COMMUNITY LIVING
Kingston and District
Inspiring Possibilities

Quality Improvement Report 2018

1412 Princess Street

Community Living Kingston and District is a CARF-accredited organization

Overview of Quality Improvement Process

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

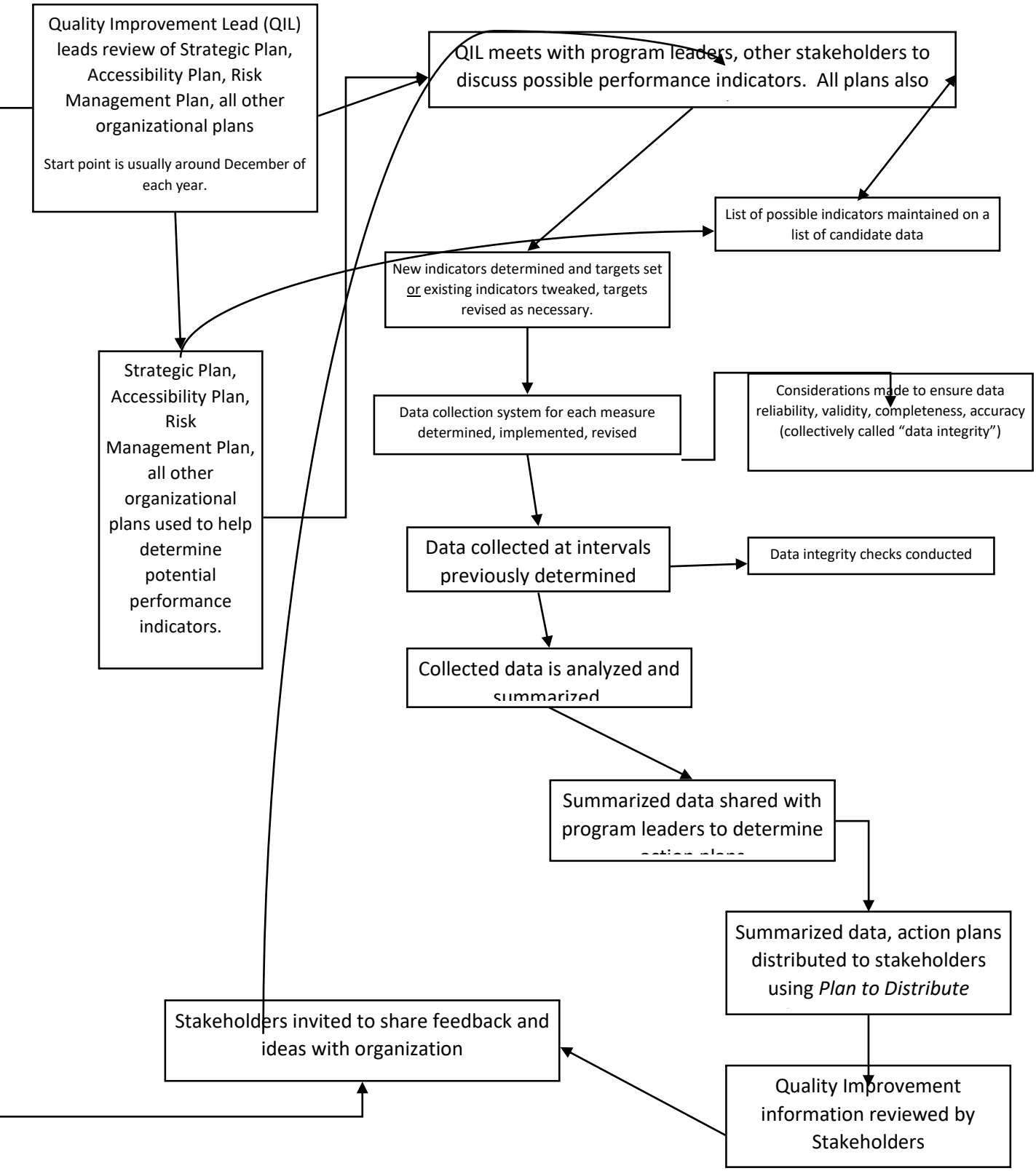
The mission of Community Living Kingston and District is to ensure that people with intellectual disabilities have every opportunity to participate fully in our community with dignity and independence.

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

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

Overview of Quality Improvement Process

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



Update
Strategic Planning Implementation Teams
May, 2018

The following is an update to the Strategic Plan developed in 2016. This Plan can be found in the 2017 Quality Improvement Report.

Board Investment

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

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

Projects:

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

Social Enterprise Committee Update

CLKD has had the opportunity to secure the resources of Jonathon Bingeman, a PhD student from Queen's School of Business. Jonathon collaborated with the Social Enterprise Committee and with management in general to review the Kwik Shred (KS) operation. Jonathon's thesis and final report determined that, with strategic investment in marketing and a tighter focus on revenue growth and cost management, the Kwik Shred business could position itself to pay minimum wage to the individuals working there. This will put the business in compliance with new labour legislation as required beginning January 1, 2019.

The future of the Cooperatives is secure as long as CLKD/KS maintains the Service Ontario shredding contract. One of Jonathon's recommendations is that the Cooperatives seek legal advice to confirm their corporate and legal status since it has been more than 25 years since their incorporation.

The Board of Directors funding for a marketing position will be mobilized soon and will work with the Manager, Coordinator and other staff members and persons served to reform the Kwik Shred business along the lines defined in Jonathon's report.

Innovative and Affordable Housing Update

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

At this point, the committee has moved forward with the Community Development Housing Outreach Worker position (Sherry Jarvis). Sherry will be working with CLKD employees and other community partners such as

the Housing Outreach Coordinator for the DSO to explore innovative housing options for persons served. This will include securing funds for housing development projects, particularly as a collaborative venture.

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

Talent Management and Succession Planning Update

CLKD experienced several changes to management positions over the past year. Two of the three vacant positions were filled via promotion, a clear illustration of the value of talent management that identifies and prepares employees for taking on positions of greater responsibility. Their advancement provided three other Coordinator vacancies which were also filled internally.

Additionally, the organization continues to direct efforts toward developing staff members to be "Leaders in Professional Practice." Examples of that include the intensive staff training facilitated by Mental Health First Aid Canada that will be offered to two or three employees who will become the internal trainers for mental health related services and supports. A further example is with the leadership in the human services training that was taken by two new managers and offered by the University of Delaware through the Provincial Network on Developmental Services. That certificate course took place over a full week in September of 2017 in Cambridge, Ontario.

Community Inclusion Two Minute Video

There are two short videos that have been completed that illustrate the lives and celebrate the accomplishments of individuals supported in the Options program. Both are professionally done and will be used for promotional and public awareness purposes. The videos were shown at the November board meeting and have been shared with other stakeholders of the organization.

Community Living Kingston and District

Risk Management Plan- 2018

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 2017. It will be reviewed again in December 2018.

Purpose

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

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

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

Community Living Kingston and District's Approach to Risk

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

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

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

General Strategies Used to Address Risk

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

Avoidance: Discontinuing an activity or not offering a service.
Modification: Implementing activities to reduce the level of risk to an acceptable level (e.g., implementing policies and procedures)

Retention: Accepting all or part of the risk and preparing for potential consequences by accepting deductible costs or self-insuring

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

Specific Strategies Used to Address Risk

People

Area of Risk	Persons Served and Families
Type of Potential Risk	Injuries and Accidents
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Policies and Procedures are followed and regularly reviewed with staff · Staff receive orientation and training in a number of areas, including safety and prevention (e.g., CPI, First Aid/CPR, WHMIS, 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 were no significant injuries to persons served.
New Strategies to be Adopted This Year	· A follow-up will be conducted to last year's initial slips, trips and falls analysis - WHMIS 2015 education and training in progress for all staff -Joint Health and Safety Committee members conducting intermittent site inspections. - Given the complexity of some persons served in Community Services, specifically around drug use and overdose potential, naloxone training should be looked into for staff.

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

Area of Risk	Persons Served and Families
Type of Potential Risk	Violence and Trauma
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Staff trained to assess safety and potential crisis (CPI) · Code of conduct used to reinforce acceptable behaviour at CIP · Abuse education for all persons served, and staff review abuse policies annually · CPI trainers available to do team-specific Applied Physical Training for teams that face significant behaviour challenges.
Results of Actions to Manage Risk	There were no major issues related to violence/trauma this year..
New Strategies to be Adopted This Year	None

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 (held over from last year). -Online training for staff to be developed when organization obtains a Learning Management System (LMS)

	-Procedure to be developed to ensure that temporary download folders are cleared on all computers on a regular basis. -New requirement in Nucleus for user passwords to be updated twice a year.

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	- Abuse education training to be provided to all new staff at New Staff Orientation sessions early in employment - Online training for staff to be implemented into new Surge Learning management system

Area of Risk	Employees
Type of Potential Risk	Injuries and accidents
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Joint Health and Safety Committee of Management and Union representatives · Policies HR 3.01 to 3.15 address employee safety. Includes policies related to lifting, slips, trips and falls, and client handling · Orientation and training for staff includes safety (CPI, WHMIS 2015) · Major injuries and accidents are reported and reviewed for trends with recommendations made to employer by Joint Health and Safety Committee · WSIB coverage, health benefits · External and internal health and safety inspections · Ministry of Labour inspections · All staff annually review policy on workplace violence prevention, as well as general health and safety refreshers · Emergency signage in vehicles; safety checklist to be completed before each use of a vehicle · Ladder safety training completed with teams as needed. · Orientation at CIP includes tips on how to avoid banging head in accessible vehicles

	· Bump caps required for use by staff when utilizing accessible vehicles. - MSD prevention and safe driving videos reviewed by new staff as part of new staff orientation.
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. There were no reported injuries of this sort in 2017. - There were two lost-time injuries in the organization this year, one related to a maintenance issue at the Kwik Shred location, the other due to a staff who injured themselves assisting a person served with a transfer.
New Strategies to be Adopted This Year	- More thorough driver education on accessible vans to be developed in 2018 and introduced to all new staff as well as existing staff that request it. - WHMIS 2015 training and education completed with all staff - All staff to be required to do further training around proper lift practices in Surge.

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

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

Year	- Training on communicable diseases introduced to staff in Surge Learning.

Area of Risk	Employees
Type of Potential Risk	Staff Turnover
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Competitive benefits · Staff recognition program · Formal monitoring of turnover by HR Director · Leadership Development Bursary Fund · Exit interview process · Human Resources section of policy manual designed to ensure a safe workplace · Participation in provincial HR strategy with OASIS and MCSS · Implementation of Core Competencies training.
Results of Actions Used to Manage Risk	· Staff turnover was much higher than usual this year.
New Strategies to be Adopted This Year	- Wellness at Work Committee may assist in advancing strategies that would assist to quell turnover - New hiring practice where staff are interviewed and screened in advance of actual hiring needs put in place in order to decrease issues related to lag time in hiring.

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	-Some articles in Collective Agreement already updated in accordance with changes to ESA based on introduction of Bill 148. Others to follow late in 2018.

Area of Risk	Employees
Type of Potential Risk	Workplace Violence, Harassment
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	High

Current Strategies Used Manage Risk	· CPI Training · Positive Behaviour Support Plans · Manager on-call system for assistance · Additional staffing at homes with high needs · Annual staff review of policies related to workplace violence prevention and harassment
Results of Actions Used to Manage Risk	There was one harassment complaint put forth this year.
New Strategies to be Adopted This Year	- Supervisor training around harassment, sexual harassment and workplace violence completed in 2017. - Online training for all staff to be developed in Surge. - New policies around harassment, sexual harassment, and workplace violence already introduced in 2018.

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

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.
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

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.

Area of Risk	Furnishings, Supplies, Equipment
Type of Potential Risk	Damage, theft
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Low
Current Strategies Used Manage Risk	· Insurance and deductibles · Policy OP 1.03 addresses client home and property issues · Policy FN 1.08 addresses many issues related to risk management
Results of Actions Used to Manage Risk	· There were no significant issues related to damage or theft this year.
New Strategies to be Adopted This Year	None

Area of Risk	Technology
Type of Potential Risk	Security information management, privacy and confidentiality, theft, damage
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	• Office sites are monitored or alarmed at all times • Technology Plan addresses information security • Insurance • Monitoring of information by Nucleus Labs and by Service First
Results of Actions Used to Manage Risk	· There were no significant issues in this area this year..
New Strategies to be Adopted This Year	Cyber security training introduced in Surge in 2018.

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

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

Area of Risk	Financial Practice
Type of Potential Risk	Passing of Bill 148 in November 2017 has potentially significant cost implications.
Frequency (Likelihood)	Certainty (bill has been passed)
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	CLKD has been monitoring this situation since Bill 148 was originally tabled.
Results of Actions Used to Manage Risk	None at this time.
New Strategies to be Adopted This Year	CLKD is drafting a detailed report of the likely costs associated with Bill 148, which will be submitted to MCSS for consideration for funding enhancements. Update: Some relief provided by MCSS in April 2018.

<u>Organization</u>

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

Area of Risk	Service Capacity

Type of Potential Risk	Ability to serve populations that increasingly include issues with homelessness, legal issues, high vulnerability. Addictions
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	· Increased scrutiny over who is accepted into services, based on these needs · Some training available to staff as opportunity arises.
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

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

Area of Risk	Financial Practice, Legal
Type of Potential Risk	There are inherent risks involved in administering private funds for families, as CLKD could be deemed to be the employer, even though families are hiring workers privately.
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	Current invoice form for private work contains language that indicates that CLKD is not the employer.
Results of Actions Used to Manage Risk	None
New Strategies to be Adopted This Year	Legal advice has been provided. 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.

Community Living Kingston and District

Accessibility Plan- 2018

Introduction

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

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

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

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

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

Identification of Barriers

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

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

Communication of Accessibility Plan

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

2018 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 2017	- New spaces for the main administrative sites have been identified. Two programs moved into a new location at 645 Gardiners Road in the summer of 2017. The main office location is slated to move in the fall of 2018. The Options program will move in the spring of 2018. As such, some issues from previous plans have been addressed. - Washrooms at the Co2 location were re-worked to make them more accessible. Total cost was approximately $8000. - The washroom at McMichael was renovated, making it more accessible. Total cost was approximately $7000.
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. **Potential Obstacles:** Cost, about $40,000 **Persons Responsible:** Mark Vass, Sherrill Boyes **Target Date:** Is targeted for between one and three years for completion **Barrier:** Back ramps at Mowat require rebuild for accessibility **Strategies to Remove Barrier:** Rebuild required. **Potential Obstacles:** Costs, about $10,000 **Persons Responsible:** Mark Vass, Sherrill Boyes **Target Date:** Is targeted for between one and three years for completion **Barrier:** Washroom not optimally accessible at 587 Arbour **Strategies to Remove Barrier:** Rebuild required. **Potential Obstacles:** Costs, about $8,000 **Persons Responsible:** Mark Vass, Sherrill Boyes **Target Date:** Is targeted for between one and three years for completion **Barrier:** Washroom at Smithfield not optimally accessible **Strategies to Remove Barrier:** Rebuild required. **Potential Obstacles:** Costs, about $8,000 **Persons Responsible:** Mark Vass, Sherrill Boyes **Target Date:** April 1, 2018 **Barrier:** Washroom not optimally accessible at Ringstead B **Strategies to Remove Barrier:** Rebuild required. **Potential Obstacles:** Costs, about $18,000 **Persons Responsible:** Mark Vass, Sherrill Boyes **Target Date:** Is targeted for between one and three years for completion

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 2017	- Options program has signed a lease to take over new space in the spring of 2018, which will ease crowding, noise, etc.
Standing Items of Concern/Areas needing improvement	None
Future Goals	None

Area(s) of Concern	**Attitudinal**. An *attitudinal* barrier is a preconceived (usually negative) attitude that people have towards persons served. Examples of this may include attitudes of neighbours or other community members, or the lack of "person first" language used by agency personnel.
Items Addressed In 2017	-Core competencies training completed with all new staff in 2017.
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 2017	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 workplace for employees. An employment barrier may also speak to measures that are in place to promote successful employment for persons with disabilities.
Items Addressed In 2017	-Job postings now reference accommodation requests -Community Development Division established in 2017, with a full-time Manager and Coordinator taking the lead around revitalizing employment supports
Standing Items of Concern/Areas needing improvement	Kwik Shred model requires review in light of new Bill 148 announcements
Future Goals	**Barrier:** Establish plan to redesign Kwik Shred **Strategies to Remove Barriers:** CLKD has established a relationship with an MBA student to look at redesign options **Potential Barriers:** Cost, time, creating a business plan **Person(s) Responsible:** Colleen Kelly-Jansen, Kelly Armitage **Target Date:** December 2018

Area(s) of Concern	**Communication.** A *communication* barrier looks at anything that inhibits information being accessible and understandable to all. Examples may include the possible absence of devices available to persons served or personnel to be able to be understood by others, or promotional materials that are not present in formats that are easily understandable.
Items Addressed In 2017	More Family Support and CCRCS documents converted to French. Promotional video designed for CIP to augment written promotional materials. Hiring of a French speaking Family Support Worker.
Standing Items of Concern/Areas needing improvement	- Program information is available only in print and assumes a relatively high level of literacy. The organization attempts to combat this via plain-language versions of many documents (rights, complaints procedure). A concerted effort to develop pictorial versions of personal plans has been underway for several years. The organization desires to develop video versions of many documents. - Ongoing need for ASL training for staff throughout agency, especially at CIP. This is addressed by offering/requiring training upgrades as classes become available in community.
Future Goals	**Barrier:** Ability to communicate with French-language families seeking service would be somewhat limited. **Strategies to Remove Barrier:** Hire a French-language Resource Consultant **Potential Obstacles:** Costs **Persons Responsible:** Jeff Harrison, Erin Impola **Target Date:** December 2018

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 2017	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 2017	Accessibility of website improved, and accessibility section added to site that shows agency efforts to meet OADA requirements.
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 2017	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:** Assign a staff member to housing development. **Potential Obstacles:** Cost, time, ability to develop partnerships **Persons Responsible:** Rob Yeo **Target Date:** April 1, 2018

Requests for Reasonable Accommodations

There were four requests for reasonable accommodations by employees in the past year. Three were documented in *Individual Accommodation Plans*. A summary of the requests follows:

Type of Request	Number of Requests
Schedule request for religious observance	1
Accommodations for documentation/record keeping	1
Accommodations for physical demands associated with position	1
Medical device required in workplace	1

Cultural Competence and Diversity Plan

(Updated February 2018)

1. Preamble

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

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

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

Cultural competency is the self-examination and in-depth exploration of various cultural backgrounds. This includes the recognition of bias, prejudice, and assumptions about individuals from various backgrounds. Such backgrounds include but are not limited to those based on disability, culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status and language. Community Living Kingston and District will be sensitive to, and respectful of the culture and diversity of individuals in regard to the following:

- Language
- Ethnicity
- 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 discriminate in any manner or at any level towards a person or persons based on the aspects of diversity listed above. Policies and practices of the organization will consistently reflect this approach.

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 BD#12, Rights of Participants
- HR Policy #1.01, Staff Code of Conduct
- HR Policy #1.03, Hiring
- HR Policy #1.08, Harassment/Sexual Harassment and Workplace Violence
- HR Policy #2.06, Cultural Competency

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. Specifically, CLKD requested and received funding to hire a bilingual Resource Consultant in order to better serve francophone children and families.

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 Annual 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. Another example of commitment to diversity at the governance leadership level is the recent recruitment of two young members of the board (under 25) to ensure accurate demographic representation.

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 Annual Quality Improvement Report along with other performance measures.

Hiring Practices: Community Living Kingston and District will endeavor 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 organization 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, Annual Report, 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. Individuals with disabilities will be recruited,

trained and compensated to be peer mentors in the process of advising service users of their rights and determining satisfaction levels for program delivery.

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

Technology Plan

(Updated March 2018)

Introduction

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

An effective Technology Plan addresses the following areas: Hardware, Software, Security, Confidentiality, Backup Policies, Disaster Recovery Preparedness, Assistive Technology, and Virus Protection. This plan addresses all of those areas of concern.

Development of the Technology Plan

The technology plan was initiated in 2007 and has been revised at least annually since then. The technology plan will be updated again no later than March 2019.

Plan

Area(s) of Concern	Confidentiality and Security
Current Practices	Personal information is hosted on CLKD servers. The data is secure through the use of passwords, user groups, server directory rights, and limited access points to data CLKD uses a remote desktop server to allow remote users to access the network in a secure manner. Only those staff members with a need to access client and Human Resources data will be permitted access to information All information in the Nucleus Labs Electronic Client Record (ECR) is password protected, with user rights granted to access information on a 'need to know' basis. HR policy 1.19 addresses employee use of the Nucleus ECR system. CLKD's e-mail is contained on an off-site exchange server within the Microsoft Office 365 Cloud and managed by Service First...Total Solutions.
New Items Addressed Since April 2018	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 2019 **Goal:** Implement policy for staff use of the new Ceridian electronic payroll system. **Potential Obstacles:** None **Persons Responsible:** Matt Luck, Jeff Harrison **Target Date:** January 2019 **Goal:** Provide "Security training" to staff as recommended by Service First. **Potential Obstacles:** None **Persons Responsible:** Matt Luck, Jeff Harrison **Target Date:** January 2019 **Goal:** Institute mandatory password reset in Nucleus every six months **Potential Obstacles:** None **Persons Responsible:** Sheri Scott **Target Date:** May 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 Community Options program sites.
New Items Addressed Since April 2018	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. Non-networked computers at day program locations are monitored with virus protection managed by Service First.
New Items Addressed Since April 2018	None.
Future Goals	**Goal:** Provide "Security training" to staff as recommended by Service First. **Potential Obstacles:** None **Persons Responsible:** Matt Luck, Jeff Harrison **Target Date:** January 2019

Area(s) of Concern	Disaster Recovery Preparedness and Back-Up Policies
Current Practices	All data and operating system software located on the agency file server(s) are backed up daily by Service First both locally onsite and offsite to the cloud—backups are monitored by Service First...Total Solutions. Email Information contained on Microsoft Office 365 servers are spread across 3 Microsoft regional data centers in Canada for redundancy—an additional specific agency backup of email is available for extra cost. Service First...Total Solutions is responsible for recovering data and technology functioning in the event of an emergency. All users are directed to maintain company data on the network in order to ensure that the 'crash' of an individual workstation is insignificant in terms of lost data and workstation replacement time. All data on the ECR system is secured by Nucleus Labs.
New Items Addressed Since April 2018	None
Future Goals	None

Area(s) of Concern	Hardware and Software
Current Practices	All servers are located at the main administrative office in a locked, environmentally controlled room Servers and work stations at all administrative offices and program locations are constantly monitored by a third-party professional In the event that a workstation requires attention, is the responsibility of the user to place a work order through a ticketing system that is managed by Service First. Tickets are addressed by Service First in priority sequence. CLKD replaces and upgrades workstation computers, smart phones, and tablets as finances permit. The vast majority of users require only minimal computing speed, power, and storage. Approximately 17 users have higher needs for computing speed/ power and as these “critical” users approach 3-4 years of use, their units are rotated to “non-critical” users with lesser requirements. New computer workstations for critical users are usually purchased every 3-4 years at an approximate cost of $600-$900 per computer. If a unit for a non-critical user is in need of replacement before a critical user’s unit is ready to be passed down, a lower cost computer is then purchased to suit their needs. Internal server equipment (3 units — apps, data and remote desktop servers) is replaced every 3-4 years upon recommendation of Service First...Total Solutions. CLKD's Princess Location 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. Residential Co2 and Milestones locations are connected through remote network. The Nucleus Labs ,Ceridian Dayforce and Surge Leaning systems are monitored by each respective company, with a contract governing the agreement between them and CLKD.
New Items Addressed Since April 2018	25 computers were acquired in total of which 21 replaced aging units and 4 units were added to the fleet to meet growing organizational needs. Also the main server was replaced according to the. In April 2017, CLKD implemented an all in one online HR solution hosted by Ceridian named Dayforce. CLKD is in the process of rolling out an online learning management system which is hosted by Surge Learning.
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, Dixie Luck **Target Date:** April 2019

Area(s) of Concern	Other– Oversight
Items Previously Addressed	As previously outlined CLKD has now contracted with Service First...Total Solutions to provide fully managed support for daily IT operations. Internal involvement with respect to IT matters is now limited to performance oversight for the third party contract arrangement as well as strategic decisions (mostly related to hardware and software planning) 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, Sheri Scott, Jeff Harrison, Matt Luck **Target Date:** April 2019, to be assessed on an ongoing basis collectively by the management team

Plan to Secure Input from Stakeholders

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

Year	Persons Served	Staff	Other Stakeholders
2018 and every third year thereafter	In 2016, a project was led by two occupational therapy students from Queen's University. This project saw a group of four persons served become trained to administer surveys to their peers. This is the desired primary method for persons served to be solicited for feedback. However, due to some logistical issues in 2018, peer surveys were not able to be completed. An online survey was distributed instead.	Staff will not be surveyed, unless specific feedback about certain issues is desired.	The agency will design a survey to elicit feedback specifically from community partners/funders.
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.
2020 and every third year thereafter	The peer-delivered surveys will be the method used, unless unforeseen circumstances dictate otherwise.	Staff will be surveyed.	No other stakeholders will be surveyed in 2020.

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	

Note

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

Review

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

Review of Agency Policies and Procedures

Best practices suggest that a strong organization ensures that the full content of their Policies and Procedures manual are reviewed on an annual basis. This is also required by the agency's CARF accreditation. The following outlines how the practice was completed in 2017-18.

Section 1- General

Policy Number	Policy Name	Review Date	Action Taken (Updated or Remained As Is)	Reviewed By
Board 01	Mission Statement and Value Based Objectives	Note: All Board and General Associations Policies were thoroughly reviewed in August of 2017 by the Executive Director and approved by the Board of Directors thereafter. This review resulted in several policies being largely reworked, and others renamed, renumbered or removed. The list of policies as noted at left reflects the updated list of policies after this review.		
Board 02	Ethical Code of Conduct: Fiduciary Duty of Directors			
Board 03	Ethical Code of Conduct: Conflict of Interest			
Board 04	Ethical Code of Conduct: Confidentiality			
Board 05	Ethical Code of Conduct: Corporate Responsibility			
Board 06	Ethical Code of Conduct: Supply Chain			
Board 07	Board Orientation, Education and Development			
Board 08	Role and Responsibilities of the Board			
Board 09	Individual Responsibilities of Directors			
Board 10	Policy Development (formerly Policy Governance Model)			
Board 11	Executive Director Role and Compensation			
Board 12	Rights of Participants			
Board 13	Succession Planning			
Board 14	Family Involvement			
Board 15	Stakeholder Engagement and Community Linkages			
Board 16	Volunteer Involvement			
Board 17	Statement on Education			
Board 18	Leadership Development Bursary			
GA 01	Privacy			
GA 02	Search Warrant, Summons, Subpoena, and Investigations			
GA 03	Prevention of Waste, Fraud, Abuse, and Wrongdoing			
GA 04	Computer and Network Use			
GA 05	Organizational Mentoring			
GA 06	Logo and Trademarks			
GA 07	Media Relations			

Section 2- Operations

Policy Number	Policy Name	Review Date	Action Taken (Updated or Remained As Is)	Reviewed By
1.01	Confidentiality	March 1 2018	Remained As Is	Operations Director
1.02	Fire Safety	March 1 2018	Remained As Is	Operations Director
1.03	Home and Property of Persons Served	March 1 2018	Remained As Is	Operations Director
1.04	Medication Monitoring and Management	March 1 2018	Remained As Is	Operations Director
1.05	Finance of Persons Served	March 1 2018	Remained As Is	Operations Director
1.06	Eligibility, Service Provision and Discharge	March 1 2018	Remained As Is	Operations Director
1.07	Use of Pornography by Persons Served	March 1 2018	Remained As Is	Operations Director
1.08	Sexuality	March 1 2018	Remained As Is	Operations Director
1.09	Visitors and Guests	March 1 2018	Remained As Is	Operations Director
1.10	Pets and Service Animals	March 1 2018	Remained As Is	Operations Director
1.11	Nutrition	March 1 2018	Remained As Is	Operations Director
1.12	Values and Attitudes	March 1 2018	Remained As Is	Operations Director
2.01	Individualized Planning	March 1 2018	Remained As Is	Operations Director
2.02	French Language Services	March 1 2018	Remained As Is	Operations Director
2.03	Service Quality	March 1 2018	Remained As Is	Operations Director
2.04	Family Home-- Full Time and Respite	November 20 2017	Updated	Operations Director
2.05	Abuse of Persons Served	March 1 2018	Remained As Is	Operations Director
2.06	Safety and Challenging Behaviour	March 1 2018	Remained As Is	Operations Director
2.07	Positive Behaviour Support Plans	March 1 2018	Remained As Is	Operations Director
2.08	Use of Physical Restraint or Intervention	March 1 2018	Remained As Is	Operations Director
2.09	Safe Lifting and MSD Prevention	March 1 2018	Remained As Is	Operations Director
2.1	Handling of Persons Served	March 1 2018	Remained As Is	Operations Director
2.11	Bathing	March 1 2018	Remained As Is	Operations Director
2.12	Medical Information, Decisions, and Support	March 1 2018	Remained As Is	Operations Director
3.01	Standard Administrative Practices	March 1 2018	Remained As Is	Operations Director
3.02	Reporting and Follow-up of Serious Incidents	March 1 2018	Remained As Is	Operations Director
3.03	Internal Investigation Process	March 1 2018	Remained As Is	Operations Director
3.04	Records of Persons Served	March 1 2018	Remained As Is	Operations Director
3.05	Conflict of Interest	March 1 2018	Remained As Is	Operations Director
3.06	Standards for Home Cleanliness	March 1 2018	Remained As Is	Operations Director
3.07	Equipment Maintenance	September 25 2017	Previous OPS 3.07, *Smoking*, removed and amalgamated with HR 2.09. Previous OPS 3.11 renumbered as 3.07	HR Director
3.08	Complaint Resolution	March 1 2018	Remained As Is	Operations Director
3.09	Purchased Service Arrangements	March 1 2018	Remained As Is	Operations Director
3.10	Enhanced Support Requests-- CCRCS	March 1 2018	Remained As Is	Operations Director
4.01	Emergency Response Process	March 1 2018	Remained As Is	Operations Director
4.02	Evacuation	March 1 2018	Remained As Is	Operations Director
4.03	Telephone, Bomb, and Personal Threats	December 20 2017	Updated	HR Director
4.04	Natural Disasters and Utility Failures	March 1 2018	Remained As Is	Operations Director
4.05	Medical Emergencies or Client Distress	March 1 2018	Remained As Is	Operations Director
4.06	Violent and Threatening Situations	February 26 2018	Updated	HR Director

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	December 20 2017	Updated	HR Director
1.02	Criminal Reference Check	December 20 2017	Updated	HR Director
1.03	Hiring	December 20 2017	Updated	HR Director
1.04	Orientation	July 14 2017	Updated	HR Director
1.05	Staff Training	August 28 2017	Updated	HR Director
1.06	Performance Appraisals	October 10 2017	Updated	HR Director
1.07	Scheduling Hours of Work	October 10 2017	Updated	HR Director
1.08	Harassment, Sexual Harassment, and Workplace Violence Prevention	December 20 2017	Amalgamated two policies and updated	HR Director
1.09	Smoking, Alcohol and Drug Use	October 10 2017	Updated	HR Director
1.1	Vehicles, Transportation and Licensing	October 10 2017	Updated	HR Director
1.11	Benefits While On Leave	July 18 2017	Updated	HR Director
1.12	Salary Advances	July 18 2017	Remained as is	HR Director
1.13	Compensation for Non-Union Employees	August 28 2017	Remained as is	HR Director
1.14	Privacy Protection for Employees	October 10 2017	Updated	HR Director
1.15	Workplace Accommodations	December 20 2017	New Policy	HR Director
1.16	Discipline	August 28 2017	Remained as is	HR Director
1.17	Attendance Management	August 29 2017	Remained as is	HR Director
1.18	Use of Social Media	February 26 2018	Updated	HR Director
1.19	Use of Electronic Records System for Persons Served	March 1 2018	Remained As Is	HR Director
1.2	Medical Marijuana and Prescription Medications	October 10 2017	New Policy	HR Director
1.21	Off-Duty Services	February 5 2018	New Policy	HR Director
2.01	Employee Assistance Program	February 12 2018	Updated	HR Director
2.02	Student and Volunteer Placement	October 10 2017	Updated	HR Director
2.03	Staff Recognition	March 1 2018	Remained As Is	HR Director
2.04	Leave for External Work	July 18 2017	Remained as is	HR Director
2.05	Self-Funded Leave	July 18 2017	Remained as is	HR Director
2.06	Cultural Competency	July 18 2017	Remained as is	HR Director
2.07	Personnel Files	March 1 2018	Remained As Is	HR Director
2.08	Meeting Accessibility Needs of Stakeholders	July 18 2017	Remained as is	HR Director
2.09	Talent Management and Succession Planning	September 25 2017	Remained as is	HR Director
3.01	Occupational Health and Safety	September 5 2017	Remained as is	HR Director
3.02	Joint Health and Safety Committee	March 1 2018	Remained As Is	HR Director
3.03	Duties and Responsibilities	March 1 2018	Remained As Is	HR Director
3.04	Workplace Safety and Insurance	August 23 2017	Updated	HR Director
3.05	Early and Safe Return To Work	March 1 2018	Remained As Is	HR Director
3.06	Workplace Inspections	September 5 2017	Remained as is	HR Director
3.07	Accident Investigations	October 10 2017	Updated	HR Director
3.08	Work Refusal	September 27 2017	Remained as is	HR Director
3.09	Communicable Diseases	March 1 2018	Remained As Is	HR Director
3.1	Infection Control	March 1 2018	Remained As Is	HR Director
3.11	WHMIS	October 10 2017	Updated	HR Director
3.12	Use of Personal Electronic Devices	February 26 2018	New Policy (replaced *Cell Phones and Driving)*	HR Director
3.13	Slips, Trips, and Falls	March 1 2018	Remained As Is	HR Director
3.14	Respiratory Protection Program	March 1 2018	Remained As Is	HR Director
3.15	Pandemic Preparedness and Response Plan	March 1 2018	Remained As Is	HR Director

All job descriptions were also reviewed in 2017, with slight updates for wording completed for some.

Section 4- Finance

Policy Number	Policy Name	Review Date	Action Taken (Updated or Remained As Is)	Reviewed By
1.01	Distribution of Financial Information	January 4 2018	Remained As Is	Director of Finance
1.02	Conflict of Interest	February 1 2018	Remained As Is	Director of Finance
1.03	Financial Reporting	March 15 2018	Remained As Is	Director of Finance
1.04	Contracts	January 4 2018	Remained As Is	Director of Finance
1.05	Officers and Signing Officers	February 1 2018	Remained As Is	Director of Finance
1.06	Insurance Coverage	March 15 2018	Remained As Is	Director of Finance
1.07	Capital Assets	January 4 2018	Remained As Is	Director of Finance
1.08	Risk Management	February 1 2018	Remained As Is	Director of Finance
2.01	Banking	March 15 2018	Remained As Is	Director of Finance
2.02	Electronic Banking	January 4 2018	Remained As Is	Director of Finance
2.03	Cheque Signing Authority	February 1 2018	Remained As Is	Director of Finance
2.04	Borrowing	March 15 2018	Remained As Is	Director of Finance
2.05	Investments	February 1 2018	Remained As Is	Director of Finance
2.06	Trusts and Specific Purpose Funds	February 1 2018	Remained As Is	Director of Finance
3.01	Budgets	January 4 2018	Remained As Is	Director of Finance
3.02	Authorization to Commit Resources	February 1 2018	Remained As Is	Director of Finance
3.03	Accounts Receivable and Invoicing	March 15 2018	Remained As Is	Director of Finance
3.04	Cash Receipts	March 15 2018	Remained As Is	Director of Finance
3.05	Accounts Payable and Payment Processing	March 15 2018	Remained As Is	Director of Finance
3.06	Travel Expenses	April 6 2017	Updated	Director of Finance
3.07	Petty Cash	February 1 2018	Remained As Is	Director of Finance
3.08	Consumer Directed Funds	January 4 2018	Remained As Is	Director of Finance
3.09	Family Home Program	February 1 2018	Remained As Is	Director of Finance
3.1	Payroll Processing	March 15 2018	Remained As Is	Director of Finance
3.11	Time Sheets			
3.12	Fundraising	January 4 2018	Remained As Is	Director of Finance
3.13	Donations	February 1 2018	Remained As Is	Director of Finance
3.14	Donations in Kind	March 15 2018	Remained As Is	Director of Finance
3.15	Capital Donations Terms and Conditions	March 15 2018	Remained As Is	Director of Finance
3.16	Hospitality	March 15 2018	Remained As Is	Director of Finance
3.17	Purchasing and Procurement	January 4 2018	Remained As Is	Director of Finance
3.18	Road Transportation	February 1 2018	Remained As Is	Director of Finance
3.19	Child Care Wage Subsidy Distribution	March 15 2018	Remained As Is	Director of Finance
3.2	CIP Transportation Fee	March 15 2018	Remained As Is	Director of Finance
3.21	Use of Facilities by Outside Organizations	January 4 2018	Remained As Is	Director of Finance
3.22	Purchasing Card Program-US Bank	February 1 2018	Remained As Is	Director of Finance
3.23	Expenses and Perquisites	March 15 2018	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 formal intervention of the program Manager has been requested or was required.

Program Area of Complaint:

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

Specific complaints for 2017-18:

- There was one complaint related to the quality of service provided to a person served;
- There were two complaints about the conduct of a staff member;
- There was one complaint about parking practices at Residential locations;

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

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

Trends

In 2016, the threshold for what was considered to be a 'formal' complaint was changed, as for many years the agency had logged no formal complaints but believed that this was misleading. The number of formal complaints has been fairly consistent over the past three years, with six noted in 2015-16 and four in each of the two successive years.

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

Actions to be Taken to Address Areas Needing Improvement
No specific actions are identified because of the variance in the types of complaints

Actions Taken or Changes Made to Improve Performance
Every situation was handled on a case by case basis. No formal investigations were required to handle any of these complaints.

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

Who did we support this year?

		CIP	Residential	Family Home	Respite	SIL/ESIL	Gananoque	CCRCS	Family Support	Employment Supports
Number of Persons Served	2016-17	152	64	28	95	79	27	197	283	n/a
	2017-18	145	49	25	93	114	26	186	254	43
Gender of Persons Served	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%	n/a
	2017-18	Male: 62.1% Female: 37.9%	Male: 67.3% Female: 32.7%	Male: 64% Female: 36%%	Male: 65.6% Female: 34.4%	Male: 58.7% Female: 41.3%	Male: 65.4% Female: 34.6%	Male: 74.2% Female: 25.8%	Male: 60.7% Female: 39.3%	Male: 72.1% Female: 27.9%
Age of Persons Served	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%	n/a
	2017-18	19-29: 20.8% 30-39: 29.8% 40-49: 21.5% 50-59: 7.8% 60-69: 16.7% 70+: 3.5%	19-29: 10.2% 30-39: 6.1% 40-49: 22.4% 50-59: 24.5% 60-69: 24.5% 70+: 12.2%	Under 19: 12% 19-29: 40% 30-39: 24% 40-49: 4% 50-59: 4% 60-69: 16%	Under 19: 36.6% 19-29: 32.3% 30-39: 17.2% 40-49: 7.5% 50-59: 4.3% 60-69: 2.6%	Under 19: 3.5% 19-29: 28.9% 30-39: 18.5% 40-49: 12.3% 50-59: 15.8% 60-69: 21.8%	19-29: 15.4% 30-39: 23.1% 40-49: 11.5% 50-59: 11.5% 60-69: 23.1% 70+: 15.3%	0-2: 0.54% 2-4: 36.6% 4-6: 32.3% 6+: 30.6%	Under 19: 51.2% 19-29: 31.1% 30-39: 8.3% 40-49: 3.9% 50-59: 3.5% 60+ 2.0%	Under 19: 30.2% 19-29: 41.9% 30-39: 9.3% 40-49: 4.7% 50-59: 9.3% 60+: 4.7%
Type of Respite Received or Desired*	2016-17				Family Home: 51.8% Group: 64.2%					
	2017-18				Family Home: 50.5% Group: 62.4%					

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

Who did we support this year?— Barriers

		CIP	Residential	Family Home	SIL/ESIL	Gananoque
Mobility of Persons Served % of persons served who require no mobility assistance	2016-17	59.1%	67.2%	63%	70.6%	70.4%
	2017-18	69.6%	54.2%	72%	66.7%	69.2%
Communication Style of Person Served % of persons served who communicate ver-bally	2016-17	73.4%	46.7%	71.4%	78.5%	85.2%
	2017-18	65.3%	51%	68.1%	88%	84.6%
Transportation Used By Persons Served*	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%
	2017-18	Accessible: 33.1% Public Transit: 24.1% Walk/Bike: 12.2% Provided Rides: 66.9%	Accessible: 24.5% Public Transit: 14.2% Walk/Bike: 2% Provided Rides: 91.8%	Accessible: 20% Public Transit: 28% Walk/Bike: 12% Provided Rides: 56%	Accessible: 13.2% Public Transit: 49.1% Walk/Bike: 49.4% Provided Rides:49.1%	Walk/Bike: 73.1% Provided Rides: 76.9% Drives own car: 15.4%

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

*

Community Inclusion Programs

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	What are we measuring? (Indicator)	Who are we looking at? (Target Population Applied)	Where are we getting the data (Data Source)?	What time period did we look at (Time of Measurement)?	How often are we measuring this (Follow up Interval)?	Awesome This would be a great result that shows all of the hard work we do for persons served	Not too bad We can do better. It shows that we are on the right track but we can improve even more.	We need to work on it We can do much better, and need to really look at improvement strategies	
For persons served to be involved in their community (*effectiveness*)	# of new community based resources developed	All persons served, Options	Program Coordinators	December 1, 2017-March 31, 2018	Annually	At least 10	Between 7 and 10	Less than 7	3
For persons served to be involved in their community (*effectiveness*)	# of new community based resources developed	All persons served, Co2	Program Coordinators	December 1, 2017-March 31, 2018	Annually	At least 8	Between 5 and 8	Less than 5	3
For persons served to be involved in their community (*effectiveness*)	# of new community based resources developed	All persons served, Milestones	Program Coordinators	December 1, 2017-March 31, 2018	Annually	At least two	One	None	0

Trends: This is the first year where this has been measured, so no comparative trends can be noted.

Extenuating Factors/Discussion: Three new ongoing resources were developed at Options— at three not-for-profit organizations. At Co2 the ongoing resources developed were at a local billiard hall, at a tai chi centre, and a chair yoga activity. At Milestones, there was disruption in the supervision of the program due to a sick leave that took a prolonged period of time to get sorted out. As such, nobody was 'assigned' to take the lead around developing new resources.

Follow-Up Completed: An emphasis has been placed with Facilitators to ensure that new community sites are being developed, as opposed to an expansion persons accessing existing sites.

Action Plan: Facilitators will continue to be instructed to develop new community sites, with frequent inquiries from their supervisor.

Community Inclusion Programs

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff in CIP	Dayforce (HR and Payroll Software)	January 1, 2017 -December 31, 2017	Every Six Months	Less than 4%	Between 4% and 5%	More than 6%	2.22%

Trends:

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

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcome measures are. In 2017, CLKD switched to a new payroll/attendance system; there is some reason to suspect that some calculations within this system may have resulted in a slightly lower sick rate than may have been calculated in previous years. This will be monitored going forward. It is noted that changes to the Employment Standards Act in 2018 may place some limits on ability to manage light absenteeism.

Follow-Up Completed: Employee sick rates are measured every six months, with follow-up done with employees with significantly heavy usage, per the agency's *Attendance Management Program.*

Action Plan The *Attendance Management Program* may require revision to reflect changes to the Employment Standards Act, as will some articles in the agency's Collective Agreement with CUPE 2635.

To ensure access to the community for persons served (*service access)*	# staff trained in person-centered planning principles	All Staff in CIP	Training Records	December 1, 2017-March 31, 2018	Annually	8 or more	6 or 7	Less than 6	6

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

Extenuating Factors/Discussion: One staff member from each of Milestones and Options and four from CO2 have been trained.

Follow-up Completed: None formal, other than to start ensuring that *some* staff were scheduled for such training. The target may have been somewhat ambitious, given the short time frame (December through March).

Action Plan: To focus further attention on this training need and ensure that staff are identified and scheduled accordingly.

Residential Services Division

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
For persons served to have 'natural' supports (*effectiveness*)	% of persons served increasing or maintaining amount of non-family/non-staff supports	All Persons Served, Residential Services	Unpaid Supports Tracking Sheets	April 1, 2017-March 31, 2018	Every Three Months	More than 80%	Between 65% and 80%	Less than 65%	40.9%
For persons served to have family supports (*effectiveness)*	% of persons served increasing or maintaining amount of family supports	All Persons Served, Residential Services	Unpaid Supports Tracking Sheets	April 1, 2017-March 31, 2018	Every Three Months	More than 80%	Between 65% and 80%	Less than 65%	67.6%

Trends: While the agency has collected data on these outcomes for many years, this is the first year where the measure was looked at in this manner. As such, no trends are currently available.

Extenuating Factors/Discussion: It should be noted that maintaining no supports through the course of the year is not considered to be 'maintaining' for the purposes of this measure. Many persons served have no known family members. They are excluded from consideration.

Follow-Up Completed: The importance of unpaid supports is reinforced with staff as part of orientation. Graphs are produced with statistics and shared with staff teams and the Volunteer Coordinator on a monthly basis. There was a focus on unpaid supports were a focus of discussion at team meetings. Training occurred in 2017 around Supporting and Developing Natural Supports.

Action Plan: Graphs may be losing their impact on staff teams because they are distributed so often. They will only be shared quarterly going forward. Unpaid supports will continue to be discussed at team meetings and shared with the Volunteer Coordinator. Unpaid supports will still be a focal point of orientation.

Residential Services Division

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	What are we measuring? (Indicator)	Who are we looking at? (Target Population Applied)	Where are we getting the data (Data Source)?	What time period did we look at (Time of Measurement)?	How often are we measuring this (Follow up Interval)?	Awesome This would be a great result that shows all of the hard work we do for persons served	Not too bad We can do better. It shows that we are on the right track but we can improve even more.	We need to work on it We can do much better, and need to really look at improvement strategies	
To reduce medication errors (*supplemental*)	Number of 'Tier 1' medication errors	All persons served, Residential Services	Nucleus Labs Report	April 1, 2017-March 31, 2018	Every Three Months	Less than 60	Between 60 and 80	More than 80	101

Trends:

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

Extenuating Factors/Discussion: While data on med errors has been collected since 2006, they were only divided into 'Tier 1' and 'Tier 2' errors starting in 2016. 'Tier 1' errors are serious errors such as non-administration of medication, administering medication at the wrong time or to the wrong person, etc. 'Tier 2' errors are signing errors, errors in written instructions, etc. There were 50 Tier 2 errors this year, down from 59 the previous year. Three locations accounted for 55% of the total Tier 1 errors, with one location alone being responsible for 27%. Six of the twelve locations had less than six errors this year.

Follow-Up Completed: Program Coordinators were supplied with data to share at staff meetings at intervals during the year. Staff making errors were contacted by their Coordinator following the error(s). Staff committing multiple errors are required to complete additional medication training. Staff are required to review all medication practices at the time of their performance evaluations.

Action Plan: A new strategy has been put in place where Tier 1 errors are committed. In these instances, staff will now be required to meet with both the Coordinator and the Manager to review the error and discuss how it may have been prevented. The staff are then given a medication training review package and an on-site medication administration observation with a Residential Coordinator who is not the one that directly supervises the staff person (to ensure that an outside set of eyes is monitoring for best practices). Options to load additional training onto Surge, the agency's new Learning Management System, will also be explored.

Residential Services Division

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Residential Services	Nucleus Labs Report	January 1, 2017 -December 31, 2017	Every Six Months	Less than 5%	Between 5% and 6%	More than 6%	3.67%

Trends:

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

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcome measures are. In 2017, CLKD switched to a new payroll/attendance system; there is some reason to suspect that some calculations within this system may have resulted in a slightly lower sick rate than may have been calculated in previous years. This will be monitored going forward. It is noted that changes to the Employment Standards Act in 2018 may place some limits on ability to manage light absenteeism. Sick rate targets for Residential Services are slightly less ambitious than in other departments in deference to the 24-hour nature of the service.

Follow-Up Completed: Employee sick rates are measured every six months, with follow-up done with employees with significantly heavy usage, per the agency's *Attendance Management Program.*

Action Plan The *Attendance Management Program* may require revision to reflect changes to the Employment Standards Act, as will some articles in the agency's Collective Agreement with CUPE 2635.

To ensure access to augmentative communication systems (*service access)*	Number of staff taking training in augmented communication systems	All Staff, Residential Services	Training Records	April 1, 2017- March 31, 2018	Once A Year	At least 4	2 or 3	Less than 2	0

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

Extenuating Factors/Discussion: None.

Follow-Up Completed: No formal follow up was completed.

Action Plan: The program Manager (or delegate) will seek out training programs. The JSEC will similarly investigate this issue to see if there is training to recommend.

Community Services Division — Supported Independent Living

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
Ensure that persons served have a chosen, socially valued role (*effectiveness*)	% of persons served with noted social role identified in personal plan	All Persons Served, Community Services	Personal Plans	April 1, 2017– March 31, 2018	Annually	More than 75%	Between 65% and 75%	Less than 65%	28%

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

Extenuating Factors/Discussion: It is possible that there are some plans that have not been uploaded to our database, which may impact the figures. In reviewing the files, it was noted that the percentage of persons served who have an up to date personal plan is only at about 48%. There were also a number of circumstances where the information in the personal plan and the agency's Personal Outcome Management System were not consistent. It appears that there is a significant procedural issue where planning is concerned that has impacted success rates at ensuring that social roles are identified in plans.

Follow-Up Completed: None at this time.

Action Plan: The program Manager has established a number of procedural objectives to work towards addressing this in 2018-19:

1. Establishing a time frame for *initial* personal plans to be completed for new persons served.
2. Establishing expectations for Compass and LTC regarding personal plans, as they do not appear to be completed at all.
3. Establishing a process for persons served who refuse to participate in planning. The agency does have a process for this, which teams will be reminded of.
4. Ensuring that when staff use the agency planning checklist , they actually ensure that items checked off on the checklist have been completed.

Community Services Division — Supported Independent Living

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Community Services	Nucleus Labs Report	January 1, 2017 -December 31, 2017	Every Six Months	Less than 4%	Between 4% and 5%	More than 5%	2.56%

Trends:

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

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcome measures are. In 2017, CLKD switched to a new payroll/ attendance system; there is some reason to suspect that some calculations within this system may have resulted in a slightly lower sick rate than may have been calculated in previous years. This will be monitored going forward. It is noted that changes to the Employment Standards Act in 2018 may place some limits on ability to manage light absenteeism. This is the first year that sick rates for SIL have included the Compass, Gananoque and Parkway programs.

Follow-Up Completed: Employee sick rates are measured every six months, with follow-up done with employees with significantly heavy usage, per the agency's *Attendance Management Program.*

Action Plan The *Attendance Management Program* may require revision to reflect changes to the Employment Standards Act, as will some articles in the agency's Collective Agreement with CUPE 2635.

To ensure that persons served enter service as soon as possible after funding is identified (*service access)*	% of persons served in service within 60 days of funding approval	All Persons Served, Community Services	Nucleus Labs Report	April 1, 2017- March 31, 2018	Once A Year	At least 75%	Between 50% and 75%	Less than 50%	100%

Trends: The previous year's result also showed 100% success.

Extenuating Factors/Discussion: Figures are based on only four referrals. There is reason to believe that the data set is unreliable due to how dates of referral are entered.

Follow-Up Completed: None

Action Plan Training with staff around data entry.

Family Services Division—Family Home

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
Ensure continuity of Family Home living arrangements (*effectiveness*)	% of persons served maintaining family home arrangement for entire year	All Persons Served in a 'Traditional' Family Home arrangement	Program Coordinator	April 1, 2017-March 31, 2018	Once a Year	More than 90%	Between 80% and 90%	Less than 80%	96%

Trends:

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

Extenuating Factors/Discussion: One situation was discontinued, which resulted from a medical emergency with a provider. As is evident from the trends, success rates have been very high in the program for many years. The program has consistently maintained rates above 80% since 2008.

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

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

Family Services Division—Family Home

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Family Home program	Nucleus Labs Report	January 1, 2017 -December 31, 2017	Every Six Months	Less than 4%	Between 4% and 5%	More than 5%	1.45% (note: combined with Respite statistics)

Trends:

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

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcome measures are. In 2017, CLKD switched to a new payroll/attendance system; there is some reason to suspect that some calculations within this system may have resulted in a slightly lower sick rate than may have been calculated in previous years. This will be monitored going forward. It is noted that changes to the Employment Standards Act in 2018 may place some limits on ability to manage light absenteeism.

Follow-Up Completed: Employee sick rates are measured every six months, with follow-up done with employees with significantly heavy usage, per the agency's *Attendance Management Program.*

Action Plan The *Attendance Management Program* may require revision to reflect changes to the Employment Standards Act, as will some articles in the agency's Collective Agreement with CUPE 2635.

Family Services Division—Family Home

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure that there are family home providers available when vacancies arise (*service access)*	# of new Family Home providers recruited, screened and approved	All Providers, Family Home program	Program Coordinator	April 1, 2017-March 31, 2018	Once A Year	At least 2	At least 1	None	1

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

Extenuating Factors/Discussion: None.

Follow-Up Completed: First steps have been taken around realigning the duties within the Family Home and Respite departments so that the recruitment duties are assigned to a different position. It is felt that this restructuring will better position the program to ensure strong recruitment of providers.

Action Plan: Completed realignment of recruitment duties, as noted above. Review materials from other organizations in an attempt to secure further recruitment ideas.

Family Services Division—Respite

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
Ensure usage of Respite House (*effectiveness*)	% of days respite house is utilized for funded or private respite	Respite House	Program Coordinator	April 1, 2017-March 31, 2018	Once a Year	More than 80%	Between 65% and 80%	Less than 65%	69.6%

Trends:

Year	2006-07	2007-08	2008-09	2009-10	2012-13	2013-14	2016-17	2017-18
% Usage	77.8%	78.96%	80%	76.43%	88.35%	93.9%	69%	69.6%

Extenuating Circumstances/Discussion: Data above is from selected years since 2006. In the two years where service usage met the target, a specific family had been allotted additional funding for their respite needs. When they no longer required respite, it left a great deal of time where the respite home was not in use. The location is used on the weekends by four rotating groups of service users. This means that the time where focus needs to be placed in order to increase service usage is during the weekdays. One individual service user utilizes the location for respite for one full week every other week.

Follow-Up Completed: The Coordinator of the Respite program has offered the location for private and emergency respite (with private workers or with agency staff), which can be cost prohibitive in the current funding environment.

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

Family Services Division—Respite

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Respite program	Nucleus Labs Report	January 1, 2017 -December 31, 2017	Every Six Months	Less than 4%	Between 4% and 5%	More than 5%	1.45% (note: combined with Family Home stats)

Trends:

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

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcome measures are. In 2017, CLKD switched to a new payroll/attendance system; there is some reason to suspect that some calculations within this system may have resulted in a slightly lower sick rate than may have been calculated in previous years. This will be monitored going forward. It is noted that changes to the Employment Standards Act in 2018 may place some limits on ability to manage light absenteeism.

Follow-Up Completed: Employee sick rates are measured every six months, with follow-up done with employees with significantly heavy usage, per the agency's *Attendance Management Program.*

Action Plan The *Attendance Management Program* may require revision to reflect changes to the Employment Standards Act, as will some articles in the agency's Collective Agreement with CUPE 2635.

Family Services Division—Respite

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure that respite allocations are being effectively used. (*service access)*	% of Family Home respite allocation utilized	All persons served, Respite program	Program Coordinator	April 1, 2017-March 31, 2018	Once A Year	More than 85%	Between 65% and 85%	Less than 65%	60.4%

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

Extenuating Circumstances/Discussion: There was $28,800 in Family Home respite available for thirteen users this year. Seven of these users utilized at least 75% of their allocation, with four using 100%. Three users used non of their allocation. At the conclusion of the fiscal year, the program Manager was able to reallocated some of the unused funds to alleviate other respite pressures. A shortage of Family Home respite providers would contribute to lack of usage.

Follow-Up Completed: In some cases where there has been significant non-usage, individuals from the waitlist were invited to use the funds.

Action Plan: Continue to offer individuals from the waitlist the opportunity to use funds that appear to be going unused. Recruit more Family Home respite providers.

Family Services Division— Child Care Resource Consultant Services

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
Ensure maximum usage of enhanced funding (*effectiveness*)	# of children reported as unable to attend child care centres due to lack of enhanced funding	All centres served by CCRCS	Program Co-ordinator	April 1, 2017-March 31, 2018	Once a Year	Less than 2	Between 2 and 5	More than 5	0

Trends:

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

Extenuating Factors/Discussion: None. The team has continued to work very hard to ensure that *some* amount of enhanced funding has been available all centres so that children are not left unable to attend. This may sometimes mean that less funding than was desired was provided, but it provided some measure of assistance.

Follow-up Completed: The organization has continued to try to make it's case for the need for more enhanced funding to meet the needs of centres/families. To this end, the City of Kington has allotted an increase of $162,000 per year in enhanced funding..

Action Plan: The program recognizes that with the significant increase in enhanced funding, but with the same resources in place to administer the funding, some processes around how enhanced funding is decided upon and dispersed may need to be changed. A review of these processes will occur in 2018-19.

Family Services Division— Child Care Resource Consultant Services

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Respite program	Nucleus Labs Report	January 1, 2017 -December 31, 2017	Every Six Months	Less than 3%	Between 3% and 4%	More than 4%	1.26%

Trends:

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

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcome measures are. In 2017, CLKD switched to a new payroll/attendance system; there is some reason to suspect that some calculations within this system may have resulted in a slightly lower sick rate than may have been calculated in previous years. This will be monitored going forward. It is noted that changes to the Employment Standards Act in 2018 may place some limits on ability to manage light absenteeism. The acceptable sick rate for CCRCS is slightly lower than in some other programs due to the nature and hours of the program.

Follow-Up Completed: Employee sick rates are measured every six months, with follow-up done with employees with significantly heavy usage, per the agency's *Attendance Management Program.*

Action Plan The *Attendance Management Program* may require revision to reflect changes to the Employment Standards Act, as will some articles in the agency's Col-

Family Services Division— Child Care Resource Consultant Services

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure that families receive service as quickly as possible after referral (*service access)*	% of persons served in service within 60 days of referral	All new referrals, CCRCS program	Nucleus Labs Reports	April 1, 2017-March 31, 2018	Once A Year	More than 67%	Between 50% and 67%	Less than 50%	86.2%

Trends:

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

Extenuating Factors/Discussion: There were 65 referrals to the program this year, which is virtually the same as the year before (65). The average wait time was 33.5 days. The shortest wait time was one day. The longest wait time was 154 days.

Follow-Up Completed: The program Coordinator and the program staff have been extremely diligent about ensuring that new referrals are processed quickly, though this can be extremely challenging given current workloads.

Action Plan The program is hiring an addition Resource Consultant with funds secured from the City of Kingston. This position will be a designated French-language job. Having an extra Resource Consultant will be helpful at trimming wait times. It will also free up the program Coordinator from some other duties, allowing her to spend more time on timely intake.

Family Services Division— Family Support

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
Ensure that families have access to information, outreach and support (*effectiveness*)	# of monthly drop in and parent group meetings attended by at least ten families	All drop ins, Family Support	Program Coordinator	April 1, 2017-March 31, 2018	Once a Year	At least 8	Between 5 and 7	Less than 5	5

Trends: In the previous year (the first year this was tracked), there were no months where these events were attended by at least ten families.

Extenuating Factors/Discussion: The lowest number of attendees was 1, in both July and August of 2017. This mirrors attendance numbers seen the previous year, when only 1 family attended the summer events. The highest numbers were 23 (December) and March (61) (in 2016-17, the highest was 6). The average number was 18 (previous year: 2.6). The median number was 8 (previous year: 3). Figures for December were likely higher because a social Christmas potluck accompanied the event. In March, the figure was higher because staff from Developmental Services Ontario were on hand to explain changes to Passport administration, which was a topic of high interest.

Follow-up Completed: The Family Support program has been piloting a satellite location at Molly Brant Public School in order to better meet families at needed locations. This has proven successful.

Action Plan: To continue to find topics of interest to families to encourage them to attend events. To continue with the satellite program at Molly Brant.

Family Services Division— Family Support

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Family Support program	Nucleus Labs Report	January 1, 2017 -December 31, 2017	Every Six Months	Less than 3%	Between 3% and 4%	More than 4%	0.19%

Trends:

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

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year as other outcome measures are. In 2017, CLKD switched to a new payroll/attendance system; there is some reason to suspect that some calculations within this system may have resulted in a slightly lower sick rate than may have been calculated in previous years. This will be monitored going forward. It is noted that changes to the Employment Standards Act in 2018 may place some limits on ability to manage light absenteeism. Acceptable sick rates are slightly lower in Family Support than in other programs due to the nature and hours of work.

Follow-Up Completed: Employee sick rates are measured every six months, with follow-up done with employees with significantly heavy usage, per the agency's *Attendance Management Program.*

Action Plan The *Attendance Management Program* may require revision to reflect changes to the Employment Standards Act, as will some articles in the agency's Collective Agreement with CUPE 2635.

Family Services Division— Family Support

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To ensure that families receive service as quickly as possible after referral (*service access)*	% of persons served in service within 60 days of referral	All new referrals, Family Support program	Nucleus Labs Reports	April 1, 2017-March 31, 2018	Once A Year	More than 67%	Between 50% and 67%	Less than 50%	91.36%

Trends:

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

Extenuating Factors/Discussion: Success rates have been very high. However, the program does not take referrals from the local Pressures and Priorities table until they are in a position to meet with the new referrals (as is the case with all local agencies). As such, families may remain waiting for service at the Pressures and Priorities table for some time. The program is only admitting children as new referrals.

Follow-Up Completed: The Program staff has simply been cautious about when they accept new referrals from the Pressures and Priorities table and diligent about meeting with new families after referrals are made.

Action Plan To continue with the strategies already in place.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	What are we measuring? (Indicator)	Who are we looking at? (Target Population Applied)	Where are we getting the data (Data Source)?	What time period did we look at (Time of Measurement)?	How often are we measuring this (Follow up Interval)?	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure staff health and safety	OSHA Recordable Injury Rate	All Staff	WSIB Reports, Dayforce reports	April 1, 2017-March 31, 2018	Every Six Months	0 per 100 FTE	Between 0 and 3 per 100 FTE	More than 3 per FTE	5.99

Trends:

Year	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Result	**2.03**	2.49	2.38	3.58	2.95	5.99

Extenuating Factors/Discussion: This was by far the highest number of recorded injuries (14) in some time (eight had been the highest in recent years). Most of the injuries (12) were minor and did not result in lost time. Causes of injuries included falls, lifts/transfers, a needle stick, a head bump, and a cut hand. In past years, concussions had been a major cause of injury. There was one concussion this year. Two injuries required accident investigations. Two injuries were the result of aggression on the part of persons served.

Follow-Up Completed: To help staff deal with challenging behavior, CPI training is required, as are Positive Behaviour Support Plans. Video training has been delivered to all staff around general lift and transfer best practices. Lift and transfer protocols are in place for those that need physical assistance at all Residential and CIP locations. Bump caps put in place when using accessible vehicles to combat concussion issue. Injury information has been shared with the Joint Health and Safety Committee.

Action Plan: Continue with all items in follow-up already noted. In 2018, online training on new Learning Management System, Surge, will made mandatory. Required training will cover many health and safety requirements.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	What are we measuring? (Indicator)	Who are we looking at? (Target Population Applied)	Where are we getting the data (Data Source)?	What time period did we look at (Time of Measurement)?	How often are we measuring this (Follow up Interval)?	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure staff health and safety	OSHA Lost Time Case Rate	All Staff	WSIB Reports, Dayforce reports	April 1, 2017-March 31, 2018	Every Six Months	0 per 100 FTE	Between 0 and 1 per 100 FTE	More than 1 per FTE	0.86

Trends:

Year	2014-15	2015-16	2016-17	2017-18
Result	0.95	2.24	0.42	0.86

Extenuating Factors/Discussion: There were two lost-time injuries this year. There had been one the year before, and five the year before that. However, this year's injuries resulted in more lost time than ever before— 228 total hours. One injury (a back injury) was at CLKD's shredding operation while another was at a Residential location, a back injury that was the result of lifting.

Follow-Up Completed: Same as for OSHA Recordable Injury Rate.

Action Plan: Same as for OSHA Recordable Injury Rate

To manage long-term costs	Unfunded Liabilities (in dollars) in Excess of 30 Days	All Staff	Finance Reports	April 1, 2017-March 31, 2018	Every Six Months	Less than $85,000	Between $85,000 and $100,000	More than $100,000	$89,662

Trends:

Year	2016-17	2017-18
Amount	$89, 523	$89, 662

Extenuating Factors/Discussion: The number of full-time staff grows slightly each year. The vast majority of full-time staff are long-tenured staff, meaning that they have access to a great deal of vacation time (five weeks at ten years, six weeks at fifteen years, plus additional days at anniversary points). Overall accruals owing are $612,000.

Follow-Up Completed: The scheduling supervisor regularly reviews full time accruals for those that they schedule and approaches staff about scheduling time off accordingly.

Action Plan The scheduling supervisor will continue with her actions. Accruals will be sent to other program Managers to monitor staff not overseen by Scheduling.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	What are we measuring? (Indicator)	Who are we looking at? (Target Population Applied)	Where are we getting the data (Data Source)?	What time period did we look at (Time of Measurement)?	How often are we measuring this (Follow up Interval)?	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure responsive on-call systems	% of calls responded to in six minutes or less	All Calls to Manager On-Call System	Alliance Wireless Reports	April 1, 2017-March 31, 2018	Every Six Months	More than 80%	Between 65% and 80%	Less than 65%	69.4%

Trends:

Year	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Result	88.3%	44%	65.6%	84.6%	86.2%	53.2%	69.8%	69.4%

Extenuating Factors/Discussion:

- Of those calls that did not meet the target, 60% had an extended period of time before the call system first tried to call Managers.
- There were 72 calls to the system
- 45.8% of calls were related to medical issues with persons served; 12.5 % were due to a property issue; 12.5% due to a person served showing challenging behavior
- The shortest response time was 1 minute; the longest was 26 minutes; the average time was 6.5 minutes.

Follow-Up Completed:

- The organization sends a prioritized list of available Managers to the service on a weekly basis
- The organization has followed up regularly with the service in order to ensure their understanding that the service needs to call Managers immediately upon receiving a call from staff

Action Plan:

- Continue with approaches already noted in 'Follow-up Completed"

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To ensure consistent staffing	Part-Time Turnover Rate	All Part-Time Staff	Dayforce and Other HR Records	April 1, 2017-March 31, 2018	Once A Year	Less than 15%	Between 15% and 25%	More than 25%	25.2%

Trends: Previous turnover rates used a different calculation system that may not have been accurate. Therefore, no comparison is being drawn to previous years

Extenuating Factors/Discussion:

- The turnover rate for full-time staff was 1.7%. The turnover rate for part-time staff was 25.2%. The overall turnover rate was 14.1%
- Of the departing part-time staff, 40.5% left for full-time work or jobs that did not involve shift work. 27% left because they moved from Kingston. The others left due to health, personal reasons, or just because they didn't find CLKD to be a good fit for them.
- Of the departing part-time staff, 51.2% had worked for the agency for less than a year
- All departures were resignations except for one occasion where a probationary staff member was dismissed.
- Full-time figures account only for bargaining-unit departures, and do not reflect Management staff who retired.

Follow-up Completed:

- A new exit interview process was put in place in the hopes of getting more information about why part-time staff are leaving. The new exit interview is quite detailed and asks for a great deal of information. It is also being sent to departing staff in a much more timely manner.

Action Plan:

- To look at the results of the exit interview in 2018 to determine areas for improvement.
- Look at more follow-up with new staff to ensure that they feel supported, in case this is an issue for new employees.
- Some departures happened because some staff reported not being comfortable with personal care. Another organization in town has had similar concerns reported by departing new staff. CLKD and the other organization have jointly approached St. Lawrence College to see if there are ways to address this issue at the college level, before even applying for work in this field. A meeting to this end is scheduled in May 2018.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure consistent staffing	% of Part-Time Vacancies Filled Within 14 Days	All Staff	HR Records	April 1, 2017-March 31, 2018	Every Six Months	More than 75%	Between 60% and 75%	Less than 60%	63.6%
Trends: No previous data available, though anecdotally it was rare to have replacements in place in this time frame **Extenuating Factors/Discussion:** The average replacement time was 12.2 days. **Follow-Up Completed:** New system was put in place in 2018. Instead of 'crisis hiring' when a vacancy came up, strong applicants were interviewed upon approaching the agency, allowing for there to be a number of pre-screened candidates on hand to whom to offer positions. **Action Plan:** Continue with approach noted in 'Follow-up Completed"									
To ensure regular feedback to staff	% of Staff Who Have Had A Performance Appraisal Within the Past Year	All Staff	Dayforce Records	Measured as of April 1, 2018	Every Six Months	More than 75%	Between 60% and 75%	Less than 60%	32%
Trends: This is the first time that this has been tracked in this manner. **Extenuating Factors/Discussion:** There are three programs where staff do not appear to be getting probationary appraisals completed. In other cases, many long-term staff are very overdue for appraisals. Appraisals for Management, administrative and supervisory-level positions are also typically overdue. **Follow-Up Completed:** The system by which supervisors are informed of overdue appraisals was a bit spotty in 2017, as records were transferred to a new system where the reporting features proved to be challenging. Follow up with Coordinators about overdue appraisals has also not been diligent. **Action Plan:** The appraisal database has been moved to Surge Learning, where reporting features are much more user-friendly. This will assist with getting up dates to supervisors much more quickly. Supervisors will receive follow-up around overdue appraisals. A new, shorter, performance appraisal form is being introduced in May 2018.									

Surveys— All Programs

What Question Did We Ask?	How are we hoping to do (target)?			How did we actually do? (Results)
All Questions Were Asked on a 'Mostly Yes' or 'Mostly No' Basis, unless otherwise noted. We Want As Many 'Mostly Yes' Answers as Possible in the Results.	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
I am treated with respect by CLKD	90% or better	Between 80% and 90%	Less than 80%	100%
When I have a question or concern, CLKD gets back to me quickly	90% or better	Between 80% and 90%	Less than 80%	100%
CLKD has helped me become more involved in the community	90% or better	Between 80% and 90%	Less than 80%	93.3%
The community activities that CLKD assists me with are meaningful	90% or better	Between 80% and 90%	Less than 80%	100%
CLKD respects my choices and wishes	90% or better	Between 80% and 90%	Less than 80%	100%
Overall, I am happy with the support I get from CLKD	90% or better	Between 80% and 90%	Less than 80%	100%

Who Took the Survey?

CIP 48.39% Community Services 19.35% Residential Services 32.26% Family Home 6.45$ Respite 12.9% Family Support 16.13% Employment 6.45%
* Respondents may be a part of multiple programs, so figures will add up to greater than 100%

Trends: Satisfaction levels have been consistently high ever since surveys were introduced in 2007.
Extenuating Factors/Discussion: There were only 31 respondents to the survey, which accounts for less than 5% of those supported by the agency. This survey was done via surveymonkey.com, which probably required persons served to have assistance from staff or advocates, bringing forward the possibility of some response bias. The organization had been completing surveys the past few years by having peers survey their peers. Because of some logistical issues, this project required some reshaping, which means that this method was not followed this year. Given the high rates of satisfaction, responses were not further examined by program, as it would not lead to further insight.
Follow-Up Completed: The peer surveyor project has been re-worked to for implementation in 2018
Action Plan: To fully re-implement peer surveyor project.

Surveys— Child Care Resource Consultant Services

What Question Did We Ask?	How are we hoping to do (target)?			How did we actually do? (Results)
All Questions Were Asked on a Yes or No Basis, unless otherwise noted. **We Want As Many 'Yes' Answers as Possible in the Results.**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
When you first started services, was your intake completed in a timely manner?	90% or better	Between 80% and 90%	Less than 80%	96.4%
The Resource Consultant is flexible in meeting our communication needs (meetings, phone calls, emails,)	90% or better	Between 80% and 90%	Less than 80%	100%
The information shared with me by the Resource Consultant is useful.	90% or better	Between 80% and 90%	Less than 80%	100%
The Resource Consultant treats our family with respect and dignity	90% or better	Between 80% and 90%	Less than 80%	100%
I am aware that my child has an Individual Program Plan and/or a One Page Profile	90% or better	Between 80% and 90%	Less than 80%	96.4%
The Resource Consultant makes us aware of other services in the community as necessary	90% or better	Between 80% and 90%	Less than 80%	92.6%
The Resource Consultant was helpful in assisting us with our child's transition to school	90% or better	Between 80% and 90%	Less than 80%	95.2% of those whose child had transitioned
Please rate your overall satisfaction with the services offered by Child Care Resource Consultant Services (Outstanding, Above Average, Satisfactory or Unsatisfactory)	At least 90% Outstanding or Above Average	Between 80% and 90% Outstanding or Above Average	Less than 80% Outstanding or Above Average	89.2% 67.8% said Outstanding! Nobody said Unsatisfactory

Who Took the Survey?

78.5% City of Kingston Residents	70% had children ages 2-6	42.9% involved with program more than two years
14.3% Frontenac Township Residents	29.6% had children age 6+	25% involved with program one to two years
7.1% from other areas	7.4% had children under age 2	32.1% involved with program less than one year

Surveys— Community Partners

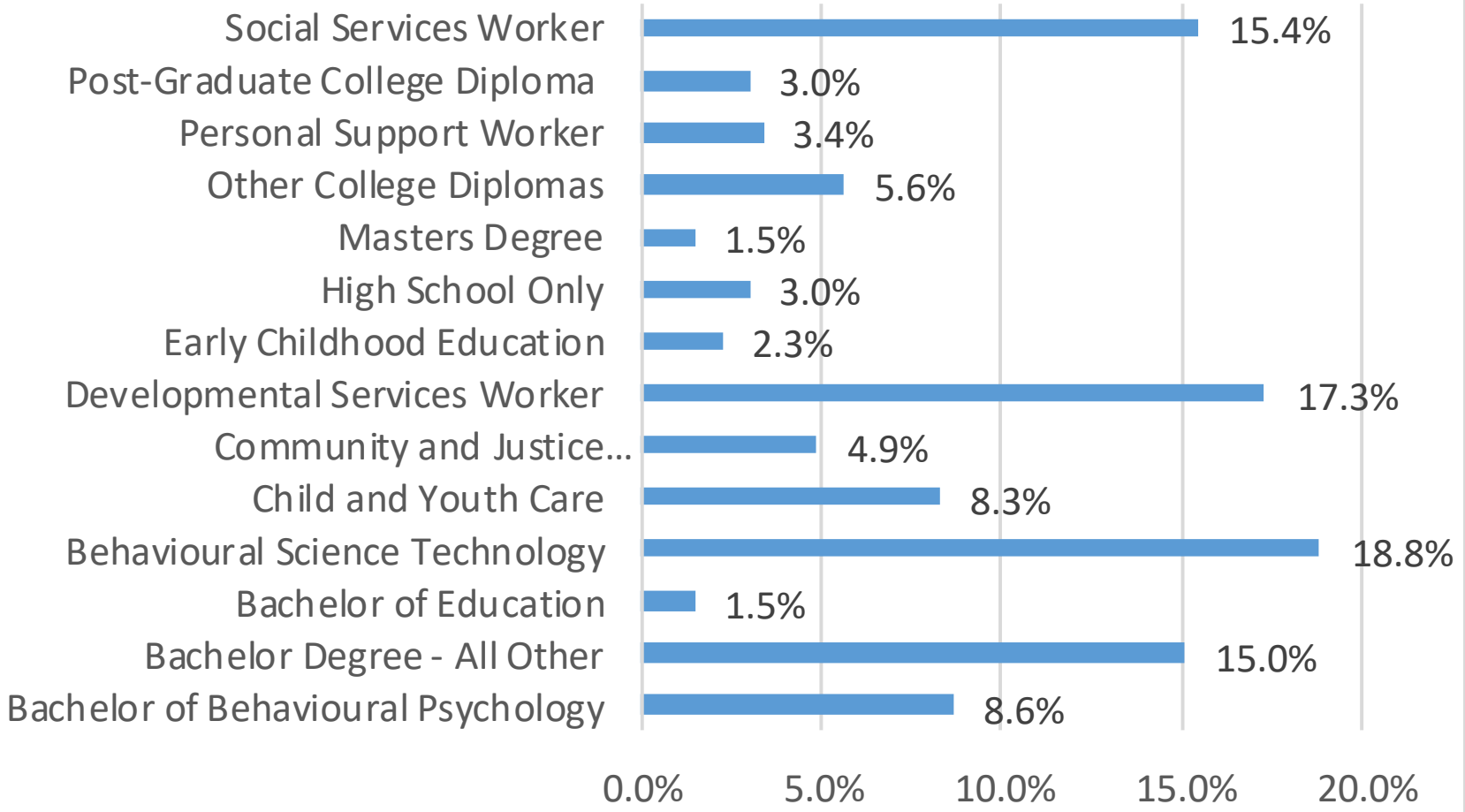
What Question Did We Ask?	How are we hoping to do (target)?			How did we actually do? (Results)
All Question Were Asked With 'Always', 'Usually', 'Infrequently' and 'Never' as the options. **We Want as Many 'Always' or 'Usually' Responses As Possible— Those are Considered Positive Responses in the Results Below**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
I am treated with dignity and respect whenever I deal with CLKD	90% or better	Between 80% and 90%	Less than 80%	100% All 'Always'!
CLKD is responsive. The organization returns calls promptly, listens to my concerns and provides information effectively	90% or better	Between 80% and 90%	Less than 80%	100% (92% 'Always')
Staff members at all levels are knowledgeable and helpful	90% or better	Between 80% and 90%	Less than 80%	100% (67% 'Always')
Overall, CLKD operates programs of high quality	90% or better	Between 80% and 90%	Less than 80%	100% (72% 'Always')
Supports and services offered by CLKD promote community inclusion for individuals with an intellectual disability	90% or better	Between 80% and 90%	Less than 80%	100% (67% 'Always')
CLKD is recognized as a positive and valued organization in the community	90% or better	Between 80% and 90%	Less than 80%	100% (92% 'Always')
CLKD operates with a high level of professionalism	90% or better	Between 80% and 90%	Less than 80%	100% (77% 'Always')
The leadership of the organization are approachable, consultative and honest	90% or better	Between 80% and 90%	Less than 80%	100% (84% 'Always')
CLKD is highly collaborative with other stakeholders and the community in general	90% or better	Between 80% and 90%	Less than 80%	100% (77% 'Always')

Who Took the Survey? The survey was sent to funders, other organizations in the sector and other community organizations.

Positive Comments: Multiple respondents noted an open and collaborative approach and the commitment made to persons served

Areas for Improvement: Multiple respondents noted that CLKD should be careful to not lose sight of the purpose and values of the organization as it grows.

Educational Background of CLKD Staff- December 2017



Notes

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

Data Integrity Assurance

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

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

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

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

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

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

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

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

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

Contact Us

Community Living Kingston and District

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Note: Kingston services will be moving to 541 Days Road in August 2018.

Gananoque Services: 26 Mill Street, Gananoque, ON, K7G 3A6 613-382-7702

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Visit our website: www.communitylivingkingston.org

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