COMMUNITY LIVING
Kingston and District
Inspiring Possibilities

Quality Improvement Report 2020

541 Days Road, Unit 6

Kingston, Ontario K7M 3R8

Phone: 613-546-6613

www.myclkd.ca

Community Living Kingston and District is a CARF-accredited organization

Performance Measurement and Management Plan

Community Living Kingston and District strives to have a very robust quality improvement process throughout the organization. This QI process will be utilized to ensure that the organization's mission and goals is being achieved by supplying data that can help inform decision-making.

Preparation

CLKD will use its QI process to identify any gaps and opportunities that might provide the organization with information needed to improve its services.

Generally speaking, this preparation stage will involve:

- Seeking input from persons served, personnel, and other stakeholders;
- Reviewing the characteristics of persons served, especially in comparison to any established community profile;
- Considering the expected results of services;
- Looking at any extenuating or influencing factors that may impact results;
- Using comparative data;
- Ensuring that performance information is communicated to stakeholders;
- Having technology that is sufficient to support the needs of the performance improvement plan.

Processes

Note: At present, whenever the 'designated Manager' is noted, it is currently assigned to the HR Director.

What needs to be done	Who will lead and how it will be done	Current plan and processes
Collecting relevant data on characteristics of persons served	The designated Manager will meet with individual program Manager and leaders to identify the most relevant data to be collected.	Data is collected on age, gender, transportation barriers, communication styles, and mobility needs. Other data, such as diagnosis, is collected in Nucleus but may not be aggregated each year.
Establishing and collecting effectiveness measures	The designated Manager will meet with individual program Manager and leaders to identify the most important measures for each program.	Each program has different effectiveness measures, depending on their specific focus. Measures may change from year to year depending on the acuity of the data and the changing needs of the program.
Experience of services received and other feedback from persons served.	As led by the designated Manager, the organization has two methods by which to receive this information from persons served: A peer delivered survey and an online/paper survey. The peer survey is the preferred course of action.	The online survey was used in 2020 because it was logistically easier to administer.
Experience of services received and other feedback from other stakeholders	As led by the designated Manager, the organization solicits feedback in a three-year cycle involving staff, families, and community partners.	In 2020, staff were surveyed specifically about their experience with the organization's EAP and other support programs.
Establishing and collecting efficiency measures.	The designated Manager will meet with individual program Manager and leaders to identify the most important measures for each program.	Because of the volume of resources dedicated to sick time, every program utilizes the same efficiency measure, which measures absence rates due to sick time.
Establishing and collecting service access measures	The designated Manager will meet with individual program Manager and leaders to identify the most important measures for each program.	Each program currently has their own service access measure that is reflective of the most pressing needs for persons served.

Collection of data about persons served at various intervals (beginning of services, appropriate intervals during services, the end of services, points in time following services)	This is led by program Managers, who direct staff to collect data in Nucleus.	This is completed at the beginning of services and is updated at least annually. Service data is also updated when service ends. It is rare that data is collected following services, as most cessation of services is due to death or simple transition to another program in the agency.
Establishing and collecting business function measures	This is led by the HR Director, in consultation with other Directors around the most important measures to collect. These are based off of regularly used reports such as those related to health and safety, finance, governance, etc.	A series of business function measures considered the most important are in evidence.
Ensuring data integrity- validity, reliability, completeness, accuracy	This is led by the HR Director, who develops data integrity measures.	Data integrity processes are noted at the end of this report.
Examining extenuating factors that may impact results	The designated manager and the individual program Managers review possible extenuating factors with program leaders when data is ready to be analyzed.	Each measure in place has extenuating factors taken into account accordingly, as noted within the QI report.
Establishing timeframes to analyze data and communicate results.	The designated Manager and individual program Managers are responsible for establishing these time frames.	Each measure is analyzed at least annually, though many are examined more frequently (as noted in the QI report). Results are communicated in the same time frame.
Determining how data is collected and analyzed and how performance improvement plans are developed and implemented	The designated Manager and individual program Managers are responsible for determining this, delegating action plans to their team for implementation.	Each measure has a separate implementation plan
Determining how performance information is communicated	The designated Manager consults with the Management team.	Information is distributed using the *Plan to Distribute Performance Information*.

This plan was last reviewed in May 2020 and will be reviewed no later than twelve months from that time.

Plan to Distribute Performance Improvement Information

Intent

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

Procedure

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

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

Note

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

Review

This plan will be reviewed on at least an annual basis.

2020-2025 Strategic Plan

COMMUNITY LIVING Kingston and District
Inspiring Possibilities

Building on a decades-long history of commitment and contribution to the Community Living movement, CLKD is on a journey of positive social change, rooted in a shared vision of inclusion and citizenship.

Our Vision: Inspiring Possibilities and Inclusion (Short Version)

Community Living Kingston and District envisions a society where everyone belongs, and genuine inclusion exists for all. We strive to build a community where anyone, regardless of disability, is accepted and enjoys equal rights, respect, and opportunities for growth.

Our vision for CLKD as an organization is to be a recognized and innovative leader in the delivery of services, offering a comprehensive spectrum of relevant supports and services to people with disabilities. We also aspire to be a model for a workplace culture based on our values, delivery of quality services, and accountability.

Our Mission:

To provide support for individuals with an intellectual disability and advocate alongside them so they are welcome, included, and have every opportunity to participate fully in their community with dignity and independence.

Defining Success:

Success will be measured in a variety of ways by the extent to which CLKD has tangibly fulfilled its mission. Objectives are closely aligned with the goals of persons served and their individual choices of where they want to live, learn, work, volunteer and enjoy their leisure time. Other major CLKD goals relate to success in promoting an inclusive community, providing supports and services, and to be a leading organization with a remarkable culture and innovative practices.

Values Shape Our Objectives:

This plan is framed by pivotal values that speak to: the value and rights of children; meaningful work and fair compensation; safe, secure and affordable homes; access to any available generic supports and services; community engagement; securing needed resources; and providing supports in ways that are free of institutional models, practices and philosophies of care.

Key Expectations and Forces for Change:

- The evolving and future needs of persons served and their families are a primary focus.
- Housing and support needs continue to be a top concern and pressure point.
- Significant financial constraints and changes in provincial policy can be expected.
- CLKD will continue to address issues related to its organizational capacity and development.

CLKD Strategic Priorities 2020-2025

The priorities identified in this strategic plan speak to areas where special attention, resources and effort are needed over the next three to five years.

HOUSING

Develop innovative and creative housing opportunities.

- Pursue innovative and creative opportunities to help ensure persons served have access to safe, adequate and affordable housing and supports.

WORK & COMMUNITY LIFE

Continued growth of employment and community participation.

- Expand supports so people can pursue and maintain competitive employment and engage in activities that promote citizenship, consistent with meeting the needs, desires and choices of persons served.

PARTNERSHIPS TO MEET NEEDS

Strategically engage stakeholders to respond to changing needs.

- Develop new or deeper partnerships for innovation and collaboration with persons served and their families, staff, community partners and government.

OUR TEAM

Deploy our human resources in the most effective ways possible.

- Adapt the agency's approaches to talent recruitment, retention and development, and the deployment of human resources, to respond to significant past growth, new service circumstances and emerging needs.

Other Important/Complementary Priorities:

Several other important issues will be addressed in CLKD's annual operational plans, including:

- Continuing to mature as an organization and stabilizing after a period of growth
- Proactively responding to growing needs for complex and/or specialized care
- Adapting to fee-for-service and alternative funding approaches
- Maintaining financial accountability
- Alignment with the Ontario Ministry of Children, Community and Social Services

Implementation:

Strategy is activated through operational plans that provide more specific direction for the work and identify responsibilities and timelines — detailing who will do what by when. Progress on these priorities will be reviewed regularly and operational plans will be updated as necessary.

Risk Management Plan- 2020

Introduction

Community Living Kingston and District developed its first formal Risk Management Plan in 2007. This plan was developed in recognition of the fact that risk is inherent in providing supports for persons served in the community. This plan was reviewed and revised in November 2019. It will be reviewed again no later than December 2020.

Purpose

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

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

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

Community Living Kingston and District's Approach to Risk

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

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

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

General Strategies Used to Address Risk

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

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

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

Specific Strategies Used to Address Risk

People

Area of Risk	Persons Served and Families
Type of Potential Risk	Injuries and Accidents
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Policies and Procedures are followed and regularly reviewed with staff · Staff receive orientation and training in a number of areas, including safety and prevention (e.g., CPI, First Aid/CPR, WHMIS 2015, Q-Straint are mandatory. ASIST and Mental Health First Aid have been added as requested) · Injuries and accidents are reported and reviewed to identify any trends · Specific interventions are noted in individual plans and Positive Behaviour Support Plans are developed as needed. PBSPs are monitored by an assigned Behaviour Therapist and psychologist · Individual risk assessments are developed as needed · Policies and procedures related to client handling require mechanical lifts to be used wherever possible · External and internal Health and Safety Inspections · Bathing protocols developed in Residential Services · Policy related to client bathing · Emergency signage in vehicles, and safety inspections required before vehicle use · Fire safety training with all teams · Controlled acts training by nurse in place · Trend analysis completed related to slips, trips, and falls. - Joint Health and Safety Committee completion of site inspections at least annually - Completion of health and safety training in Surge - All staff receive Driver Orientation training, reviewing use of Q-Straints, vehicles and lifts. - Individual transportation protocols in place for all persons served. - Mental Health First Aid training completed with interested staff on regular basis. - Worker reps trained in hazard recognition complete monthly health and safety inspections at each location
Results of Actions Used to Manage Risk	· There were two significant injuries to persons served, one who fell off a sidewalk while driving wheelchair, the other who was injured in the shower/washroom of a home.
New Strategies to be Adopted This Year	- Given the complexity of some persons served in Community Services, specifically around drug use and overdose potential, naloxone training should be looked into for staff (this was listed each of the last two years, but not completed). - Joint Staff Education Committee to continue to approve Mental Health First Aid training. Forty staff targeted for 2020.

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, including client distress policy.
Results of Actions Used to Manage Risk	There was one instance where a person served had gone missing for an hour.
New Strategies to be Adopted This Year	- As follow up to the instance from this year, that program location will look into a coherent search strategy similar to those used in CIP. The team at Fortune Crescent may also look into this.

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. - Staffing levels adjusted as necessary to reflect need. - New guidelines were adopted in 2019 to assist Family Services staff with processes in case they feel that it is unsafe for them to work in a private home.
Results of Actions to Manage Risk	There were no reports of injury 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. - Training around confidentiality put in place via Surge Learning Management System. All staff required to complete in 2018/19. - Privacy and Confidentiality training completed at all new staff orientation sessions - Paper files of person served in process of being digitized and uploaded to Nucleus as of November 2019 - User access settings regularly reviewed to ensure confidentiality (see issue from 2019, below). This was implemented Spring 2019. - Nucleus instituted mandatory password re-sets every six months starting in 2019.

Results of Actions to Manage Risk	There was one issue related to possible violation of confidential information because of user access settings. A subsequent investigation revealed little likelihood of a data breach.
New Strategies to be Adopted This Year	-Policy related to use of personal devices to access agency information to be developed (held over from last year). -Procedure to be developed to ensure that temporary download folders are cleared on all computers on a regular basis (held over from last year).

Area of Risk	Persons Served
Type of Potential Risk	Abuse and Neglect
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	· Policy OP 2.05 addresses abuse and neglect · Board Policy 16 addresses rights and how to make a complaint · Employees and volunteers are screened and supervised · Mistreatment, abuse, and neglect is reported to appropriate authorities · Reports of all abuse/neglect filed with MCSS · All staff and volunteers required to complete annual training on abuse prevention and reporting · All persons served receive annual education on abuse prevention. Specialized classes can be facilitated by Cathy Lawrence and Catharine Gibson. - Abuse education training provided to all new staff at New Staff Orientation sessions early in employment - Online training for staff implemented via Surge.
Results of Actions to Manage Risk	- There was one allegation brought forward this year, which was found to have no basis.
New Strategies to be Adopted This Year	None

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 tips on how to avoid banging head in accessible vehicles · Bump caps required for use by staff when utilizing accessible vehicles. - MSD prevention and safe driving videos reviewed by new staff as part of new staff orientation. - Cell phones provided to Residential staff for emergency use if in community. - Driver education training to ensure safety around lifts, driving, Q-Straint, etc. - MSD prevention training in Surge. - Inspections by reps training in hazard recognition at each location. - Footwear policy in place. - All staff assistants at Kwik Shred are trained in proper health and safety procedures.
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 2018. - There was one lost-time injury this year, the result of a staff member slipping off the truck at Kwik Shred.
New Strategies to be Adopted This Year	Health and Safety training for Supervisors to be completed in December 2019.

Area of Risk	Employees
Type of Potential Risk	Illness or mental health
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Low
Current Strategies Used Manage Risk	· Flu shot clinic held annually · All employees have sick time for use when ill · Fit testing (respirators) for all employees · Policies related to infection control and pandemic preparedness - Joint Wellness at Work Committee - Peer Support and Peer Mentoring teams - EAP Program - Mental Health First Aid training completed twice per year - Training in compassion fatigue and vicarious trauma done with new staff at orientation.
Results of Actions Used to Manage Risk	· Counsellors were brought in to assist teams dealing with grief after deaths of persons served and to assist with critical incident debriefing.
New Strategies to be Adopted This Year	- Internal Mental Health First Aid training to be explored (with internal trainers) - JSEC has approved $7600 to train 40 more staff on Mental Health First Aid in the interim

Area of Risk	Employees
Type of Potential Risk	Communicable Diseases
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Low
Current Strategies Used Manage Risk	· Employees requested to disclose any contagious disease · Agency will pay for required immunizations as applicable to employee's work situation · Policies HR 3.09 and 3.10 address disease and infection control. Policy HR 3.14 addresses respiratory protection program

	· Employees informed of persons served that may have communicable diseases · Flu shot clinic held annually -Respiratory protection program. Team of Fit testers (for respiratory protection) expanded. All staff to be re-fitted in 2018 and 2019. - Training around communicable diseases put in place in Surge.
Results of Actions Used to Manage Risk	· There were no issues related to communicable diseases this year.
New Strategies to be Adopted This Year	None

Area of Risk	Employees
Type of Potential Risk	Staff Turnover
Frequency (Likelihood)	High
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Competitive benefits · Staff recognition program · Formal monitoring of turnover by HR Director · Leadership Development Bursary Fund · Exit interview process · Human Resources section of policy manual designed to ensure a safe workplace · Participation in provincial HR strategy with OASIS and MCSS · Implementation of Core Competencies training. - Wellness at Work Committee to attempt to assist in advancing strategies that would assist to quell turnover - Hiring practice where staff are interviewed and screened in advance of actual hiring needs put in place in order to decrease issues related to lag time in hiring
Results of Actions Used to Manage Risk	· Staff turnover was low for full-time staff (4%), but high (37%) for part-time staff. Staff Retention Task Force put in place early 2019 to investigate possible causes.
New Strategies to be Adopted This Year	Agency has stated commitment to try to create more full-time work. Five new full-time jobs were created in 2019.

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

Area of Risk	Employees
Type of Potential Risk	Workplace Violence, Harassment
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	· CPI Training · Positive Behaviour Support Plans · Manager on-call system for assistance · Additional staffing at homes with high needs · Annual staff review of policies related to workplace violence prevention and harassment (training completed in Surge) - Annual review of harassment policy by JHSC - Supervisor training around harassment, sexual harassment and workplace violence training last done in 2017. To be completed again on regular basis. - Supervisors trained biannually around harassment policies and their expectations. - Staff retrained on harassment policies regularly
Results of Actions Used to Manage Risk	There were two harassment complaints put forth this year, which were investigated and dealt with by the organization. On another occasion this year, Bill 148 required processes were put in place to deal with a domestic violence issue that had the chance of carrying over to the workplace.
New Strategies to be Adopted This Year	None

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 - Board Members do not have access to funds.
Results of Actions Used to Manage Risk	· There were no concerns related to Board conduct this year.
New Strategies to be Adopted This Year	- Executive Director to explore with Board the possibility of requiring CPICs for all Board members.

Area of Risk	Community
Type of Potential Risk	Complaints
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate

Current Strategies Used Manage Risk	· Complaints procedure · Proactive communication and input · Complaints may be directed to Executive Director with expectation of open dialogue
Results of Actions Used to Manage Risk	· Complaints were minimal this year (see summary of complaints in this report).
New Strategies to be Adopted This Year	None

Property and Assets

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

Area of Risk	Vehicles
Type of Potential Risk	Damage, accidents, theft
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	· Insurance and deductibles · Policies HR 1.10 and FN 1.08 address many issues · Completion of safety checks prior to each use. - 40 staff per year required to submit updated driver's abstracts - Staff required to self-disclose driving infractions exceeding 3 demerit points - Driver orientation training in place for all new staff.
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. - One staff required to attend defensive driving as a condition of hire due to driving record
New Strategies to be Adopted This Year	None

Area of Risk	Furnishings, Supplies, Equipment
Type of Potential Risk	Damage, theft
Frequency (Likelihood)	Low

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

Area of Risk	Technology
Type of Potential Risk	Security information management, privacy and confidentiality, theft, damage
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	- Office sites are monitored or alarmed at all times - Technology Plan addresses information security - Insurance - Monitoring of information by Nucleus Labs and by Service First - Cybersecurity training in Surge - Password resets required in Nucleus every six months.
Results of Actions Used to Manage Risk	- There was one issue where a potential security breach was identified, but an investigation found it to be safe.
New Strategies to be Adopted This Year	None formal.

<u>Financial</u>

Area of Risk	Financial Practice
Type of Potential Risk	Fraud, legal requirements, investment losses
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	· Finance policies · Insurance · External audit completed annually · Experienced finance staff · Revenue Canada audits - Access to finance offices is limited to key parties through fob system - Agency's investments are in nothing more risky than GICs
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	Loss of Funding
Type of Potential Risk	All funding for adult services flows through Ministry of Children, Community and Social Services. In the current political climate, there is the risk of a reduction in funding that is crucial to service provision. This includes the possibility of agency stabilization funding, introduced in 2018-19, not being provided for 2020-21.
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	- Frequent interaction with MCCSS representatives. - Involvement in provincial associations to lobby for ongoing funding. - Strong financial practices to maintain overall health and project response to various financial pressures
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

<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. - Increased requests for clinical supports
Results of Actions Used to Manage Risk	· While concerns around serving these populations continue, we were able to manage them this year.
New Strategies to be Adopted This Year	- Nucleus to institute a risk identification tool. - Committee being developed to assist with development of proper risk assessment tools

Inclusion of risk reduction into performance improvement activities

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

Accessibility Plan 2019-20

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 2018 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.

2019-20 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 who are deaf, or even something as simple as the location of furniture.
Items Addressed In 2019	-Signage placed at Gardiners Road to make families aware of presence of elevator. - The washroom at Smithfield was rebuilt in an attempt to increase accessibility. However, the job was improperly completed and has not eased health and safety concerns that were also present. As such, the washroom was re-done again in February 2020 - An external egress was re-done at McMichael both to ensure efficient evacuation and to improve accessibility.
Standing Items of Concern/Areas needing improvement	- Slow snow and ice removal can restrict access to and from program locations. The agency continues to utilize snow removal guidelines put in place in 2008, but CLKD must continue to be vigilant. - As the needs of persons served in Family Home arrangements change, CLKD must be prepared to offer assistance to meet accessibility needs. This often requires requests for funding from MCCSS.
Future Goals	**Barrier:** Back ramps at Mowat require rebuild for optimal accessibility **Strategies to Remove Barrier:** The organization has decided that a completely new Mowat location is required. A new home will be designed and built. **Potential Obstacles:** Costs, Ministry approval, building permits, zoning confirmation, secure lot, tender contract, design house. **Persons Responsible:** Mark Vass, Sherrill Boyes **Target Date:** Is targeted for between two and four years for completion **Barrier:** There is no automatic door open switch at Fortune, and the threshold at the front door has a lip that would make entry difficult for someone with a wheelchair. **Strategies to Remove Barrier:** Install automatic door switch and a stopgap. **Potential Obstacles:** Costs **Persons Responsible:** Mark Vass, Colleen Kelly-Jansen **Target Date:** Is targeted for between two and four years for completion **Barrier:** No front ramp at Melanie to allow for accessibility. **Strategies to Remove Barrier:** Build front ramp **Potential Obstacles:** Costs, and design issue could be challenging **Persons Responsible:** Mark Vass, Sherrill Boyes **Target Date:** Is targeted for between two and four 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 2019	A scent-reduced workplace policy was put in place in 2019. One workplace accommodation has been put in place as requested.

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 2019	- Minor issues where staff have been observed to call person served 'honey' or 'sweetie', which could be condescending, have been addressed on an as-needed basis.
Standing Items of Concern/Areas needing improvement	-There can be challenges with community partners who struggle to understand that individuals with intellectual disabilities may need other services that address mental health, addictions, etc. This is dealt with via advocacy. -- 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 2019	Attempts were made to provide more respite supports. This was done by moving guests to alternate weekends, freeing up funding that had been assigned to a now-deceased person served, expanding respite for one person served, and sitting on the provincial respite working group.
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 MCCSS on a situational basis for funds.
Future Goals	**Barrier:** CIP is currently charging less for services than it costs to provide. When prices are raised accordingly, some families may need to reduce service. **Strategies to Remove Barrier:** Communication strategy needed with families to see if there are other avenues to pursue **Potential Obstacles:** Costs. **Persons Responsible:** Rob Andrews, Sheri Scott **Target Date:** January 1, 2021

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 2019	-Plan executed to redesign Kwik Shred to pay persons served minimum wage. - Agency floated costs to be able to keep Employment Facilitator position through March 2021
Standing Items of Concern/Areas needing improvement	Long-term staffing in employment supports division is not secured, as most positions are grant-based.
Future Goals	**Barrier:** No funding for Employment Facilitator position in Employment Services past March 2021 **Strategies to Remove Barrier:** Try to secure grant or other funding to continue position **Potential Obstacles:** Lack of grants/funding available. **Persons Responsible:** Matt Luck, Colleen Kelly-Jansen **Target Date:** March 31, 2021

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 2019	-ASL group held at Options for staff in order to increase their skills. - JSEC approved two staff to attend ASL training through Canadian Hearing Society. - JSEC approved four staff to attend workshop around augmented communication skills.
Standing Items of Concern/Areas needing improvement	- Program information is available only in print and assumes a relatively high level of literacy. The organization attempts to combat this via plain-language versions of many documents (rights, complaints procedure). A concerted effort to develop pictorial versions of personal plans has been underway for several years. The organization desires to develop video versions of many documents. - Ongoing need for ASL training for staff throughout agency, especially at CIP. This is addressed by offering/requiring training upgrades as classes become available in community.
Future Goals	**Barrier:** Increase in number of referrals to CCRCS who do not speak English or French. **Strategies to Remove Barrier:** Develop list of possible volunteer interpreters in other languages **Potential Obstacles:** Time to develop.. **Persons Responsible:** Erin Impola, Maria Victoria **Target Date:** October 1, 2020 (this goal is held over from last year). **Barrier:** Lack of interpreter services for deaf employee in CIP **Strategies to Remove Barrier:** Work with local providers to try to find a more stable source of interpreters

	Potential Obstacles: Limited supply of ASL interpreters in community may not be within CLKD control **Persons Responsible:** Rob Andrews **Target Date:** March 31, 2021

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 2019	-Family Support now holding drop-ins in two locations each month in order to allow families to attend the one that is closest to them (one is in north end of Kingston, one in west end) - Six new vehicles were purchased in 2019 (more than the planned three). A plan still exists to continue to replace fleet vehicles as they age.
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 2018	Removing community integration barriers are at the core of the organization's everyday work.
Standing Items of Concern/Areas needing improvement	Items listed under *transportation* and *financial* are also related to community integration.
Future Goals	**Barrier:** City of Kingston has requirements that now limit Resource Consultants to only be able to work with licensed child care centres but not playgroups or facilitated drop-ins. This limits ability of children with disabilities to easily access inclusive activities at these types of programs. **Strategies to Remove Barrier:** Advocate to City of Kingston's Special Needs Resourcing department to allow for mandate to include these sites. **Potential Obstacles:** Time. **Persons Responsible:** Erin Impola, Maria Victoria **Target Date:** October 1, 2020 (held over from last year)

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 2019	- AODA compliant website completed January 2020
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 **Lack of affordable accessible housing**
Items Addressed In 2019	- Housing Facilitator position continued for five hours a week, as planned.
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	**None**

Area(s) of Concern	**Other.** A barrier that is not easily categorized **Lack of ability to provide some funded services because of other needed resources**
Items Addressed In 2019	- New half-time position added to Family Support to help ease wait list. This position is committed for sixteen months starting in November 2019.
Standing Items of Concern/Areas needing improvement	None
Future Goals	**Barrier:** Lack of Family Home providers to provide funded services **Strategies to Remove Barrier:** Adopt Life Share brand and supporting materials. **Potential Obstacles:** Waiting for MCCSS to complete improvements to this brand. **Persons Responsible:** Erin Impola, Kelly Agazzi **Target Date:** November 1, 2020 (this has been held over from last year, as MCCSS still has not rolled out its materials).

Requests for Reasonable Accommodations

There were a number of requests for reasonable accommodations by employees or prospective employees in the past year. When applicable, these were documented in *Individual Accommodation Plans*. All requests were able to be accommodated. A summary of the requests follows (note that these do not include short-term accommodations directly related to WSIB claims, and includes only **new** requests made in 2019):

Type of Request	Number of Requests
Schedule request for religious observance	1
Accommodations for documentation/record keeping	3
Requested OT assessment to assist with record keeping	1
Medical device required in workplace	1
Accommodations for physical nature of work	1

The accessibility plan was reviewed in December 2019. Monitoring of items will continue throughout the year, with a formal update of the plan again being completed no later than March 2021.

Cultural Competency and Diversity Plan

(Updated January 2020)

1. Preamble

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

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

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

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

- Language
- Culture
- Gender and Gender Identity
- Sexual Orientation
- Spiritual Beliefs
- Age
- Socioeconomic Status
- Disability

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

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

	- Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	- The organization would like to explore methods to better assist persons served of First Nations descent to receive services that are respectful of their culture and beliefs. - The organization will look into signing on to the City of Kingston's Workplace Inclusion charter for 2020.

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

Area(s) of Concern	**Gender and Gender Identity**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions - Numerous agency policies outline principles that promote diversity* - Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	The organization will complete training with all supervisors that better educates them about the evolvement of issues related to gender and gender identify.

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

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

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

Area(s) of Concern	**Language**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions - Numerous agency policies outline principles that promote diversity* - Adherence to provincial French language requirements designed to ensure promotion of French culture and accommodation for Francophones seeking service in their native tongue. French language designated positions in both Family Support and Child Care Resource Consultant Services. - Collection of data in HRIS about staff able to communicate in French - Completion of personal plans in language of person's choice, where requested - French language website and signage - Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	- The organization will seek training for staff teams about proper terminology to use when referring to those who are deaf vs. hearing impaired. - The organization's CCRCS and Family Support departments frequently encounter families whose first language is not English or French. Efforts will be put in to securing a bank of interpreters to be available accordingly.

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

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

This plan will be monitored/reviewed throughout the 2020 calendar year and will be updated formally no later than March 2021.

Technology Plan

Updated April 2020

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 2021.

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 February 2019	Institute mandatory password reset in Nucleus every six months.

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 2021 **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 2021 **Goal:** Provide "Security training" to staff as recommended by Service First. **Potential Obstacles:** None **Persons Responsible:** Matt Luck, Jeff Harrison **Target Date:** January 2021

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 Inclusion program sites.
New Items Addressed Since February 2019	iPads were purchased for the Childcare Resource Consultants team to support early learning and communication for kids attending licensed childcare centres who are on the spectrum.
Future Goals	**Goal:** Explore the use of Apple Business Care program in an effort to improve the functionality of agency owned Apple devices. **Potential Obstacles:** None **Persons Responsible:** Dixie Luck**,** Matt Luck **Target Date:** January 2021

Area(s) of Concern	Virus Protection
Current Practices	The off-site email exchange server as well as all network servers and workstations are protected by virus protection software and spyware/anti-spam programs. Services are purchased, monitored and regularly updated by Service First...Total Solutions. Scripts are written to disallow all .zip files, which pose significant risk. Non-networked computers at day program locations are monitored with virus protection managed by Service First.
New Items Addressed Since February 2019	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 2021

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. Recovery plan is in place, in the situation of a catastrophic event that would detail the steps involved to mitigate down-time, including: Rent temporary space, deploy temporary servers, restore servers from back-ups, ensure top 10 most crucial users are up and running immediately then expand to all users. 'Master Install Document' has been created that provides all necessary information to rebuild our network which includes: server details, license numbers, configuration information, router information, passwords etc. All data on the ECR system is secured by Nucleus Labs.
New Items Addressed Since February 2019	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 Days Rd location internet access is 50Mb/second dedicated true fibre. This ensures the reliability and speed of internet access. CLKD has photocopiers with scanning capabilities, including Optical Character Recognition format that allows for scanned documents to be edited. Residential, Gananoque and Respite House locations are connected through remote network. Days Rd, Bath Rd, Gardiners Rd, CO2 and Milestones connect directly through the network. The Nucleus Labs, Ceridian Dayforce and Surge Leaning systems are monitored by each respective company, with a contract governing the agreement between them and CLKD.
New Items Addressed Since February 2019	16% of the computer fleet was replaced and 3 new units were added to the fleet to meet growing organizational needs.
Future Goals	**Goal:** Replace approximately 10-20 computers (10-20% of the overall equipment fleet). **Potential Obstacles:** Cost of at least $16,000 **Persons Responsible:** Matt Luck, Dixie Luck **Target Date:** April 2021

Area(s) of Concern	Other– Oversight
Items Previously Addressed	As previously outlined CLKD has contracted with Service First...Total Solutions to provide fully managed support for daily IT operations. Internal involvement with respect to IT matters is now limited to performance oversight for the third party contract arrangement as well as strategic decisions (mostly related to hardware and software planning), purchasing and policy governance.
Future Goals	**Goal:** Expand Microsoft Team's workflow capabilities as a means of advancing the organization's capacity for communications, work flow, projects and general collaboration. **Potential Obstacles:** Time needed to research and logistical complications around training. **Persons responsible:** Sheri Scott, Dixie Luck **Target date:** January 2021

Review of Complaints Received

Background

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

Program Area of Complaint:

Program	2015-16	2016-17	2017-18	2018-19	2019-20
Residential Services	1	2	3	2	2
CIP	2	0	0	0	1
CCRCS	0	0	0	0	0
SIL/ESIL	0	1	0	0	2
Family Home	3	1	0	0	1
Respite	0	0	0	0	0
Family Support	0	0	0	0	1
Employment Services	n/a	n/a	0	1	0
Summer Programs	0	0	1	0	0
Total Complaints	6	4	4	3	7

Specific complaints for 2019-20:
- There was one complaint about possible abuse/neglect;
- There was one complaint about the conduct of a staff member;
- There was one complaint about a program relocation/renovation;
- There was one complaint about overall service quality;
- There were three complaints about the quality of support provided by specific staff

Type of Complaint	2015-16	2016-17	2017-18	2018-19	2019-20
Service Quality	4	2	1	1	1
About specific staff/individual	2	0	2	1	4
Possible mistreatment of person served	0	2	0	0	2
Agency Practices	0	0	1	1	1

Source of Complaint	2015-16	2016-17	2017-18	2018-19	2019-20
Family Member	6	3	1	1	4
Community Member	0	0	2	0	2
Other Agency	0	0	1	1	1
Staff Member	0	0	0	1	0

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 five years, having decreased slightly.

Areas Requiring Performance Improvement

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

Actions to be Taken to Address Areas Needing Improvement

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

Actions Taken or Changes Made to Improve Performance

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

Status of Complaints

All but one of the complaint brought forward this year appear to have been resolved to the satisfaction of all parties involved. The unresolved complaint continues to be discussed with the complainant, who has not chosen to escalate it as per the agency's complaint resolution process.

Who did we support this year?

		CIP	Residential	Family Home	Respite	SIL/ESIL	Gananoque	CCRCS	Family Support	Employment Supports
Number of Persons Served	2018-19	141	50	23	90	123	26	220	244	46
	2019-20	136	51	18	76	123	25	240	251	60
Gender of Persons Served	2018-19	Male: 61% Female: 39%	Male: 70% Female: 30%	Male: 60.9% Female: 39.1%	Male: 62.2% Female: 37.8%	Male: 58.5% Female: 40.7% Other: 0.8%	Male: 57.6% Female: 42.2%	Male: 73.2% Female: 26.8%	Male: 59.4% Female: 40.6%	Male: 69.5% Female: 30.5%
	2019-20	Male: 61.7% Female: 38.3%	Male: 68.6% Female: 31.4%	Male: 61.1% Female: 38.9%	Male: 63.2% Female: 36.8%	Male: 56.9% Female: 43.1%	Male: 56% Female: 44%	Male: 75.8% Female: 24.2%	Male: 61.4% Female: 38.6%	Male: 63.3% Female: 36.7%
Age of Persons Served	2018-19	19-29: 15.6% 30-39: 29.8% 40-49: 26.9% 50-59: 9.2% 60-69: 14.9% 70+: 3.5%	19-29: 8% 30-39: 6% 40-49: 26% 50-59: 24% 60-69: 24% 70+: 12%	Under 19: 8.7% 19-29: 47.8% 30-39: 21.8% 40-49: 4.3% 50-59: 4.3% 60-69: 13%	Under 19: 42.2% 19-29: 32.2% 30-39: 12.2% 40-49: 8.9% 50-59: 3.3% 60-69: 1.1%	Under 19: 5.1% 19-29: 25.5% 30-39: 20.4% 40-49: 14.3% 50-59: 16.3% 60-69: 11.2% 70+: 7.1%	19-29: 23.1% 30-39: 23.1% 40-49: 11.5% 50-59: 11.5% 60-69: 19.2% 70+: 11.5%	0-2: 1.4% 2-4: 36.8% 4-6: 33.6% 6+: 28.2%	Under 19: 52% 19-29: 30.3% 30-39: 8.6% 40-49: 4.1% 50-59: 3.7% 60+ 1.2%	Under 19: 13% 19-29: 50% 30-39: 10.9% 40-49: 8.7% 50-59: 8.7% 60+: 8.7%
	2019-20	19-29: 13.9% 30-39: 27.9% 40-49: 28.7% 50-59: 11% 60-69: 13.2% 70+: 5.3%	19-29: 5.8% 30-39: 7.8% 40-49: 25.5% 50-59: 21.6% 60-69: 23.5% 70+: 15.8%	Under 19: 0% 19-29: 55.5% 30-39: 16.7% 40-49: 11.1% 50-59: 0% 60-69: 16.7%	Under 19: 36.8% 19-29: 40.8% 30-39: 10.5% 40-49: 9.3% 50-59: 1.3% 60-69: 1.3%	Under 19: 2.6% 19-29: 35.9% 30-39: 15.7% 40-49: 13.3% 50-59: 13.3% 60-69: 13.3% 70+: 5.9%	19-29: 16% 30-39: 28% 40-49: 8% 50-59: 16% 60-69: 24% 70+: 8%	0-2: 0% 2-4: 35% 4-6: 40% 6+: 25%	Under 19: 52.2% 19-29: 30.7% 30-39: 9.1% 40-49: 3.2% 50-59: 3.2% 60+: 1.6%	Under 19: 6.9% 19-29: 55.3% 30-39: 20.2% 40-49: 6.9% 50-59: 8.5% 60+: 2.2%
Type of Respite Received or Desired*	2018-19				Family Home: 46.7% Group: 66.7%					
	2019-20				Family Home: 27.2% Group: 76.3%					

* 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	2018-19	73.4%	60%	65.2%	83.7%	70.8%
	2019-20	72.8%	58.8%	66.7%	82.1%	68%
Communication Style of Person Served % of persons served who communicate ver-bally	2018-19	74.4%	64%	56.5%	90.2%	86.9%
	2019-20	73.5%	64.7%	55.6%	91.8%	84%
Transportation Used By Persons Served*	2018-19	Accessible: 28.5% Public Transit: 32.6% Walk/Bike: 22.7% Provided Rides: 85.1%	Accessible: 26% Public Transit: 18% Walk/Bike: 6% Provided Rides: 96%	Accessible: 39.1% Public Transit: 43.8% Walk/Bike: 21.8% Provided Rides: 78.3%	Accessible: 13.8% Public Transit: 74% Walk/Bike: 65% Provided Rides: 74.8%	Walk/Bike: 78.2% Provided Rides: 78.3% Drives Own Car: 17.4%
	2019-20	Accessible: 24.3% Public Transit: 32.4% Walk/Bike: 22.1% Provided Rides: 84.6%	Accessible: 25.5% Public Transit: 21.6% Walk/Bike: 7.8% Provided Rides: 96.1%	Accessible: 38.9% Public Transit: 27.8% Walk/Bike: 27.2% Provided Rides: 88.9%	Accessible: 13% Public Transit: 70.7% Walk/Bike: 64.2% Provided Rides: 74%	Walk/Bike: 80% Provided Rides: 72% Drive Own Car: 12%

- * indicates that figures may not add up to 100%, as multiple or no categories could be selected in the original data set.
- Family Home, Respite, CCRCS, and Family Support figures may include individuals that have been referred for service, be in the midst of matching processes and/or had initial intake complete, but are not yet receiving services
- 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)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
For persons served to be involved in their community (*effectiveness*)	# of new community based resources developed	All persons served, CIP	Program Coordinators	April 1, 2019-March 31, 2020	Annually	At least 15	Between 8 and 14	Less than 8	11

Trends:

Year	2018-19	2019-20
New resources developed	12	11

Extenuating Factors/Discussion: Two of the three CIP programs saw new Coordinators come on board this year, which spurred new ideas but also meant that it took time to transition the programs to new leadership. Included in the new resources developed were: The WAVES group at Canadian Hearing Society, a community garden, a social group at a local retirement home, and jobs at a local museum, One Roof, and with a local realtor,

Follow-up Completed: Planning processes continued to be used to identify activities of interest, which then spurred program Facilitators looking to develop the necessary resources.

Action Plan: The hallmark of the CIP program is the fact that persons served are not forced to choose activities from a pre-developed catalogue, and that the support teams look for activities based on the needs and wishes of persons served. This will continue in the future, led by the planning processes currently used. This ties in with the program's service access measure of ensuring that program staff receive training in person centered planning processes, as they must be effective in order to assist persons served to identify activities that they wish to pursue.

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, 2019 -December 31, 2019	Every Six Months	Less than 4%	Between 4% and 5%	More than 6%	3.08%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018	2019
Sick Rate	5.53%	3.79%	2.98%	3.07%	4.19%	2.22%	3.25%	3.08%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year. It is likely that actual sick rates are higher than represented, as the data set includes only those individuals who are actively working as of Jan 1, 2020, and not all who may have departed during the year. Reliability may also be compromised on a program comparison basis, as staff are coded only to their home division, not to all services where they may have worked and actually used sick time.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, per the agency's *Attendance Management Program*.

Action Plan: .Continue to administer the *Attendance Management Program.* However the agency would also like to look at other indicators that may be spinoffs of sick time that may more accurately measure the impact, such as Required to Stay. **Note: Because of the organization encouraging people to stay home if sick during COVID-**

To ensure access to the community for persons served (*service access)*	# staff trained in person-centered planning principles	All Staff in CIP	Training Records	April 1, 2019-March 31, 2020	Annually	8 or more	6 or 7	Less than 6	9

Trends:

Year	2018-19	2019-20
# staff trained	8	9

Extenuating Factors/Discussion: None **Follow-up Completed:** While some of the staff this year went to formal H.S.A training, much of the training was internal

Action Plan: Continue with current strategies with training via H.S.A and internal expertise.

Residential Services Division

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
For persons served to have 'natural' supports (*effectiveness*)	% of persons served increasing or maintaining amount of non-family/non-staff supports	All Persons Served, Residential Services	Unpaid Supports Tracking Sheets	April 1, 2019-March 31, 2020	Every Three Months	More than 70%	Between 50% and 70%	Less than 50%	60.5%

Trends:

Year	2017-18	2018-19	2019-20
Natural Supports	40.9%	41.8%	60.5%

Extenuating Factors/Discussion:

The average change in natural supports was an increase of 0.1 hours, which is quite modest. The highest increase was 5.9 hours per month and the largest decrease was 5.5 hours per month. Of those who saw an increase in natural supports, most were quite modest (an hour or two per month)

The use of Best Buddies, who volunteer in pairs, has generally resulted in increased and more consistent supports (if one cancels, the other may still volunteer). However, the province's allocation of $5,000 in Passport for every person served may have indirectly reduced natural supports, as paid supports are stepping in where unpaid supports may otherwise have been sought out.

Follow-up Completed: Focus has been on developing natural supports at existing connections. The primary volunteer base recruited has typically been seasonal– generally students from September to April.

Action Plan: The organization intends to focus more on older volunteers, as they may be more likely to match the age/interests of many persons served. A further focus on volunteers that might be more active in the summer may also be explored.

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 family supports (*effectiveness)*	% of persons served increasing or maintaining amount of family supports	All Persons Served, Residential Services	Unpaid Supports Tracking Sheets	April 1, 2019-March 31, 2020	Every Three Months	More than 70%	Between 50% and 70%	Less than 50%	31.1%

Trends:

Year	2017-18	2018-19	2019-20
Family Supports	67.6%	37.2%	31.1%

Extenuating Factors/Discussion:

The average change in family supports was actually an increase of 1.09 hours per month. This highest increase was 43.2 hours a month, which greatly influenced that result. The largest decrease was 24.1 hours per month. As persons served age, many of their loved ones do also, which may impact results more over time.

Many families are aging and developing health issues, meaning that they may not be able to visit their loved ones as frequently as in the past. There has also been an increase in families retiring and moving out of the city.

Follow-up Completed: During COVID, there has been a focused increase in video chats where in person visits may not be possible. This may be reflected in 2020-21 data.

Action Plan: Increased focus on technology to maintain family connections.

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, 2019-March 31, 2020	Every Three Months	Less than 60	Between 60 and 80	More than 80	85

Trends:

Year	2016-17	2017-18	2018-19	2019-20
Number of Tier 1 Errors	95	101	87	85

Extenuating Factors/Discussion: A more rigid process to follow-up medication errors, especially after repeated errors, has been helpful. However, at times, there has been a gap in completing the medication error follow-up steps because of scheduling conflicts, supervisor/Manager busyness, etc. The agency's training Coordinator has also developed a detailed online course that staff are required to complete after medication errors.

Note: A 'Tier 1' error is one that had potential to have significant impact on a person served, e.g., administering the wrong medication, administering at the wrong time, failure to administer. Minor errors such as forgetting to sign off on an administered medication are not a 'Tier 1' error.

Follow-up Completed: . As noted, more developed follow-up process has been helpful in putting a small dent in errors.

.

Action Plan: . Develop strategies to ensure more timely follow-up around medication errors. Continue to follow other procedures recently established.

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, 2019 -December 31, 2019	Every Six Months	Less than 5%	Between 5% and 6%	More than 6%	5.03%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018	2019
Sick Rate	4.84%	4.99%	5.15%	518%	3.84%	3.67%	5.29%	5.03%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year. It is likely that actual sick rates are higher than represented, as the data set includes only those individuals who are actively working as of Jan 1, 2020, and not all who may have departed during the year. Reliability may also be compromised on a program comparison basis, as staff are coded only to their home division, not to all services where they may have worked and actually used sick time.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, per the agency's *Attendance Management Program*.

Action Plan: .Continue to administer the *Attendance Management Program.* However the agency would also like to look at other indicators that may be spinoffs of sick time that may more accurately measure the impact, such as Required to Stay. **Note: Because of the organization encouraging people to stay home if sick during**

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, 2019-March 31, 2020	Once A Year	At least 4	2 or 3	Less than 2	4

Trends: Last year saw four staff access augmented communication training.
Extenuating Factors/Discussion: The four staff attended out of town events funded through the Joint Staff Education Committee (JSEC).
Follow-up Completed: None formal.
Action Plan: . Continue to send training opportunities to staff as they come up and encourage applications to JSEC.

Community Services Division — Supported Independent Living

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 persons served have a chosen, meaningful valued social role (*effectiveness*)	% of persons served with noted social role identified in personal plan	All Persons Served, Community Services	Personal Plans	April 1, 2019-March 31, 2020	Annually	More than 75%	Between 65% and 75%	Less than 65%	69%

Trends:

Year	2017-18	2018-19	2019-20
Results	28%	60%	69%

Extenuating Factors/Discussion: The definition of 'socially valued role' is somewhat interpretive, which may impact reliability. This is mitigated by having only the program Manager involved in examining the data so that it is interpreted consistently.

Follow-up Completed: Last year's action plan continued to be followed, which included:

1. Establishing a time frame for plans to be completed with new persons served;
2. Continuing with expectations for plans to be completed in programs or by staff where it had previously been inconsistent.
3. Continuing with established process to complete planning with those persons served who are resistant to doing so.

Action Plan: To continue with action plan noted above, though it is noted that time constraints on those responsible are challenging.

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, 2019 -December 31, 2019	Every Six Months	Less than 4%	Between 4% and 5%	More than 5%	3.74%

Year	2012	2013	2014	20015	2016	2017	2018	2019
Sick Rate	1.87%	2.25%	2.98%	3.75%	2.91%	2.56%	3.57%	3.74%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year. It is likely that actual sick rates are higher than represented, as the data set includes only those individuals who are actively working as of Jan 1, 2020, and not all who may have departed during the year. Reliability may also be compromised on a program comparison basis, as staff are coded only to their home division, not to all services where they may have worked and actually used sick time.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, per the agency's *Attendance Management Program*.

Action Plan: .Continue to administer the *Attendance Management Program.* However the agency would also like to look at other indicators that may be spinoffs of sick time that may more accurately measure the impact, such as Required to Stay. **Note: Because of the organization encouraging people to stay home if sick during COVID-19, it is anticipated that sick rates for 2020-21 will be higher. The *Attendance Management Program* will not be administered during COVID-19.**

Community Services Division — Supported Independent Living

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
To ensure that persons served enter service as soon as possible after funding is identified (*service access)*	% of persons served in service within 60 days of funding approval	All Persons Served, Community Services	Nucleus Labs Report	April 1, 2019-March 31, 2020	Once A Year	At least 75%	Between 50% and 75%	Less than 50%	100%

Trends:

Year	2016-17	2017-18	2018-19	2019-20
Target Rate	100%	100%	80%	100%

Extenuating Factors/Discussion: As was the case last year, figures are based on only five referrals.

Follow-up Completed: As was the case last year, diligence on the part of program staff in facilitating service commencement is the approach taken.

Action Plan: The current approach is sufficient provided that the number of referrals remains manageable.

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, 2019-March 31, 2020	Once a Year	More than 90%	Between 80% and 90%	Less than 80%	83.3%

Trends:

Year	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Maintenance Rate	100%	95.5%	90%	93%	85%	96%	91.7%	83.3%

Extenuating Factors/Discussion: Discontinuations this year were the result of family breakups or providers with younger children who were unable to manage the changing needs of persons served.

Follow-up Completed: .Attempts were made to help 'shore up' the supports with additional support hours, but these were not sufficient to maintain the living arrangement.

Flexibility around service provision continues to be the major approach to maintaining these arrangements.

Action Plan: Continue with existing approach.

Family Services Division—Family Home

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Family Home program	Nucleus Labs Report	January 1, 2019 -December 31, 2019	Every Six Months	Less than 4%	Between 4% and 5%	More than 5%	3.5%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018	2019
Sick Rate	2.66%	2.30%	3.54%	4.65%	1.89%	1.45%	2.10%	3.5%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year. It is likely that actual sick rates are higher than represented, as the data set includes only those individuals who are actively working as of Jan 1, 2020, and not all who may have departed during the year. Reliability may also be compromised on a program comparison basis, as staff are coded only to their home division, not to all services where they may have worked and actually used sick time.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, per the agency's *Attendance Management Program*.

Action Plan: .Continue to administer the *Attendance Management Program.* However the agency would also like to look at other indicators that may be spinoffs of sick time that may more accurately measure the impact, such as Required to Stay. **Note: Because of the organization encouraging people to stay home if sick during**

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, 2019-March 31, 2020	Once A Year	At least 2	At least 1	None	2

Trends:

Year	2018-19	2019-20
% Usage	4	2

Extenuating Factors/Discussion: Because of the relatively small size of the program, providers were recruited this year only on an as needed basis.

Follow-up Completed: When new providers are needed, the first step always involves brainstorming with the person served and significant people in their lives to look at their immediate circle and acquaintances first. Over the past four years, this method has been very successful, as our recruitment has included families who already knew and had long term relationships with the person served.

Action Plan: Continue with existing approach.

Family Services Division—Respite

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
Ensure usage of Respite House (*effectiveness*)	% of days respite house is utilized for funded or private respite	Respite House	Program Coordinator	April 1, 2019-March 31, 2020	Once a Year	More than 80%	Between 65% and 80%	Less than 65%	70.9%

Trends:

Year	2007-08	2008-09	2009-10	2012-13	2013-14	2016-17	2017-18	2018-19	2019-20
% Usage	78.96%	80%	76.43%	88.35%	93.9%	69%	69.6%	70.7%	70.9%

Extenuating Factors/Discussion: Trends continue to be steady. Base budget amounts continue to be stagnant, so the only avenue to increase usage of the house is via consumer-direct funding. The house was used on multiple occasions in 2019-20 for those supported in Residential Services whose homes were either being renovated or were otherwise unavailable to them.

Follow-up Completed: Private respite options continued to be explored and utilized as possible. The cancellation of respite during COVID-19 did decrease use of the house in March accordingly.

Action Plan: To continue to look for private respite option usage.

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, 2019 -December 31, 2019	Every Six Months	Less than 4%	Between 4% and 5%	More than 5%	3.5%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018	2019
Sick Rate	2.86%	2.38%	4.81%	1%	1.9%	1.45%	2.10%	3.5%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year. It is likely that actual sick rates are higher than represented, as the data set includes only those individuals who are actively working as of Jan 1, 2020, and not all who may have departed during the year. Reliability may also be compromised on a program comparison basis, as staff are coded only to their home division, not to all services where they may have worked and actually used sick time.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, per the agency's *Attendance Management Program*.

Action Plan: .Continue to administer the *Attendance Management Program.* However the agency would also like to look at other indicators that may be spinoffs of sick time that may more accurately measure the impact, such as Required to Stay. **Note: Because of the organization encouraging people to stay home if sick during COVID-19, it is anticipated that sick rates for 2020-21 will be higher. The *Attendance Management Program* will not be administered during COVID-19.**

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, 2019-March 31, 2020	Once A Year	More than 85%	Between 65% and 85%	Less than 65%	83.3%

Trends:

Year	2018-19	2019-20
% Usage	70.7%	83.3%

Extenuating Factors/Discussion: Where respite allocations were not used it was usually in the cases of former TAY who are extremely capable people and do not require supports such as private workers or respite providers to be in place for their providers to take a break. They can stay home with other family members

Follow-up Completed: None specific. Continue to work with persons served and providers to ensure that they are getting all of the respite services required.

Action Plan: Continue with current approaches.

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, 2019-March 31, 2020	Once a Year	Less than 2	Between 2 and 5	More than 5	0

Trends:

Year	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Number of Children Unable To Attend Centre	2	0	1	0	0	0

Extenuating Factors/Discussion: None, but the team is querying whether or not this measure continues to be worthwhile given the steady nature of the results, and the limited control that the program has over reaching the target.

Follow-up Completed: None formal.

Action Plan: A new measure will be developed for 2020-21

Family Services Division— Child Care Resource Consultant Services

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To manage staff absenteeism, which makes sure that supports are consistent (*efficiency*)	% of payroll assigned to sick pay	All Staff, Respite program	Nucleus Labs Report	January 1, 2019 -December 31, 2019	Every Six Months	Less than 3%	Between 3% and 4%	More than 4%	2.16%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018	2019
Sick Rate	2.35%	2.74%	2.49%	1.54%	1.63%	1.26%	2.01%	2.16%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year. It is likely that actual sick rates are higher than represented, as the data set includes only those individuals who are actively working as of Jan 1, 2020, and not all who may have departed during the year. Reliability may also be compromised on a program comparison basis, as staff are coded only to their home division, not to all services where they may have worked and actually used sick time.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, per the agency's *Attendance Management Program*.

Action Plan: .Continue to administer the *Attendance Management Program.* However the agency would also like to look at other indicators that may be spinoffs of sick time that may more accurately measure the impact, such as Required to Stay. **Note: Because of the organization encouraging people to stay home if sick during COVID-19, it is anticipated that sick rates for 2020-21 will be higher. The *Attendance Management Program* will not be administered during COVID-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 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, 2019-March 31, 2020	Once A Year	More than 67%	Between 50% and 67%	Less than 50%	83.5%

Trends:

Year	2015-16	2016-17	2017-18	2018-19	2019-20
Success Rate	77%	67%	86.2%	97.5%	83.5%

Extenuating Factors/Discussion: There were 85 referrals to the program (last year: 82). The average wait time was 40.7 days (last year: 26.5). The shortest wait was 0 days (last year: 0). The longest wait was 117 days (last year: 69).

Follow-up Completed: Intake is completed by the Program Coordinator who is no longer responsible for a caseload or centres. Previously the Program Coordinator would have been responsible for the site in Sharbot Lake, which included a physical monthly visit. This role was assigned to another Resource Consultant, freeing up about the equivalent of two days per month. A review was done of the collection of committees the program Coordinator as well as all of the Resource Consultants sit on and made adjustments to who goes to what and CLKD declined participation on a redundant committee or two. Coordinator coverage has allowed for ongoing service access. Previously there was no one covering this role while the Coordinator was off creating a back log of referrals and a bit of a bottle neck in service access. Typically the Coordinator does two to four intakes a week.

Action Plan: Continue with current practices.

Family Services Division— Family Support

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	
Ensure that families have access to information, outreach and support (*effectiveness*)	# of monthly drop in and parent group meetings attended by at least ten families	All drop ins, Family Support	Program Coordinator	April 1, 2019-March 31, 2020	Once a Year	At least 8	Between 5 and 7	Less than 5	1

Trends:

Year	2016-17	2017-18	2018-19	2019-20
Result	0	5	5	1

Extenuating Factors/Discussion: The lowest number of attendees was 0 (July). The highest was 10 (March). The average was 5.5 (last year: 16.4). The median number was 5 (last year: 8). It is noted that last year's numbers reflect two very highly attended events of 40+ people.

Follow-up Completed: The program continued with its practice of having drop-ins available at locations in different areas of Kingston so as to better fit family needs.

Action Plan: The program may choose to focus less on 'big' information seminars, which may no longer be how families wish to receive information, in favour of more targeted information or support sessions.

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, 2019 -December 31, 2019	Every Six Months	Less than 3%	Between 3% and 4%	More than 4%	4.41%

Trends:

Year	2012	2013	2014	2015	2016	2017	2018	2019
Sick Rate	1.81%	0.88%	3.47%	1.36%	2.73%	0.19%	2.07%	4.41%

Extenuating Factors/Discussion: Sick rates are calculated by calendar year, not by the fiscal year. It is likely that actual sick rates are higher than represented, as the data set includes only those individuals who are actively working as of Jan 1, 2020, and not all who may have departed during the year. Reliability may also be compromised on a program comparison basis, as staff are coded only to their home division, not to all services where they may have worked and actually used sick time.

Follow-up Completed: Employee sick rates are measured every six months, with follow-up done with employees in the top five percent of absenteeism, per the agency's *Attendance Management Program*.

Action Plan: .Continue to administer the *Attendance Management Program.* However the agency would also like to look at other indicators that may be spinoffs of sick time that may more accurately measure the impact, such as Required to Stay. **Note: Because of the organization encouraging people to stay home if sick during COVID-19, it is anticipated that sick rates for 2020-21 will be higher. The *Attendance Management Program* will not be administered during COVID-19.**

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, 2019-March 31, 2020	Once A Year	More than 67%	Between 50% and 67%	Less than 50%	20.7%

Trends:

Year	2015-16	2016-17	2017-18	2018-19	2019-20
Success Rate	74%	84.8%	91.36%	27.2%	20.7%

Extenuating Factors/Discussion: The average wait period was 118 days (last year: 134). The lowest wait time was 0 days (last year: 7). The longest wait time was 211 days. (last year: 273). The median wait was 123 days (last year: n/a). There were 29 referrals.

Follow-up Completed:

Action Plan:

Employment Services Division— Organization Employment Supports/Kwik Shred

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
For persons served to work frequently at Kwik Shred for minimum wage *(effectiveness)*	% of 'regular' persons served staff working at least two shifts per week.	All persons served working at Kwik Shred	Employee time sheets	April 1, 2019-March 31, 2020	Once A Year	100%	Between 80% and 100%	Less than 80%	100%

Trends:

Year	2018-19	2019-20
Success Rate	100%	100%

To ensure that the newly redesigned Kwik Shred is financially viable *(efficiency)*.	Amount of revenue generated above basic operating costs	All expenses and revenues at Kwik Shred	Finance records	April 1, 2019-March 31, 2020	Once a year	At least $80,000	Between $70,000 and $80,000	Less than $70,000	$33,000

Trends:

Year	2018-19	2019-20
Revenue Above	$70,000	$33,000

Extenuating Factors/Discussion: Two issues contributed to a challenge here. First, the price of metal (Kwik Shred sells shredded license plates for scrap metal) was generally low. Second, this was the first year that all workers were paid minimum wage, and the agency was not successful in adjusting for those costs.

Follow-up Completed: Cost for shredding services has recently been increased.

Action Plan: Monitor for new revenue streams and adjust costs where needed.

Employment Services Division— Organization Employment Supports/Kwik Shred

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To generate additional work opportunities at Kwik Shred *(Service Access)*	Number of 'casual' positions created at Kwik Shred	All persons served working at Kwik Shred	Employee HR Records	April 1, 2019-March 31, 2020	Once A Year	At least 3	At least two	Two or less	1

Trends:

Year	2018-19	2019-20
Number of Positions	4	1

Extenuating Factors/Discussion: This figure is largely the result of the fact that the crew of regular workers has been so solid that there simply hasn't been a need or opportunity to create new casual positions.

Follow-up Completed: None formal

Action Plan: Continue to monitor for opportunities.

Employment Services Division— Employment Supports

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To create employment opportunities for persons served (*Effectiveness)*	Number of individuals served securing paid employment of three months or longer	All persons served, Employment Supports	Nucleus	April 1, 2019-March 31, 2020	Once A Year	At least 6	Between 3 and 5	Less than 3	6
To ensure that jobs are secured in a fiscally responsible manner *(efficiency)*.	% of persons served who secured employment with less than four weeks of job training	All persons served who secured paid employment	Nucleus	April 1, 2019-March 31, 2020	Once a year	At least 75%	Between 50% and 75%	Less than 50%	100%

Trends:

Year	2018-19	2019-20
Number of Positions	1	6

Year	2018-19	2019-20
% positions	100%	100%

Extenuating Factors/Discussion: The program is using the job development model, which is considered the 'gold standard' in this sector.

Follow-up Completed: The program moved to new space at Fortune Crescent, which has been helpful in having dedicated program space. The Employment Facilitator has also spent a great deal of time developing a network of partners in the community. The program has also committed to ensuring frequent follow up with employers.

Action Plan: The program intends on running pre-employment programming, which will allow for a full wraparound service. The organization has committed to funding the Employment Facilitator position for another fiscal year.

Employment Services Division— Employment Supports

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To ensure that referrals are suitable (*Service Access)*	% of referrals that result in a written employment plan	All referrals to Employment Supports	Nucleus	April 1, 2019-March 31, 2020	Once A Year	At least 60%	Between 40% and 60%	Less than 40%	76.2%

Trends:

Year	2018-19	2019-20
Results	100%	76.2%

Extenuating Factors/Discussion: None.

Follow-up Completed: None formal, simply good information being shared with community partners around the program and who would be suitable for services.

Action Plan: None formal.

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, 2019-March 31, 2020	Every Six Months	0 per 100 FTE	Between 0 and 3 per 100 FTE	More than 3 per FTE	2.53
To ensure staff health and safety	OSHA Lost Time Case Rate	All Staff	WSIB Reports, Dayforce reports	April 1, 2019-March 31, 2020	Every Six Months	0 per 100 FTE	Between 0 and 1 per 100 FTE	More than 1 per FTE	0.72

Trends:

Year	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Recordable Injury Rate	**2.03**	2.49	2.38	3.58	2.95	5.99	6.66	2.53

Year	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Lost Time Case Rate	0.95	2.24	0.42	0.86	0.83	0.72

Extenuating Factors/Discussion: There were seven injuries reported to WSIB last year, down from sixteen last year and fourteen the year before. Two of the injuries resulted in lost time, both the result of staff being struck by the same person served. In previous years, lost time injuries were the result of slips, trips and falls. Of the overall injuries reported to WSIB, two were related to slips, trips and falls, two to aggression by persons served, and three related to lifts/transfers.

Follow-up Completed: The Positive Behaviour Support Plan for the person served involved in the lost time cases was reviewed by the Behaviour Therapist. Training around communicable diseases, slips trips and falls and MSD prevention continues in Surge and in person, where applicable.

Action Plan: Continue current practices.

Business Function Measures— Supplemental Information

The following is a summary of staff injuries in the 2019-20 fiscal year. No targets are associated with this data at this point, and this information should be considered supplemental to the agency's other health and safety business targets.

Category	**2017-18**	**2018-19**	2019-20
Number of Fatalities	0	0	0
Number of WSIB-reportable injuries	14	16	7
Number of Lost-Time Injuries	2	2	2
Total Number of Hours Lost	228	210	139
Number of non-WSIB reportable injuries	20	23	28
Types of Injuries	Lift/Transfer/Physical Support with Person Served: 9 Slip, Trip or Fall 10 Bumped Head 4 Aggression by Person Served 4 Cut Caused by Object 2	Lift/Transfer/Physical Support with Person Served: 11 Slip, Trip or Fall 14 Bumped Head 2 Aggression by Person Served 4 Cut Caused by Object 0 Other lifting (items) 4 Other 4	Lift/Transfer/Physical Support with Person Served: 7 Slip, Trip or Fall: 9 Bumped Head 0 Aggression by Person Served: 11 Cut Caused by Object 0 Other lifting (items) 2 Other 6

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 manage long-term costs	Unfunded Liabilities (in dollars) in Excess of 30 Days	All Staff	Finance Reports	April 1, 2019-March 31, 2020	Every Six Months	Less than $85,000	Between $85,000 and $100,000	More than $100,000	$46,087

Trends:

Year	2016-17	2017-18	2018-19	2019-20
Amount	$89, 523	$89, 662	$50, 582	$46, 087

Extenuating Factors/Discussion: At the end of 2018-19, CLKD paid down a significant amount of staff accruals. This year, Managers and scheduling received payroll information more frequently so that they could monitor time off as it was building.

Follow-up Completed: Regular reports were distributed for follow up through the year. In March 2020, some vacation time was paid down for staff who had excessive amounts built up (greater than 30 vacation days or 40 lieu hours), while some others were required to develop a time off plan to bring accruals down.

Action Plan: Continue with existing actions.

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, 2019-March 31, 2020	Every Six Months	More than 80%	Between 65% and 80%	Less than 65%	58.7%

Trends:

Year	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Result	44%	65.6%	84.6%	86.2%	53.2%	69.8%	69.4%	70.1%	58.7%

Extenuating Factors/Discussion:

- Of those calls that did not get a response within six minutes, 68% had an extended period before the answering service made the first call.
- There were 108 calls to the system this year (last year: 66). This is a significant increase in the number of calls going to the system.
- Reasons for calls:
    - Medical issue with person served: 48.1% (last year: 44.7%)
    - Property issue (alarms, no power, etc.): 30.5% (last year: 32.8%)
    - Challenging Behaviour: 4.6% (last year: 13.4%)
    - Informing MOC about having called emergency services: 8% (last year: no data)
- The shortest response time was one minute. The longest was 33. The average was 7.1 minutes (last year: 6.5 minutes)

Follow-up Completed: The organization sends a prioritized list of Managers to the on-call service weekly and reinforces the need for calls to be started immediately.

Action Plan: It is time to see if there is a more technologically advanced method of conducting the on-call service. Sheri Scott will lead this search in 2020-21.

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	Part-Time Turnover Rate	All Part-Time Staff	Dayforce and Other HR Records	April 1, 2019-March 31, 2020	Once A Year	Less than 15%	Between 15% and 25%	More than 25%	28.1%

Trends:

Year	2017-18	2018-19	2019-20
Amount	25.2%	38.7%	28.1%

Extenuating Factors/Discussion: This is the third year in a row that the agency was above the 25% marker, but is a significant improvement over 2018-19. Of that left this year. Of those that left CLKD, 50% left for full-time employment, 20% moved from Kingston, and 12.5% returned to school. Of those who left, 37.5% had worked for the agency for less than six months.

The full-time turnover rate this year was 2.3%, a significant difference from the part-time rate, and an improvement over the 4% rate in 2018-19.

Follow-up Completed: The agency spent a great deal of time trying to better understand this issue in 2019. A *Staff Retention Task Force* made up of Managers and front-line workers worked together to poll staff about how to get staff to stay, and full-time employment was consistently the highest reason after increased wages. Improving the retention rates was also a focus in strategic planning focus groups this year, as evidenced in the agency's new Strategic Plan. The organization created seven new full time positions in 2019-20 as a partial response to this. In addition, some new Collective Agreement provisions stemming from collective bargaining may assist with retention, as it increases minimum hours and changes some scheduling provisions.

Action Plan: The organization would like to continue to create full-time work. Among the manners by which to do this will be to hire two full-time 'floaters' in 2020.

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 that appropriate applicants are being recruited	Number of hires stemming from employee referral program	All Staff	HR Records	April 1, 2019-March 31, 2020	Annually	10	6	3	7

Trends: This was the first year of the employee referral program, so no trends can be determined.

Extenuating Factors/Discussion: The referral bonus was fairly well received by staff. Seventy percent of referrals resulted in a hire.

Follow-up Completed: Staff are acknowledged publically when their referred person passes probation and the bonus is paid. This also serves as a reminder to all staff about the program.

Action Plan: Continue with current practices.

Business Function Measures

What are we doing and how are we doing it?						How are we hoping to do (target)?			
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies	**How did we actually do? (Results)**
To ensure regular feedback to staff	% of Staff Who Have Had A Performance Appraisal Within the Past Two Years	All Staff	Dayforce Records	Measured as of April 1, 2020	Every Six Months	More than 75%	Between 60% and 75%	Less than 60%	71.2%

Trends:

Year	2017-18	2018-19	2019-20
Amount	32%	73.5%	71.2%

Extenuating Factors/Discussion: Supervisors at all levels of the agency struggle to keep up with appraisals. Coordinators have many staff to supervise, and staff moving between programs causes disruptions. Managers also have high workloads and are behind in appraisals for Coordinators. The fact that over 70% of employees have an up to date appraisal is a testament to the diligence and hard work of the agency's supervisors.

Follow-up Completed: All supervisors receive updated lists of appraisal due dates each month.

Action Plan: Continue with this course while trying to free up supervisor time to be able to address appraisals.

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 (or my loved one) is 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 and with the information I need.	90% or better	Between 80% and 90%	Less than 80%	96.6%
I am happy with the amount of support I get from CLKD	90% or better	Between 80% and 90%	Less than 80%	96.6%
CLKD helps people with intellectual disabilities to be more included in the community	90% or better	Between 80% and 90%	Less than 80%	93.1%
Overall, I am happy with the support that I get from CLKD	90% or better	Between 80% and 90%	Less than 80%	93.1%

Wo Responded to the Survey?:

-CIP: 51.7%, Residential: 38%, Community Services: 24.1%, Family Services: 3.5%, Employment Services: 3.5%

Note: Respondents could note that they were involved in multiple programs, so percentages will add up to more than 100%

Trends: This is a high level of satisfaction across the board. It is the first year in a while that CLKD has sent out an electronic survey to all service users rather than using the peer-led survey team, which was not able to operate this year. Whenever a respondent noted 'mostly no' for a response, a separate question opened up to allow them to comment further. In every case where a comment was made, it was related to frustration around not having enough funding to purchase the services desired, which is ultimately not in the control of the organization.

Extenuating Factors/Discussion: About 55% of the surveys noted that it was a family member or advocate assisting with the responses, which leads to the possibility that the true opinion of the persons served are not being reflected. Survey response rates are fairly low, accounting for only about 20% of those served in adult programs.

Follow-up Completed: None, as not warranted by very positive survey results.

Action Plan: The organization's preference remains with using the peer-led survey team. CLKD will look for avenues to reinstate this again in 2020.

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%	97.7%
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%	100%
The Resource Consultant makes us aware of other services in the community as necessary	90% or better	Between 80% and 90%	Less than 80%	88.4%
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%	95.7%
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	100%

Who Took the Survey?

By area		By Age of Child		By Time in Service			
City of Kingston	86%	0 to 2	0%	Under 6 months	16.3%	1 to 2 years	20.9%
Frontenac Township	7%	2 to 6	83.7%	6 to 12 months	44.2%	2+ years	18.6%
Other	7%	6 to 12	16.3%				

Surveys— Staff

What Question Did We Ask?	How are we hoping to do (target)?			How did we actually do? (Results)
All Question Were Asked With 'Mostly Yes' or 'Mostly No' as the options. **We Want as Many 'Very Satisfied' and 'Somewhat Satisfied' 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 aware that CLKD has an Employee Assistance Program that offers counselling and online resources	90% or better	Between 80% and 90%	Less than 80%	95.88%
If you have used the EAP, please indicate your satisfaction with the service	90% or better	Between 80% and 90%	Less than 80%	77.1%
I am aware that CLKD has a Peer Support Team	90% or better	Between 80% and 90%	Less than 80%	93.8%
If you have used the Peer Support Team, please indicate your satisfaction with the service	90% or better	Between 80% and 90%	Less than 80%	83.1%
I am aware that CLKD has a Peer Mentor program for new staff	90% or better	Between 80% and 90%	Less than 80%	82.4%
If you have used the Peer Mentor program , please indicate your satisfaction with the service	90% or better	Between 80% and 90%	Less than 80%	90%
I am aware that CLKD has a Social Committee that plans fun events designed to encourage employee wellness	90% or better	Between 80% and 90%	Less than 80%	95.8%
If you attended a Social Committee event, how happy were you with it?	90% or better	Between 80% and 90%	Less than 80%	98.2%
Overall, between EAP, Peer Support, Peer Mentoring and the Social Committee, how happy are you with the wellness options offered by CLKD?	90% or better	Between 80% and 90%	Less than 80%	91.5%

Comments: There was a single repeated theme in comments made by respondents, which was that they were unhappy with the EAP provider that CLKD switched to in 2018. Many respondents requested a return to Resolve Counselling, the previous EAP provider.

Action Plan: Because of the survey feedback, as well as other previous concerns, CLKD made arrangements to return to Resolve as of February 2020.

Data Integrity Assurance

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

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

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

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

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

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

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

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

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

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

Contact Us

Community Living Kingston and District

Kingston Services: 6-541 Days Road, Kingston ON, K7M 3R8 613-546-6613

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

Executive Director	Peter Sproul	peter.sproul@clkingston.ca
Director of Operations	Sheri Scott	sheri.scott@clkingston.ca
Director of Finance	Matt Luck	matthew.luck@clkingston.ca
Director of Human Resources	Jeff Harrison	jeffrey.harrison@clkingston.ca
Manager, Residential Services	Sherrill Boyes	sherrill.boyes@clkingston.ca
Manager, Family Services	Erin Impola	erin.impola@clkingston.ca
Manager, Community Development	Colleen Kelly-Jansen	colleen.kelly-jansen@clkingston.ca
Manager, Community Inclusion	Rob Andrews	robert.andrews@clkingston.ca
Manager, Community Services	Rob Yeo	robert.yeo@clkingston.ca
Manager, Properties	Mark Vass	mark.vass@clkingston.ca

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.