributable Errors** (e.g., person independent with medications does not take them, etc.). **Not included in total.**
Aberfoyle	2	1	1	0
Arbour	12	12	0	0
Compass	1	1	0	23
Davis	24	9	15	1
Dolshire	0	0	0	0
IB- In Home	2	2	0	0
McMichael	11	11	0	0
Melanie	4	2	2	0
Mowat	22	14	8	1
Parkway	13	6	7	10
Ringstead	21	10	11	0
Roosevelt	28	17	11	0
Smithfield	11	7	4	0
Splinter	3	3	0	8
Pharmacy (are included in overall total)	16	#N/A	#N/A	#N/A

Discussion:
Three locations account for approximately 44% of all of the medication errors.

As was the case last year, all of the errors attributed to the pharmacy were packaging errors, which were all somewhat minor in nature.

Staff teams were given details of the errors committed in their programs in October of 2016, which is the midway point of the reporting year. While the number of overall errors was higher in the second half of the year, the number of Tier 1 errors was 14% lower. Two locations saw Tier 2 errors more than triple in the second half of the year. Closer investigation reveals that these were largely cases where medications were administered but not signed off on.

In previous years, there was no evidence to support the suspicion that newer staff were responsible for a large percentage of errors. This was looked into again this year, as there was significant staff turnover in some programs in 2016. It appears that staff hired in the 2016 calendar year were responsible for about 40% of errors, which is substantial.

Follow-Up Completed:
Error details were sent to program supervisors at the six-month mark of last year so that they could be reviewed with their teams. Follow-up summaries were then done for staff team meetings in December 2016 and in March/April 2017. Much more frequent discussions with staff teams have therefore occurred over the past year. This is consistent with the planned action of making medication administration practices a standing agenda item at all team meetings.

Follow-up occurred with Shoppers Drug Mart around pharmacy errors.

The tracking and monitoring processes for individual staff, which were put in place in 2009, have continued.

Last year, two programs were identified as having the highest rate of errors and were chosen to pilot a colour coded system to make medication administration and documentation more clear.

Proposed Action Plan*:*
All of the above procedures will stay in place.

Because the majority of errors were at a handful of locations, those programs will be targeted for improvement this year. Each of these teams has been asked to come up with a list of strategies to implement this year that might reduce errors at that location.

Future Monitoring:
The organization will continue with this measure, but will adapt it for two reasons: First, it has decided to focus on the much more serious Tier 1 errors, while still measuring Tier 2 and Pharmacy errors. Second, because the Compass and Parkway teams will be moved out of Residential Services and into the Community Services division, targets will be adjusted to reflect this change.

Target: Fewer than 60 Tier 1 errors will be committed in the Residential Services Division.

Slips, Trips and Falls Analysis

Overview:
It had been anecdotally reported by program Managers that a large number of incident reports seemed to be connected to slips, trips and falls. The organization wished to start examining this further in the hopes of finding additional information, causes, or trends.

No goals are associated with this analysis. Rather, it is simply an information seeking exercise at this time. Data was extracted from the Nucleus Labs ECR, which has the ability to sort incident reports where staff can label the types of incidents that occurred.

Results

By agency program location:

Program Location	Number of Slips, Trips, and Falls	Percentage of Agency Total
Smithfield	36	18.95%
Arbour	31	16.32%
Roosevelt	27	14.21%
Milestones	19	10.00%
Options	11	5.79%
Mowat	11	5.79%
Parkway	10	5.26%
McMichael	10	5.26%
SIL	7	3.68%
Davis	7	3.68%
Gananoque	6	3.16%
Co2	4	2.11%
Ringstead	4	2.11%
Family Home	3	1.58%
Dolshire	2	1.05%
Melanie	1	0.53%
Aberfoyle	1	0.53%

By persons served:

Person Served	Number of Slips, Trips, and Falls	Percentage of Agency Total
1 person served	25	13.23%
1 person served	22	11.64%
1 person served	19	10.05%
1 person served	14	7.41%
1 person served	9	4.76%
1 person served	8	4.23%
1 person served	6	3.17%
4 persons served	5 each	2.65% each
2 persons served	4 each	2.12% each
5 persons served	3 each	1.59% each
10 persons served	2 each	1.06% each
23 persons served	1 each	0.53% each

A handful of observations were brought forward:

- At the Mowat location, one person served has experienced increased challenges with transfers, resulting in a higher number of incidents.

- At the Davis location, eavestroughs run through the middle of the driveway, resulting in ice buildup in the winter. It may be the case that this will need to be addressed in order to keep further slips, trips and falls.

- The Milestones location supports individuals that are senior-aged. Most of the incidents at that location were due to light falls when a person served became unsteady on their feet while walking without assistance.

- At each of the Smithfield, Arbour, and Roosevelt locations, one person served accounted for the majority of the slips, trips, and falls.

- Six persons served account for over 51% of the slips, trips, and falls.

- Only one fall resulted in a serious injury. This occurred at the Milestones location when a person served was being escorted to a vehicle by a non-agency support.

- It is noted that CLKD generally takes the approach of over-reporting incidents, which means that many of the 'incidents' reported here are extremely minor in nature.

At this juncture, no further conclusions are being drawn. Data will be reviewed again in 2017-18 to look for trends, and future steps will be taken from there.

Service Access Measures— All Programs

Objective:
To ensure that families receive service as quickly as possible after referral.

Rationale:
Community Living Kingston and District strives to engage families in services as quickly as possible after referral and confirmed funding. This is key to the organization being responsive to community pressures and needs of families and persons served.

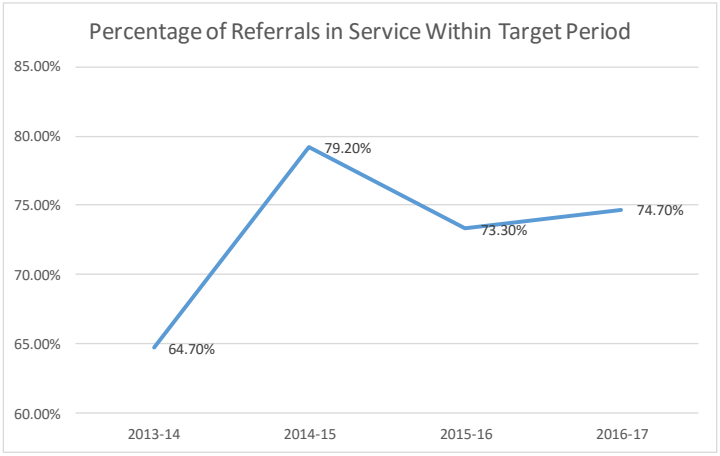
Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Percentage of Persons Served In Service within sixty days of referral	All New Referrals	April 1, 2016-March 31, 2017	Annually	Nucleus Labs ECR	Quality Improvement Lead	At least 67% in each program.

Program	Number of Referrals	Target	Actual	Target Met?	Last Year's Result
Child Care Resource Consultant Services	66	67%	81.8%	Met	77%
Community Inclusion Programs	3	67%	100%	Met	67%
Residential Services	3	67%	33.3%	Not Met	100%
SIL	14	67%	100%	Met	0%
Gananoque	1	67%	100%	Met	0%
Family Home	2	67%	50%	Not Met	25%
Respite	24	67%	25%	Not Met	16%
Family Support	33	67%	84.8%	Met	74%

Referrals made within the last sixty days of the reporting period are excluded unless service has started, as there is insufficient data to determine if the target was met or not.

Limitations:
Some data in the Respite program requires more interpretation due to how that program is structured, which may reduce data reliability somewhat.

Key Findings/Trends/Discussion:
Across the agency, 74.7% of persons served commenced service with sixty days of referral. This compares favourably to last year, as noted in the graph at right.



As has traditionally been the case, CCRCS and Family Support have the most referrals, as noted on the previous page.

The Family Support program is largely at capacity. As consistent with it's mandate, it responds quickly to referrals for children. However, few adults are taken from the community wait list at the Pressures and Priorities table, which means that families are essentially placed on a waiting list before even being assigned a local support agency.

Follow-up Completed
None formal. Staff are encouraged to contact families to commence service as quickly as possible after referral.

The Community Inclusion Program, which was at capacity at the time of last year's report, increased the size of the Co2 program, and is now able to take on referrals in a prompt fashion.

Proposed Action Plan
None.

Future Monitoring
All programs will continue to have a goal of at least 67% of persons served commencing service within sixty days of referral.

Business Function Measures— Instances of Staff Injury

Objective:
To reduce the number of work-related staff injuries.

Rationale:
Staff injuries are frequently indicative of Health and Safety concerns in the workplace. Any patterns or trends in the occurrence of staff injuries should be studied by the employer and the bargaining unit of the employees to ensure that any Health and Safety concerns that arise are addressed.

Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
OSHA Recordable Injury Rate	All Staff	April 1, 2016-March 31, 2017	Annually	Super HR Records of Staff Injury	Quality Improvement Lead	Zero

Notes:

1. In previous years, this measure looked at the number of injuries as a whole number. However, this did not give the best comparison over time, as there has been significant growth in the size of the organization and the number of employees. As such, CLKD opted to start looking at this measure related to the OSHA Recordable Injury Rate, which looks at the number of injuries per 100 full-time employees by using a calculation per overall labour hours worked.
2. On principle, the organization has decided to set the target at zero, which means that no injuries are seen as acceptable.

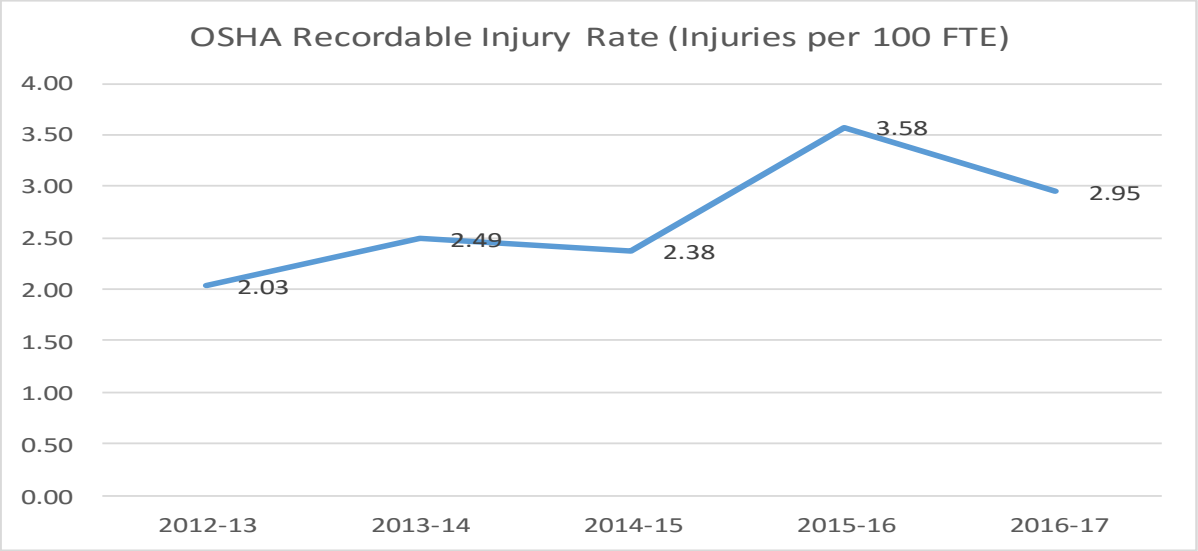
Outcome/Results:
The OSHA Recordable Injury Rate was 2.95 per 100 FTE. Therefore, the target was not met.

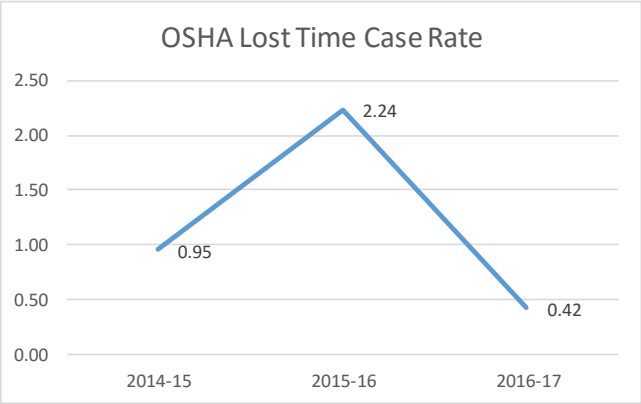
Limitations:
None

This measure was developed based on themes identified in the organization's Health and Safety reports, Risk Management plans, HR reports, Finance Reports, and outside Health and Safety Inspections

Key Findings/Trends::

As noted in the graph below, the recordable injury rate of 2.95 was less than the previous year, but slightly higher than the years prior to 2015.





Only one of this year's injuries resulted in lost time. As such, as noted in the graph at right, the OSHA Lost Time Case Rate (which measures lost time cases per 100 FTEs) was lower than the previous year. There was a total of three lost days of work.

When data was first formally collected around this measure in the early 2000s, the majority of staff injuries were the result of challenging behaviour on the part of persons served, or were related to handling of persons served (i.e., lifts, transfers, etc.). However, over the past few years, this trend has slowly changed, which was reflected in this year's data. In 2016-17, challenging behaviour accounted for only 14.3% of injuries, with handling of persons served accounting for another 14.3%. All of the other injuries this year were the result of slip, trip, and fall incidents.

Discussion:

As noted above, there have been significant changes to the types of incidents causing staff injuries in recent years.

It is noted that over the past three years, there had been an increased number of staff injuries resulting from staff bumping their heads while in accessible vans, which resulted in concussions. There were no instances of such injuries this year.

Follow-Up Completed:
Measures continue to be in place to ensure staff safety around challenging behaviour and handling of persons served, including:

- Continued (required) certification for all staff in CPI.
- Continued development and implementation of Positive Behaviour Support Plans for individuals with challenging behaviour.
- In early 2017, staff were required to complete video training around best practices related to lifting, transfers, etc..
- Lift and transfer protocols for persons served who require physical assistance are in place at all Residential locations, and are in development in the Community Inclusion Programs.

Similarly, staff are required to complete annual reviews around a number of health and safety procedures.

In 2016, measures were taken to combat the concerns about concussions arising from staff bumping their heads in accessible vehicles. All staff are now required to wear bump caps when they are in and around accessible vehicles. These caps have a protective plastic lining that helps to protect staff should they bump their heads.

Proposed Action Plan:
All of the above preventative strategies will continue to be in place.

While traffic accidents have not been a major cause of staff injuries over the years, measures will be taken to promote staff safety in this area. In 2017, all staff will be required to complete video training related to safe/defensive driving. In addition, all new staff will be given the opportunity to drive accessible vehicles with an experienced staff person prior to their first shift. This is in response to staff concerns about the difficulty of learning to drive these unique vehicles without prior experience.

Strategies to reduce the likelihood of slips, trips, and falls will be investigated by the Management team and by health and safety representatives.

Future Monitoring:
The organization will continue to monitor this, with the same target of zero staff injuries. The OSHA measures described here will continue to be used.

Business Function Measures— Staff Training

Objective:
To ensure that staff are up-to-date in CPR/First Aid and crisis intervention (CPI) training.

Rationale:
These training programs are of utmost importance. CPR training ensures that staff have basic skills to deal with overall health and first aid concerns. CPI training ensures that staff have the basic skills needed to verbally deescalate agitated individuals. Current certification is required of direct service employees by the Ministry of Community and Social Services. While the agency takes great pains to ensure that this training is always up to date, it can be difficult to ensure because of the large size of the organization's staff pool.

Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Percentage of Employees with Current Certification in CPI	All Active Employees	As of March 31, 2017	Annually, with scheduling personnel reviewing more frequently to schedule training	HR Database Report	Quality Improvement Lead .	Greater than 90%
Percentage of Employees with Current Certifications in CPR/First Aid.	All Active Employees	As of March 31, 2017	Annually, with scheduling personnel reviewing more frequently to schedule training	HR Database Report	Quality Improvement Lead	Greater than 90%

Outcome (Results):
As of March 31st, 93.3% of staff had current certification in CPR/First Aid. Therefore, the target was met.

As of March 31st, 94.5% of staff had current certification in CPI. Therefore, the target was met.

Limitations:
'Point in time' measurements do not indicate situations where a staff person may have had a lapsed certification at some point during the year

Key Findings/Trends:
These figures are comparable to 2016 (92.6% for CPR and 95.3% for CPI), and are significantly higher than in 2015. The organization's scheduling department pays close attention to these staff training matters.

Discussion:
The size of the staffing complement, which continues to grow each year, means that keeping up with required staff training is extremely difficult. Increased training needs also cause stress in relation to costs and in relation to the internal staff trainers in CPI having time to dedicate to training.

Future Direction:
The organization will continue to monitor this, with the same targets.

This measure was designed based on themes identified in the organization's Health and Safety Reports, Risk Management Plan, and in accordance with the requirements of the organization's primary funder.

Business Function Measures— Reduction of Unfunded Liabilities

Objective:
To decrease unfunded liabilities related to employee accruals (vacation and lieu time).

Rationale:
The organization is obligated to have funds available to pay out such accruals, and it is thus extremely important that the accruals be at a manageable level. On another scale, the organization is required to pay out employee accruals whenever they leave the organization. This can put tremendous strain on the operating budget of the organization.

Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Unfunded Liabilities (in dollars) in Excess of Thirty Days	All Full-Time Employees	Measured at March 25, 2017	Twice Annually	Finance Reports	Finance Director	Less than $86,971

Note: In previous years, this measure had been formulated to examine the percentage of employees carrying less than 240 hours of vacation and lieu time. It has been altered to be more reflective of how this issue is monitored by the Finance Director and the Finance Committee of the Board of Directors.

Outcome (Results):
Accruals in excess of thirty days were an unfunded liability of $89,523. Therefore, the target was not reached.

Limitations:
None

'**Key Findings/Trends:**
The total dollar figure for accruals rose from $570,298 in 2016 to $582,447 in 2017.

Discussion:
That the overall figure for accruals rose is not overly surprising, as it will increase with wage increase, and with new full-time employees resulting from service expansion. However, the significant number of excess (greater than 30 days) accruals continues to be a concern. The sheer volume of long-term employees who accrue maximum vacation credits is very large.

Follow-up Completed, Proposed Action Plan and Future Monitoring
This is closely monitored by the Finance Committee of the Board. Program Managers have been encouraged to require staff in excess of thirty days to take time off to reduce accruals. These strategies will remain in place. The same goal will remain in place for 2017-18.

Note: This measure was developed based on themes in the organization's Finance reports and Risk Management plan, along with recommendations based in an outside auditor's report.

Business Function Measures— Manager On-Call Response Time

Objective:
To ensure quick response to all calls that go to the Manager On-Call system.

Rationale:
This system is designed to ensure that a member of the Management team is aware of emerging situations as quickly as possible. The system is essential to ensuring that staff receive direction and support in challenging situations, and to ensure that the organization is reporting situations to MCSS or the police as necessary.

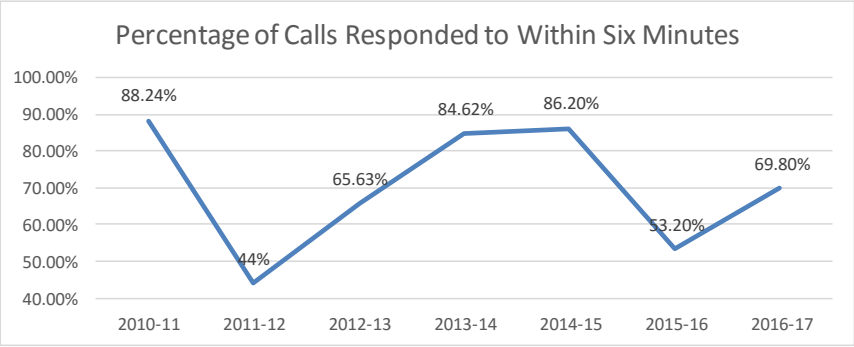
Indicator	Applied To	Time of Measurement	Follow-Up Interval	Data Source	Obtained By	Target
Percentage of calls responded to in six minutes or less	All Calls to Manager On-Call System	April 1, 2016- March 31, 2017	Annually	On-call reports from Alliance Wireless.	Quality Improvement Lead	At least 80%

Outcome (Results):
69.8% of calls were responded to within six minutes. Therefore, the target was not met.

Limitations:
None.

Key Findings/Trends:
As noted in the graph below (at right), while this year's result is stronger than in 2016, it is still lower than previous years and falls short of the target.

As noted in the chart below (at left), the average response time was 7.8 minutes. Again, this was an improvement over last year, but was lower than in some previous years.



Year	Average Response Time
2011	6.33 minutes
2012	13.88 minutes
2013	6.29 minutes
2014	4.44 minutes
2015	4.75 minutes
2016	10.1 minutes
2017	7.8 minutes

Note: This measure was originally developed based on information brought forward by the organization's staff and their bargaining unit, CUPE 2635.

Key Findings/Trends (continued):
The longest response time was 34 minutes. The shortest was 1 minute. The median response time was 5 minutes.

There were 53 calls to the Manager On-Call system this year, up from 47 in 2015-16.

In terms of types of calls, 22.6% were related to a person served with challenging behaviour, 20.8% were related to maintenance issues (including alarm systems), and 18.9% were related to medical emergencies

Discussion of Results:
Responsiveness increased this year, but not substantially enough to meet the goal. In 81% of the calls that did not meet the target, it appears that there was a substantial (at least five minute) time lag before the answering service made their first call. In 50% of the calls that did not meet the target, they occurred during the months between May and August, when fewer Managers were likely available to the service due to vacations.

Follow-Up Completed:
The organization's Director of Operations contacted the answering service halfway through the year to address time lags, as well as the order in which Managers are called.

Proposed Action Plan:
To continue the practice of sending the answering service a prioritized list of available Managers on a weekly basis.

To reinforce to the answering service the need for calls to Managers to be made immediately following being contacted by a staff member.

When interim results were reviewed with the organization's Board of Directors, it was suggested that the organization should look at newer technology options that might replace the answering service. This will be looked into in 2017-18.

Future Monitoring:
CLKD will continue to monitor this measure, with the same target.

Target for 2017-18: At least 80% of calls to the Manager On-Call system will be responded to within six minutes.

Glossary Of Terms

Outcome/Results: A description of whether or not the target was achieved.

Limitations: Any vulnerabilities in the method of collecting and/or analyzing the data which may impact the outcome.

Key Findings/Trends: A description of any noteworthy information that may have been uncovered when analyzing the data, including a comparison of data over time.

Discussion of Results: An explanation of those factors that may have contributed to the results.

Follow-Up Completed: Any actions already taken to address the item being measured. Any action plans from the previous year are addressed here.

Proposed Action Plan: Those improvements that the agency intends to make in order to achieve the targets or otherwise improve service. The action plan may also involve changing the method by which data is collected or analyzed.

Future Monitoring: A brief description of what the agency intends to do for the next year with regards to this measure.

Measure: The specific area being studied on which data is being collected.

Target: The level to which the program aspires to reach. Unless otherwise specified, the target is based on the results from the previous year's data.

A Note About Characteristics of Persons Served

Throughout the following report, each program has compiled a summary of the characteristics of the persons served by that program. Except where noted, this summary includes all of the persons served by the program in the past year, including those who may not be active with the program at the time of the report. This may also include referrals to the program who have not started services.

Types of Measures

Effectiveness: A measure that looks at direct impact of our services on the persons served

Efficiency: A measure that looks at different aspects of resource use such as dollars spent or use of staff time

Service Access: A measure that looks at some aspect of the barriers involved in getting into our services

Satisfaction: A measure that looks at the extent to which persons served and other stakeholders are happy with the services that we provide.

Business Function: A measure that looks at some function of the administrative aspects of the agency

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 internal documents such as Medication Error Reports or Finance or HR Reports, virtually eliminating any danger of the data not being collected the same way on another occasion. Much data is provided directly from the Nucleus Labs system, which can run reports directly from its system.
- 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. This is also done on all satisfaction survey items, where persons from outside the agency are sometimes used to determine face validity.

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. For data accessed from the Nucleus Labs system, reports are run that allow the Quality Improvement Lead to identify persons served for whom data is missing.

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 Manager 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 the normal distribution.

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www.communitylivingkingston.org

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