Community Living
DRYDEN - SIOUX LOOKOUT

QUALITY IMPROVEMENT PLAN



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Community Living
DRYDEN - SIOUX LOOKOUT

QUALITY IMPROVEMENT REPORT 2023

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Community Living
DRYDEN - SIOUX LOOKOUT

2019-2023 Strategic Plan on a Page

Vision: No Barriers…Just Life

Priority 1: Philosophy and Values

Continue to use and refine CLDSL's philosophy and approach to services. Add to its value statements and ensure they guide the organization's day-to-day work.

Priority 2: Services

Make CLDSL's services even better using a continuous improvement framework

Mission: Advocate. Mentor. Collaborate

Priority 3: Management and Administration

Further enhance the work of the management and administration to support staff and people supported.

Priority 4: Board of Directors

Further enhance the effectiveness of the Board of Directors

CORE VALUES: People. Community. Quality

Priority 1: Philosophy and Values

Continue to use and refine CLDSL's philosophy and approach to services. Add to its value statements and ensure they guide the organization's day-to-day work.

Actions & Key Steps

Action 1.1 - Continue with CLDSL's person-centred philosophy of services and utilizing the "just enough support" approach.

Action 1.2 - Review CLDSL's values and adjust them as needed.

Action 1.3 – Starting with hiring and training, develop and implement a strategy for ensuring that the values are known, understood and used in the organization's day-to-day work.

Priority 2: Services

Make CLDSL's services even better utilizing a continuous improvement framework.

Actions & Key Steps

Action 2.1 – Address issues related to quality assurance.

Action 2.2 – Undertake initiatives that will enhance specific services.

Action 2.3 - Strategize and take action on ways to improve transportation for people supported.

Priority 3: Management and Administration

Further enhance the work of the management and administration to support people supported and staff.

Actions & Key Steps

Action 3.1 – Take advantage of ideas put forward for enhancing CLDSL's administrative functions.

Action 3.2 – Continue to enhance CLDSL's management performance.

Priority 4: Board of Directors

Further enhance the effectiveness of the Board of Directors.

Actions & Key Steps

Action 4.1 – Enhance the information flow to the Board of Directors:

Action 4.2 - Develop and implement a yearly Board work plan.

Action 4.3 - Increase the size and resilience of the Board through improved board recruitment.

Action 4.4 – Across Ontario, promote the pioneering work of CLDSL and collaborate with others to enhance our services.

Performance Measurement and Management Plan

Community Living Dryden 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

Items considered When Identifying Gaps and Opportunities	Current Plan and Processes
Input from persons served, personnel, and other stakeholders	**Current Processes**: Input is sought through formal surveys and in face-to face meetings/correspondence as issues arise. **Gaps:** Lack of structured manner by which to proactively obtain personalized input. **Opportunities:** Growth of our QA department allows for more structured reach-outs in the future.
Characteristics of Persons Served	**Current Processes**: Data is collected on age, gender, transportation barriers, communication styles, language(s) spoken, diagnoses, interests, family/friend involvement, marital status, religion, mobility needs, ethnicity, ext. Other data is collected in Nucleus Labs but may not be aggregated each year. **Gaps:** Missing recordable data. Likely much more data that can be mined and gathered in order to have a better baseline of information on people supported. **Opportunities:** The growing Quality Assurance department will allow for more focus on data collected. Emphasis will be put on report 23 (Missing Information Report) within Nucleus Labs.
Expected results	**Current Processes:** Targets were based on gathering information to set a baseline. **Gaps:** Recognizing gaps(divergences) in outcome measures when calculating results, as our surveys did not produce the outcome/information that we intended to gather. **Opportunities:** Strengthening our surveys, and questions asked, to better collect information we are looking to obtain.
Extenuating Factors Influencing Results	**Current Processes**: These are extensively discussed as part of data evaluation. **Gaps:** None identified **Opportunities:** None identified
The Comparative Data Available	**Current Processes:** Our targets are based on our 'best guess' as we are setting a baseline. **Gaps:** None identified **Opportunities:** As we continue to collect and analyze data, we will compare from year to year.
Communication of Performance Information	**Current Processes:** Newsletter, website, and social media used to convey 'user friendly' report cards to communicate information. **Gaps:** Not sure how many people this reaches. **Opportunities:** Revamped website will offer more opportunity to push information via social media.
Technology to Support Implementation of PMM	**Current Processes**: Significant use of technology and evolving tech practices in conjunction with Nucleus, Surge-Learning Management System (LMS), Serious Occurrence Reporting and Residential Licensing (SOR-RL). **Gaps:** None identified. **Opportunities:** None identified.

Processes

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 Manager of Quality Assurance 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, language(s) spoken, diagnoses, interests, family/friend involvement, marital status, religion, mobility needs, ethnicity, ext. Other data is collected in Nucleus Labs but may not be aggregated each year.
Results achieved for the persons served (effectiveness)	The Manager of Quality Assurance will meet with the management team 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 Manager of Quality Assurance, the organization has one method by which to receive this information from persons served: A paper survey delivered by a member of the Quality Assurance team.	A member of the Quality Assurance team meets annually, one-on-one, with the person supported to complete the survey. In future the survey will be revamped to reflect people in multiple programs. The survey will also be available electronically for easier/better access for those able to do so.

Experience of services received and other feedback from other stakeholders	As led by the Manager of Quality Assurance, the organization solicits feedback in a three-year cycle involving families and community partners. Staff complete survey's twice per year.	In 2022, two staffing surveys were completed. Staff will continue to be surveyed twice per year. In 2023, community partners and families will be surveyed.
Resources used to achieve results for the persons served (efficiency)	The Manager of Quality Assurance will meet with the management team 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.
Service Access	The Manager of Quality Assurance will meet with the management team to identify the most important measures for each program.	Each program currently goes through the intake process to access services. Data is collected through our Intake department.
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)	Depending on the data collection in need, this is led by program Managers, as well as the Manger of Quality Assurance, who direct the appropriate teams.	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.
Identification of priority measures determined by the organization for business function objectives	This is led by the Manager of Quality Assurance, 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. These currently encompass needs related to human resources, health and safety, and finance.
Ensuring data integrity- validity, reliability, completeness, accuracy	This is led by the Manager of Quality Assurance, who develops data integrity processes.	Data integrity processes are noted at the end of this report.
Examining extenuating factors that may impact results	The Manager of Quality Assurance and management team will review possible extenuating factors 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 Manager of Quality Assurance and management team 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 Manager of Quality Assurance, along with the management team, are responsible for determining this and delegating action plans to their team for implementation.	Each measure has a separate implementation and follow-up strategy.
Determining how performance information is communicated	The Manager of Quality Assurance consults with the Management team.	Information is distributed using the *Plan to Distribute Performance Information*.

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 families, community partners, and MCCSS).

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 Surge (for staff), on website, and paper copies are available upon request.	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, social media and in administrative offices. It will also be made available in the CLDSL-An Inside Look (newsletter), and the Annual Report.	Report card will use simplified 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.	Wherever possible	Telephone and email contact information will be provided in order to encourage feedback.
Personnel	Updates are provided at staff meetings by Service Managers, Quality Assurance Manager, or designate.	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	Emails 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

Last review: January 2023 Next review: No later than January 2024

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 meaning- less 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 Dryden-Sioux Lookout 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. Those staff that collect data are trained accordingly.
- 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 data measures what it intends to measure.

- The organization's data is reflective of the needs of stakeholders as gleaned from PCPs 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 the Quality Assurance Department and the Management Team 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.

Efficiency Measures– All Programs

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve?	**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 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 employee (Oct 31, 2022)	HR- Payroll Software	2022 (January-October) Calendar	Annually	Less than 2 %	Between 2-3 %	Over 3 %	See chart below.

Results:

Year	2022
	2.9 %

Extenuating Factors/Discussion: COVID continued to have a significant impact on sick rates in 2022, especially given that Public Health directives required isolation periods. Sick rates increased over the past 10 months as more virulent strains of COVID and non-covid viruses became dominant.

Follow-up Completed: While managing absenteeism is important, the organization could not put a priority on it in 2022. The need to adhere to public health directives required staff absences. In addition, the continuing emotional toll of COVID impacted staff greatly, especially in those programs geared more towards direct support.

Action Plan: Continue with current practices. Continue efforts to increase awareness of workplace wellness and managing pandemic stressors. Many of these efforts have already (and will continue to be) led by the Wellness committees.

Effectiveness Measures– All Programs

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served.	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies.	
People Supported set and accomplish meaningful personal outcomes based on their wishes	% of people who accomplish at least one goal within a year	All people supported who participated in the program	POMS, PCPs, Passports	November 1st, 2021-Nov 1st, 2022	Annually	More than 85%	Between 50-85%	Less than 50%	See chart below.

Results:

Year	2022
Community Accommodations	50%
Life Share	64%
SIL	61%
Community Participation	51%

Extenuating Factors/Discussion: Due to extenuating circumstances of the pandemic, people have been limited in the number of goals they were able to work towards. As communities continue to open up, more opportunities to fulfil goals are becoming available.

Follow-up Completed: Taking the focus off of covid and centralizing on people's individual goals. Going back to the basics, retraining staff on person centered goals and responsibilities.

Action Plan: Training all staff on person centered approaches, as well as tracking and documenting goals in order to better measure successes.

Effectiveness Measures– All Programs

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served.	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies.	
Increase safety of people supported	Percentage of people supported who have had decrease in critical incidents in the past year	People who have police/EMS/mental health services in the last two years	NLs, SOR, on-call logs	November 1st, annually	Annually	Reduction of more than 50%	Reduction between 25-50%	Reduction below 25%	See chart below.

Results:

Year	2022
Community Accommodation	0%
Life Share	50%
SIL	36%
Community participation	28%

Extenuating Factors/Discussion: Individuals newly accessing services with extreme traumas and mental health issues.

Follow-up Completed: We worked with community partners and put in place protocols to mitigate the risk.

Action Plan: To continue to educate staff and partners, and to continue to adjust protocols with Emergency Medical Services.

Service Access– All Programs

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served.	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies.	
To get transition age youth (TAY) into services within 18 months of eligibility	Percent of new TAY that transition into services within 18 months	All new and eligible TAY coming into services.	Nucleus Labs	Annually (January 1st-Dec 31st)	Annually	More than 80%	Between 50-80%	Less than 50%	See chart below.

Year	2022
Community Accommodations	50%
Life Share	33%
SIL	86%
Community Participation (Not Applicable)	0%

Extenuating Factors/Discussion: Due to the pandemic, the ministry had restricted our ability to transition people into services. The ministry has also been slow to approve individual budget submissions.

Follow-up Completed: Began working towards transitioning people from waitlists into intake services.

Action Plan: Continue to provide training and awareness to community partners regarding intake services, DSO processes, and the variety of services that we offer.

Satisfactions– All Programs

What are we doing and how are we doing it?						How are we hoping to do (target)?			How did we actually do? (Results)
What are we trying to achieve? (Outcome)	**What are we measuring? (Indicator)**	**Who are we looking at? (Target Population Applied)**	**Where are we getting the data (Data Source)?**	**What time period did we look at (Time of Measurement)?**	**How often are we measuring this (Follow up Interval)?**	**Awesome** This would be a great result that shows all of the hard work we do for persons served.	**Not too bad** We can do better. It shows that we are on the right track but we can improve even more.	**We need to work on it** We can do much better, and need to really look at improvement strategies.	
Deliver services that people we are supporting are satisfied with	Percentage of people supported (who completed the survey) who say they have positive interactions with their staff.	People supported at the time of the survey	Satisfaction survey	Fall (annual)	Annually	More than 85%	Between 65-85%	Less than 65%	See chart below.

Year	2022
	86%

Extenuating Factors/Discussion: Only 49 of 99 people supported completed the satisfaction survey. Of the 50 people that did not complete the survey, 3 refused to participate or their family refused to allow them to participate.

Follow-up Completed: We met one on one with People Supported to ask the questions around their level of satisfaction with the services provided to them.

Action Plan: To re-evaluate our survey in order to obtain more accurate results. We also want to create a process in which we will be able to engage more people supported and families.

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, and reduce injuries and lost time.	OSHA recordable injury rate; Percentage of lost time hours due to workplace injury	All Employees	Payroll, notice of accident's, health and safety meeting minutes, and WSIB	January 1st, 2022 (annual)	Annually	0 %	Between 1-1.5 %	Greater than 1.5%	See chart below.

Trends:

Year	2020	2021	2022
	8.5%	11%	1%

Extenuating Factors/Discussion: Significant improvement from the previous year. Significant improvement regarding lost time from people being struck by a person served.

Follow-up Completed: CLD-SL continues to find creative ways to keep people working by utilizing the 'Stay at work, return to work' policy, which assists in decreasing lost time.

Action Plan: WSIB; Evaluate and establish better communication and tracking of lost time. Increase communication effectiveness between Managers, HR and Payroll processes.

Business Function Measures- The following is a summary of staff injuries in the last 5 years.

Category	2018	2019	2020	2021	2022
Number of Fatalities	0	0	0	0	0
Number of Occupational Injuries/Illnesses	22	26	16	27	23
Number of WSIB reportable injuries	13	11	4	4	8
Number of non WSIB reportable injuries	9	15	12	23	12
Number of lost days	53	15	105	25	25
Types of Injuries	Slips, trips, falls 5 Material Handling 4 Musculoskeletal disorders/client handling 11 Unsafe Equipment/environment 2 Workplace Violence/Harassment 0 Needle Stick 0 Exposure to hazardous bio/chem/phys agents 2 Other 0	Slips, trips, falls 7 Material Handling 2 Musculoskeletal disorders/client handling 9 Unsafe Equipment/environment 5 Workplace violence/harassment 1 Needle Stick 0 Exposure to hazardous bio/chem/phys agents 2 Other 2	Slips, trips, falls 7 Material Handling 0 Musculoskeletal disorders/client handling 5 Unsafe Equipment/environment 3 Workplace violence/harassment 1 Needle Stick 1 Exposure to hazardous bio/chem/phys agents 2 Other 0	Slips, trips, falls 7 Material Handling 0 Musculoskeletal disorders/client handling 3 Unsafe Equipment/environment 8 Workplace violence/harassment 6 Needle Stick 1 Exposure to hazardous bio/chem/phys agents 2 Other 0	Slips, trips, falls 8 Material Handling 2 Musculoskeletal disorders/client handling 5 Unsafe Equipment/environment 3 Workplace violence/harassment 4 Needle Stick 3 Exposure to hazardous bio/chem/phys agents 2 Other 0

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 peri- od 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 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.	
Increase the number of staff to complete the survey (2x per year)	Percentage of people to complete the survey	All staff	WorkWell Survey	June 2021, March 2022, October 2022	Two times annually	Greater than 79%	Between 65-79%	Less than 65%	See chart below.

Trends:

Year	June 2021	March 2022	October 2022
	41%	42%	49%

Extenuating Factors/Discussion: Mental health and wellbeing of people during covid. Still in the early stages of deployment of the survey process.

Follow-up Completed: Continue to build trust and relationships among staff, which will result in greater participation.

Action Plan: Continue to educate staff on the importance of participation and feedback.

Who did we support in 2022

Programs	Community Participation	Community Accommodation	Life Share	SIL
Number of Persons Served	100	32	10	49
Gender of Persons Served	Male: 54 Female: 46 Other: 0	Male: 14 Female: 17 Other: 1	Male: 9 Female: 1 Other: 0	Male: 27 Female: 22 Other: 0
Age of Persons Served	19-29: 27 30-39: 24 40-49: 15 50-59: 18 60-69: 12 70-79: 3 80-89: 1	19-29: 3 30-39: 7 40-49: 2 50-59: 8 60-69: 8 70-79: 3 80-89: 1	19-29: 5 30-39: 2 40-49: 2 50-59: 0 60-69: 1	19-29: 20 30-39: 13 40-49: 8 50-59: 6 60-69: 2

Who Works for CLD-SL?

As measured October 2022. This document captures those who are currently employed by CLD-SL.

Position and Description	Full-Time	Part-Time
Directors: Oversight of all functions in a broad structural area of the organization (Operations, Finance, Human Resources, etc.).	4	0
Managers: Oversight of all functions in a specific program area (Residential, Community Services, Family Services, CIP, Employment, Human Resources, Quality Assurance, Properties)	6	0
Administration: Perform duties that provide administrative support in the organization (Scheduling, Payroll/Benefits, Finance, Reception, HR)	6	0
Coordinators: Day-to-day coordination of programs and associated staff teams, ensure quality of supports to persons served (active in all areas of service) Service, PCP, Intake, Passport	5	0
Coordinators – MMW/HG: Provide broad consultation services to community and to persons served (Behaviour Therapist, Child Care Resource Consultants)	3	0
Maintenance: Performs key maintenance functions throughout organization	1	0
IT: Performs key IT functions throughout the organization **IT Contractor:** Performs specific IT functions	1 1	
Direct Support Professionals: Provide direct service to persons served, ensuring that they receive supports consistent with their goals/Personal Plan, and agency mission	59	33
Direct Support Professionals Casual: Provide direct service to persons served, ensuring that they receive supports consistent with their goals/Personal Plan, and agency mission	C = 23	
Student Placements: Complete short term post-secondary practicums by augmenting supports at CLD-SL	0	5
Students: Complete short term post-secondary practicums by augmenting admin supports	0	1

Risk Management Plan 2023

Community Living Dryden-Sioux Lookout (CLDSL) developed its first official Risk Management Plan in January 2020. This plan was developed recognizing that there is inherent risk supporting people in the community. It will be reviewed again in January 2023.

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 Dryden-Sioux Lookout, 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 Crisis Ready Playbook to Risk Management and there may be significant overlap between the two.

Community Living Dryden-Sioux Lookout's Approach to Risk

Risk exists in the day-to-day operations of CLDSL. 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 agency also seeks to develop partnerships with other community agencies wherever possible. Internally, a Leadership team led by the Executive Director, who reports directly to the Board of Directors, manages and monitors the agency.

Where necessary and appropriate, individual risk assessments are completed in an effort to determine the level of risk faced by the people we support, staff members and the agency 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 be assessed for risk.

The Risk Management plan is developed and reviewed by the Management team, who are also 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 agency or contracting the service to another business.

Specific Strategies Used to Address Risk

People	
Area of Risk	Persons Supported
Type of Potential Risk	Injuries and Accidents (including self-harm)
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used to 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, are mandatory. ASIST and Mental Health First Aid are accessed as per needs of person's supported) • Injuries and accidents are reported and reviewed to identify any trends • Specific interventions are noted in individual plans and Positive Behaviour Support Plans (PBSP) 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 person supported handling require mechanical lifts to be used wherever possible • External and internal Health and Safety Inspections • Bathing protocols developed in Residential Services • Fire safety training with all teams • Naloxone training for staff • Annual Health and Safety courses done by all employees on Surge • Emergency drills conducted monthly • Controlled acts training by agency trainers (train the trainer model) • Trend analysis completed for Serious Occurrence of Person's supported • Joint Health and Safety Committee completion of site inspections at least annually • Training on use of van lifts and lifts with New Hires.
Results of Actions Used to Manage Risk	This is our first plan
New Strategies to be Adopted This Year	• Given the complexity of some persons served in Community Services, specifically around drug use and potential overdose, as well as suicidal behavior and self-harm, Peer to Peer Support training has been initiated and we are looking at making it available to more staff. • In the process of getting a Peer-to-Peer Support Team off the ground. • Additional staff will take the Mental Health First Aid this year as well as the ASSIST training.
Area of Risk	Persons Supported
Type of Potential Risk	Missing Persons

Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	• Specific protocols/interventions developed as needed • Missing persons protocol • Policy related to Supervision of Persons Supported (PS-8) • Manager On-Call system available to assist in these circumstances • Serious Occurrence reports filed with MCCSS • Annual staff review of emergency procedures
Results of Actions Used to Manage Risk	This is our first plan
New Strategies to be Adopted This Year	Develop individual protocols as applicable to need.
Area of Risk	Persons Supported
Type of Potential Risk	Violence and Trauma
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	• Staff trained to assess safety and potential crisis (CPI, ASSIST) • Abuse education for all persons served, and staff review abuse policies annually • Work with clinical service providers • Training on Trauma informed care • CPI trainers available to do team-specific Applied Physical Training for teams that face significant behaviour challenges.
Results of Actions to Manage Risk	This is our first Plan
New Strategies to be Adopted This Year	
Area of Risk	Persons Supported and Staff
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 HR-03 and HR-05 address confidentiality of information • Nucleus Labs system is password protected so that users have access on a need-to- know basis. HR-17 addresses the use of electronic records system. • Nucleus system is monitored for possible security breaches, and all data is backed up. • We have a contract with Apatco for security of networked documents. • Training around confidentiality put in place via Surge Learning Management System. All staff required to complete. • Privacy and Confidentiality training completed with all new staff

	• We have software on all staff computer to daily remove downloaded files. • Staff have use of online encrypted space for temporary files.
Results of Actions to Manage Risk	This is our first official plan
New Strategies to be Adopted This Year	• Policy related to use of personal devices to access agency information will be looked at • Policies and procedures related to privacy records will be reviewed to make sure they comply with the new set-up. • Archived Paper files of persons supported are in process of being digitized and uploaded to Nucleus.
Area of Risk	Persons Supported
Type of Potential Risk	Abuse and Neglect
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	• Policy PS -05 addresses abuse and neglect • Policy PS -06 and PS-11 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 MCCSS • All staff and volunteers required to complete annual review of abuse prevention and reporting • All persons served receive annual education on abuse prevention. Specialized classes can be facilitated by the Quality Assurance team and frontline staff. • Abuse education training provided to all new staff at New Staff Orientation sessions early in employment.
Results of Actions to Manage Risk	
New Strategies to be Adopted This Year	
Area of Risk	Staff
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 OHS-01 addresses employee safety. Health and Safety Program also includes procedures related to staff Health and Safety. Other policies address slips, trips and falls, and person supported handling • Orientation and training for staff includes safety (CPI, WHMIS) • 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 • Vehicle safety checklist to be completed before each use of a vehicle • Ladder safety training completed with appropriate team member as needed.
Results of Actions Used to	
Manage Risk	
New Strategies to be Adopted This Year	
Area of Risk	Staff and people supported
Type of Potential Risk	Illness or mental health
Frequency (Likelihood)	moderate
Severity (How Bad, if it occurs)	moderate
Current Strategies Used Manage Risk	• We make people aware of Flu shots seasonally • All employees have sick time for use when ill • Fit testing (respirators) for all employees • Policies related to infection control and pandemic preparedness • Wellness Committee • Peer to Peer Support Team • Mental Health First Aid and ASSIST training done as needed
Results of Actions Used to Manage Risk	
New Strategies to be Adopted This Year	• Peer Support team to be fully operationalized
Area of Risk	Staff and people supported
Type of Potential Risk	Communicable Diseases
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Low
Current Strategies Used Manage Risk	• Promote Universal Precautions • Agency will pay for recommended immunizations as applicable to employee's work situation • Section 11 of the Health and Safety Program addresses disease and infection control. Section 16 addresses respiratory protection program

	• Team of Fit testers put in place internally and equipment purchased. • Training around communicable diseases put in place in Surge. • Covid protocols developed and implemented.
Results of Actions Used to Manage Risk	We managed well during the pandemic. Very few People Supported got sick. A high number of staff did however we managed to cover absence relatively well.
New Strategies to be Adopted This Year	
Area of Risk	Employees
Type of Potential Risk	Staff Recruitment
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 • Human Resources section of policy manual designed to ensure a safe workplace • Participation in provincial HR strategy with OASIS and MCCSS • Implementation of extra special training.
Results of Actions Used to Manage Risk	
New Strategies to be Adopted This Year	• Design an exit interview process • Incentive program put in place for staff to refer potential new employees. • Explore further social media avenues for recruitment
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 Professionalism policy • Employment Standards Act • Collective Agreements with UNIFOR
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 training related to workplace violence prevention and harassment (training completed in Surge) • Workplace investigation training done with all Managers and Leadership
Results of Actions Used to Manage Risk	
New Strategies to be Adopted This Year	
Area of Risk	Board of Directors
Type of Potential Risk	Criminal activity, fraud, theft, legal requirements, liability, Board turnover
Frequency (Likelihood)	High
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 BRD01-08 addresses many issues related to Board Operation
Results of Actions Used to Manage Risk	· There were no concerns related to Board conduct this year.
New Strategies to be Adopted This Year	
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 Management 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 FIN-03 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)	Moderate
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	• Insurance and deductibles • Policy FIN-03, HR-10 and HR-11 addresses many of these issues • Completion of safety checks prior to each use.
Results of Actions Used to Manage Risk	• While there were accidents with damage to vehicles this year, these were easily managed within our insurance policies.
New Strategies to be Adopted This Year	
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 FIN-03 addresses many of these issues
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 Apatco • Cybersecurity training in Surge
Results of Actions Used to Manage Risk	There were no significant issues in this area this year.
New Strategies to be Adopted This Year	None formal.

Financial	
Area of Risk	Financial Practice
Type of Potential Risk	Fraud, legal requirements, investment losses
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	• Finance policies • Insurance • External audit completed annually • Experienced finance staff • Revenue Canada audits • Access to finance offices is limited to key parties through fob system
Results of Actions Used to	There were no reported concerns related to financial practices this year.

Manage Risk	
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 agency wide pressures as they arise. As this revenue grows there is risk that CLDSL will begin to budget for this flexibility on an annual basis and there would be vulnerability should this revenue decrease in the future.
Frequency	Moderate
(Likelihood)	
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	• Billing for individualized funding is frequent, meaning that it is recovered quickly. • Intricate reporting systems between the programs offering service and the finance department are in place, assuring up-to-date information on budget needs and incoming funds. • We have a dedicated Passport Coordinator to ensure people supported are utilizing all their individualized supports. This ensures that we have the stability in the percentage of the administrative amount.
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	Another Passport Coordinator is needed to meet the need as we still have a great amount of unspent Passport.

Agency	
Area of Risk	Reputation and Profile
Type of Potential Risk	Negative media coverage, loss of credibility, community misunderstanding the direction of the agency as far as inclusion and community supports.
Frequency (Likelihood)	Low
Severity (How Bad, if it occurs)	Moderate
Current Strategies Used Manage Risk	• Avoid activities that threaten the agency's profile or may cause a negative impact on its reputation • Membership in provincial agencys (Community Living Ontario, etc.) • Adherence to Vision and Mission Statements • 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. • There was no negative media attention. • There is some trends on families and or community partners misunderstanding the direction of the agency on community inclusion efforts, rights, dignity of risk and harm reduction strategies,

New Strategies to be Adopted This Year	Continue to develop individual specific protocols including community partners.
Area of Risk	Service Capacity
Type of Potential Risk	Ability to serve populations that increasingly include issues with homelessness, legal issues (high criminal activity), high vulnerability, addictions, aggression, suicidal ideation
Frequency (Likelihood)	High
Severity (How Bad, if it occurs)	High
Current Strategies Used Manage Risk	• Increased scrutiny over who is accepted into services, based on these needs • Training available to staff as required. • Increased requests for clinical supports • Develop community partnerships • Risk assessments are done at the point of intake to help assess whether we have the capacity to support someone.
Results of Actions Used to Manage Risk	·
New Strategies to be Adopted This Year	
Area of Risk	Governance
Type of Potential Risk	Low membership
Frequency (Likelihood)	Moderate
Severity (How Bad, if it occurs)	Low
Current Strategies Used Manage Risk	The Board is in the process of pursuing a 'closed membership' structure this year after extensive consultation within the sector and with consultants regarding risk mitigation.
Results of Actions Used to Manage Risk	A board committee has been established to bring forward the new language for the relevant bylaws.
New Strategies to be Adopted This Year	The new membership structure will be brought to the membership for vote at the 2022 AGM (2021 fiscal year review)

Inclusion of Risk Reduction Activities into Performance Indicators

Where possible, performance indicators will be developed to assist with risk reduction.

Accessibility Plan 2023

Introduction

Community Living Dryden-Sioux Lookout (CLD-SL) has completed a formal Accessibility Plan in January 2023. The plan will be reviewed on an annual basis thereafter.
Community Living Dryden-Sioux Lookout's Accessibility Plan addresses accessibility issues at our program locations and in the community at large. Community Living Dryden-Sioux Lookout is committed to identifying and removing barriers that reduce the ability of persons supported to fully access both our programs and the community as a whole. Community Living Dryden-Sioux Lookout's Accessibility Plan is designed to summarize the following:

- Those barriers that were removed or otherwise addressed by the agency in the past.
- Those items that the agency 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 Dryden-Sioux Lookout utilized several methods in which to identify accessibility barriers:

- The agency's 2023 Accessibility Plan was used to identify items that were already considered to have been a concern.
- Individual persons supported and staff's concerns were used and contributed to the identification of issues and potential ideas on how to rectify them.
- The agency'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 supported by the agency.
- The agency's leadership is brought up to speed on accessibility issues by staff and by persons supported 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 CLD-SL, 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 agency's Accessibility Plan will be completed at least annually. A member of the Leadership 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 (www.cldsl.ca), and will be available to staff via Surge.

2023 Accessibility Plan

Area(s) of Concern	**Architectural**. An architectural barrier is any physical factor that makes accessibility difficult for an individual. This may include narrow doorways, bathrooms that might need to be made more accessible, alarms that are not able to be heard by individuals with hearing impairments, or even something as simple as the location of furniture.
Items addressed prior	**Automatic door openers** installed at following locations: 41 King Street, 280 Arthur Street, 4-288 Arthur Street (all are public access) **Lifts** installed at following locations: Hub Dryden, 19 Anton Road, 3-288 Arthur Street, 32 First Avenue **Chair Lift** installed at 83-C Colonization Avenue **Outdoor elevator** installed at 83-A Colonization Avenue **Accessible bathroom/shower** at following locations: 32 First Avenue, 94 Prince Street, 20 Centennial Drive, 2 Meadwell Drive, 41 King Street, 280 Arthur Street, 3-288 Arthur Street, 19 Anton Road, 98 Queen Street **Lighting** in Administration at 41 King and 32 First was upgraded **Portable ramp** was purchased and donated to the Dryden bowling alley
Standing Items of Concern/Areas needing improvement	As people we support age, they are more in need of equipment and modification to their environment to keep them, as well as the staff who support them, safe. We are slowly addressing these issues as they come up on a case by case basis, however, it is important to keep this in mind when doing any future planning.
Future Goals	**Barrier:** 4-288 Arthur Street does not have an accessible bathroom **Strategies to Remove Barrier:** Add a second bathroom to the space that is fully accessible **Potential Obstacles:** Cost and location for plumbing **Persons Responsible:** Director of Finance and Assets **Target Date:** May 2023

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 prior to first official plan	**Renovations** of the office areas in both Dryden and Sioux Lookout created more space and eased crowding. **Security cameras** installed at 41 King Street and 288 Arthur Street.
Standing Items of Concern/Areas needing improvement	-As our agency keeps growing, lack of office space and crowding is always an issue. -Safety also is an issue to be aware of around our buildings as we are located in an area where several social issues co-exists. This is the case in both Dryden and Sioux Lookout.
Future Goals	**Barrier:** Lack of office space in Dryden, crowding in program area at 288 Arthur **Strategies to Remove Barrier:** Purchase new building, renovate and furnish **Potential Obstacles:** Costs, City By-Laws **Persons Responsible:** Senior Leadership **Target Date:** December 2023

Area(s) of Concern	**Attitudinal**. An attitudinal barrier is a preconceived (usually negative) attitude that people have towards people we support. Examples of this may include attitudes of neighbours or other community members, or the lack of "person first" language used by employees.
Items addressed prior to first official plan	We have changed the language we use to refer to the people we support. We officially adopted the language "person/people supported" instead of the word client.
Standing Items of Concern/Areas needing improvement	-The rights of the people we support are sometimes not respected or recognized. They are sometimes disregarded without due process in the name of safety, liability or perceived liability. - Negative attitudes of community members can sometimes stigmatize the people we support. This is addressed on an ongoing basis through follow-up where such concerns are expressed. Raising the profile of the agency and its mission is also one way to address this.
Future Goals	**Barrier:** The rights of the people we support are sometimes disregarded without due process in the name of safety or perceived liability. **Strategies to Remove Barrier:** Establish a Rights Committee **Potential Obstacles:** Recruitment of qualified committee members **Persons Responsible:** Quality Assurance Department **Target Date:** June 2023

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 agency level, or may be specific to funds possessed by persons supported.
Items addressed prior to first official plan	None in a widespread manner; many instances where issues have been addressed on a case-by-case basis. For example the agency has covered the cost of private addictions treatment at Aurora's for a few people we support. The program is better suited to people we support and more accessible than publicly funded programs, although not easily affordable.
Standing Items of Concern/Areas needing improvement	Funding and finances for people we support are not always sufficient, limiting community participation and quality of life. CLD-SL combats this by being active in provincial agencies that advocate for additional funding, and by petitioning MCCSS and ODSP on a situational basis for funds.
Future Goals	**Barrier:** Funding is often not available to fund special projects **Strategies to Remove Barrier:** Continue to invest in grant software **Potential Obstacles:** Ability to designate time to do grant applications **Persons Responsible:** Sherry Baum **Target Date:** December , 2023

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 prior to first official plan	- A number of years ago, changes were put in place so that the people we support shared 100% of the profit of all contracts they worked on. -In 2018, the agency eliminated all in house contract work and focused on helping people we support being employed directly for at least minimum wage rather than taking in contracts. -In 2018, the agency assisted three persons we support to start their own independent business which has grown very much in profitability since.
Standing Items of Concern/Areas needing improvement	ODSP employment support program does not currently receive the attention needed to grow to its full potential. Since its service recipients are not only the people we support, our focus needs to grow in order to succeed. We do not have the manpower to take it to the next level at present.
Future Goals	**Barrier:** No appropriate resources in place to fully develop the ODSP Employment Support Program **Strategies to Remove Barrier:** Evaluate the hiring of a coordinator who has the connection and the drive for a one year contract to give the program the full time attention needed to make it successful. **Potential Obstacles:** Finding and retaining the right candidate **Persons Responsible:** Senior Leadership **Target Date:** September, 2023 **Barrier:** No appropriate resources in place to fully develop the ODSP Employment Support Program **Strategies to Remove Barrier:** After the successful completion of the one year contract, continue to establish a separate program for ODSP Employment Support. The goal of the program is to find employment for the service recipients, help them start their own business, establish a business that can be used as grounds for training as well as be profitable enough to sustain itself. **Potential Obstacles:** Finding and retaining the right candidate as well as jobs for service recipients. **Persons Responsible:** Director of Services **Target Date:** April 1, 2028. This is a five year project.

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 supported or staff to be able to be understood by others, or promotional materials that are not present in formats that are easily understandable.
Items addressed prior to first official plan	-Contracted a French-language Resource Consultant to translate our website. -Put in place e-mail for all staff. -Adopted a new Client Software System (NucleusLabs) so that all staff have up to date information about the people we support at their fingertips.
Standing Items of Concern/Areas needing improvement	-Program information assumes a relatively high level of literacy. The agency attempts to combat this via plain-language versions of many documents (rights, complaints procedure). -The agency desires to develop video versions of many documents.
Future Goals	**Barrier:** Person Centered Plans (PCP) assume a relatively high level of literacy. **Strategies to Remove Barrier:** Develop pictorial versions of PCP where appropriate. **Potential Obstacles:** Time to develop the process **Persons Responsible:** Quality Assurance Department **Target Date:** November, 2023 **Barrier:** Consistent direct messaging is difficult to achieve. **Strategies to Remove Barrier:** Increase communication with our stakeholders through videos and via website integration. **Potential Obstacles:** Time to set up, cost of new equipment **Persons Responsible:** Director of Finance and Assets **Target Date:** September, 2023

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 prior to first official plan	**Accessible vehicles** purchased for following locations: 32 First Avenue, 19 Anton Road, 98 Queen Street, 2 Meadwell
Standing Items of Concern/Areas needing improvement	**-**Lack of accessible and regular transportation is an issue both in Dryden as well as Sioux Lookout. There are no regular public transportation in place in either communities. Both communities have an accessible public transportation service available but only during day time weekdays which must be booked in advance and only within City limits. There are no services evenings and weekends. -Both municipalities are in the process of trying to address these issues as part of their Community Well Being Plans. CLDSL has representations on these committees. -People supported rely greatly on transportation provided by CLDSL through agency vehicles as well as staff vehicles.
Future Goals	**Barrier:** Funds available for the replacement of accessible vehicles. **Strategies to Remove Barrier:** Complete an assessment of current accessible vehicles and estimate the remaining useful life. This will be useful to be proactive with grant applications. **Potential Obstacles:** Time and expertise to reasonably estimate remaining useful life. **Persons Responsible:** Director of Finance and Assets **Target Date:** October 2023

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 prior to first official plan	Removing community integration barriers are at the core of the agency'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:** Legal legislation regarding capacity in Ontario restrict people we support's ability to make decisions for themselves. **Strategies to Remove Barrier:** Participation in Supported Decision Making Pilot Project. **Potential Obstacles:** Failure to affect change in legislation, inability to find partners to participate in project. **Persons Responsible:** Sherry Baum, Lynda Ménard-Penner, Jill Davis **Target Date:** This is a five year study

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 prior to first official plan	Purchase of i-guard stove technology for Meadwell basement and Centennial basement as a safety measure.
Standing Items of Concern/Areas needing improvement	Persons supported have limited access to technology which can assist in giving them more independence. This relates to the Just Enough Support model of support.
Future Goals	**Barrier:** People we support could be more independent with the help of technology. **Strategies to Remove Barrier:** Invest time in researching appropriate technology that could address this issue. **Potential Obstacles:** Time **Persons Responsible:** Sheldon Turner **Target Date:** December, 2023 **Barrier:** Have an area where all stakeholders as well as the community can find information about our agency. **Strategies to Remove Barrier:** Have a full, bilingual, complete and accessible website. **Potential Obstacles:** Time **Persons Responsible:** Sherry Baum **Target Date:** June, 2023

Area(s) of Concern	**Other.** A barrier that is not easily categorized **Lack of affordable accessible housing/Lack of housing**
Items addressed prior to first official plan	-Participated in a housing summit hosted by the municipality of Sioux Lookout
Standing Items of Concern/Areas needing improvement	There is a growing concern in both Dryden and Sioux Lookout surrounding lack of housing. This makes it difficult for people to stay safe, receive services, find employment, etc. This also makes it difficult for our agency to recruit personnel in Sioux Lookout specifically as there is nowhere to live.
Future Goals	**Barrier:** No housing for prospective people supported or staff. **Strategies to Remove Barrier:** Work in partnership with KDSB on housing initiative. **Potential Obstacles:** None **Persons Responsible:** Sherry Baum **Target Date:** September, 2023

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 prior to first official plan	-Updated processes around recruitment and screening for Host Family providers -Negotiated new language with our union around basic requirements of casual staff
Standing Items of Concern/Areas needing improvement	-Difficulty with Host Family recruitment -Difficulty recruiting staff
Future Goals	**Barrier:** Difficulty hiring casual staff and filling shifts in Sioux Lookout **Strategies to Remove Barrier:** Creating a full time position and schedule them with casual shifts. **Potential Obstacles:** Could be a failure, fill as a temp trial **Persons Responsible:** Barb Kirouac, Lynda Ménard-Penner **Target Date:** June, 2023

Requests for Reasonable Accommodations

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

Type of Request	Number of Requests
Schedule request for religious observance	0
Accommodations for documentation/record keeping	0
Requested ergonomics assessment	0
Medical device required in workplace	0
Accommodations for physical nature of work	2
Request assistance with external interview process	0
Request scent reduced workplace	0
Schedule request for medical reason	0

The accessibility plan was updated in January 2023. Monitoring of items will continue throughout the year, with a formal update of the plan again being completed no later than January 2024.

Cultural Competence and Diversity Plan

(January 2023)

1. Preamble

Community Living Dryden-Sioux Lookout 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 Dryden-Sioux Lookout 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 Dryden-Sioux Lookout will consistently reflect support and respect for cultural differences and richness of diversity.

Community Living Dryden-Sioux Lookout 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 CLDSL 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 Dryden-Sioux Lookout will be sensitive to, and respectful of the culture and diversity of individuals (persons served, staff and other stakeholders) in regard to the following:

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

Community Living Dryden-Sioux Lookout 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.
	- Accommodation available to all stakeholders as needed in order to better serve specific needs in this area.
Standing Items of Concern/Areas needing improvement	Misunderstandings with communication styles due to culture
Further Steps for This Year	• A baseline assessment was done by YMCA Workwell through part of a survey link. • A focus group will look at the intersection of Cultural diversity and Inclusion, Core Gifts and Person Centred Approaches to discuss how staff can bring their whole selves to work. • Training and orientation needs will be assessed and enhanced • Celebrate Cultural days through a diversity calendar and multi-cultural events. • Develop a cultural competency policy

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

Further Steps for This Year	None

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

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

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

Further Steps for This Year	None

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

Area(s) of Concern	**Language**
Methods Used to Ensure Diversity	- Agency has non-discrimination hiring principles for external and internal positions - Numerous agency policies outline principles that promote diversity* - Adherence to provincial French language requirements designed to ensure promotion of French culture and accommodation for Francophones seeking service in their native tongue. - Collection of data in HRIS about staff able to communicate in French - Completion of personal plans in language of person's choice, where requested - French language website and signage - Accommodation available to all stakeholders as needed in order to better serve specific needs in this area
Standing Items of Concern/Areas needing improvement	- none
Further Steps for This Year	- none
Area(s) of Concern	**Race**

Methods Used to Ensure Diversity	− The agency has non-discrimination hiring practices for external and internal positions − Numerous agency policies promote diversity − We have a very diverse workforce
Standing Items of Concern/Areas needing improvement	- More training on the understanding of Truth and Reconciliation and how it effects our staff and people supported in our communities
Further Steps for This Year	- All staff training for 2023 on Truth and Reconciliation

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. - Feedback from people supported on their satisfaction with services is evaluated - Accommodation available to all stakeholders as needed in order to better serve specific needs in this area. - One Page profiles present how people want to be supported
Standing Items of Concern/Areas needing improvement	None
Further Steps for This Year	None

*Policies that outline principles and practice of cultural diversity include:

PS-06, Rights Responsibilities, Rights Review Committee
HR-25, Code of Conduct of Professionalism
HR-01, Staff Recruitment, Training and skills Development
HR-21, Harassment and Violence in the Workplace

This Plan will be monitored throughout 2023

Technology Plan

CLD-SL also manages a very comprehensive Technology Plan, which is not included in this document. If you would like more information about CLD-SL's technology planning, please feel free to contact Shauna Spalding at shauna.spalding@cldsl.ca

Review of Complaints Received

Background

Community Living Dryden-Sioux Lookout has a complaint policy and procedure that is available for all stakeholders to follow (including staff, where the Collective Agreement with UNIFOR may not apply and it is not a regular HR matter). For the purposes of this report, it is considered to be a formal complaint if the formal intervention of a member of the management Team or above is requested or warranted.

Program Area of Complaint:

Program	2015	2016	2017	2018	2019	2020	2021	2022
Community Accommodations	0	2	0	2	0	2	0	1
Community Participation/CI Hubs	1	0	0	0	0	0	0	0
SIL/ESIL	0	2	1	0	0	0	0	0
Life Share	1	1	0	0	2	0	0	0
Healthy Generations	0	0	0	0	0	0	1	0
Ojibway Park	0	0	0	0	0	N/A	N/A	N/A
Employment Services	0	0	0	0	0	0	0	0
Administration/Management	1	0	1	0	0	0	0	0
Total Complaints	3	5	2	2	2	2	1	1

(Note – some complaints cover more than one type):

Type of Complaint	2015	2016	2017	2018	2019	2020	2021	2022
Service Quality	0	1	1	1	2	1	1	0
About specific staff/individual	1	3	2	2	0	1	1	1
Possible mistreatment of person served	2	1	1	1	0	1	0	1
Agency Practices	1	0	1	0	2	0	1	0
Other	0	1	0	0	0	0	0	0

Source of Complaint	2015	2016	2017	2018	2019	2020	2021	2022
Family Member	1	0	1	0	0	2	1	0
Community Member	0	2	0	2	0	0	0	0
Other Agency	0	0	1	0	0	0	0	0
Staff Member	0	1	0	0	0	0	0	1
Life Share Provider	0	1	1	0	2	0	0	0
Person Supported	0	1	0	0	0	0	0	0

Areas Requiring Performance Improvement: There was a confusion identified this year about where complaints are recorded. These complaints are only against the agency or its staff.

Actions to be Taken to Address Areas Needing Improvement: All relevant reporting was done and the internal process was be cleaned up.

Actions Taken or Changes Made to Improve Performance: Every situation was handled on a case-by-case basis. One investigation was required to handle the complaint in 2022 but no external investigations required.

Status of Complaints: All of the complaints brought forward this year appear to have been resolved to the satisfaction of all parties involved and followed the process outlined in the Policy.

Contact Us

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Visit our website: www.cldsl.ca

If you have questions about this report, or if you would like this information in an alternate format, please contact Kendall Miller (kendall.miller@cldsl.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.