KNOWLES CENTRE INC.
Helping Individuals Find Their Path: Yesterday, Today, and Tomorrow

Performance and Quality Improvement Report

September 1, 2010 – August 31, 2011

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Performance and Quality Improvement Report

Contents

Executive Summary

One of the benefits of COA accreditation is the development and implementation of the Performance and Quality Improvement (PQI) process. Therefore, Knowles Centre (KC) can ensure that its programs and services are both effective and efficient. The PQI process culminates with an annual report that is a collective effort of the senior management group. This PQI report covers the period from September 1, 2010 to August 31, 2011. KC's PQI process is comprised of seven sections, and each section can result in corrective action plans (CAPs) being identified and implemented.

1. *Case record review* assesses the quality of client files and is done quarterly during the year.

2. *Risk management report* is a monthly analysis of reported incidents, accidents, and grievances generated by clients. Its purpose is to discern any trends with incident reports in order to reduce risk.

3. *Stakeholder satisfaction surveys* are completed annually, soliciting their opinions about different aspects of KC's services. Its purpose is to identify how KC could be improved, according to KC's stakeholders.

4. *Client outcome measures* are reviewed semi-annually (using standardized measures) to assess how effective treatment is in helping clients improve their functioning and achieve their treatment goals.

5. The *John G. Stewart annual report* involves an analysis of data collected on attendance, class completion rate, and change in student achievement scores. This report is completed by the school principal.

6. *Staff retention* data is analyzed.

7. A *financial report* assesses KC's financial performance.

Some of the highlights from the above seven sections appear below.

Concerning case record review, client files were in good condition. Each program generated specific recommendations to ensure continuous improvement in this area.

Concerning risk management report, each program identified relevant professional development for staff. Programs also identified a number of positive findings. For example, the Group Care Program only had 11 cases of using the containment unit or using physical intervention with clients. The previous investment in non-violent crisis intervention (NVCI) training has helped staff de-escalate verbally with clients. As well, the Independent Living Program implemented a CAP (based on previous data identifying a concern with client AWOLs) to create an outreach positioning in the program, which resulted in a decrease in client AWOLs.

Concerning stakeholder satisfaction surveys, the majority of clients rated KC programs and services favorable on different aspects. As well, the majority of adult stakeholders (foster parents, clients' social workers, funders, KC staff and board members) also rated KC programs and services favorably.

Concerning client outcome measures, the results varied across programs, and each program has provided a detailed explanation. Clients tended to report an improvement on depressive symptoms, but no change on other selected measures. KC has implemented a new client outcome measure for the 2011-12 PQI year, which should be a more sensitive measure for assessing client emotional and behavioral functioning over time (i.e., Child and Adolescent Functioning Assessment Scale/CAFAS will replace the Child Behavior Checklist).

Concerning the John G. Stewart report, the school identified that students were older, as there were more 16 and 17 year olds (who also had more AWOLs and longer periods of incarceration). Those students present had improved school attendance, but demonstrated only a small improvement in reading ability. The school also analyzed the reason for discharging clients (whether planned or unplanned).

Concerning staff retention, KC had a 92% staff retention rate for this reporting period, which was a 5% improvement from last year's report.

Concerning the audited financial statement, KC reported a surplus for the year ending March 31, 2011.

In closing, the KC senior management group believes the 2010-11 PQI report is a significant improvement over the inaugural 2009-10 PQI report. The overall results were encouraging. KC also continues to fine-tune its programs and services in response to these findings with the implementation of CAPs.

Case Record Review

Case Record Review
Executive Summary

CRR Committee Members:

Tiffany Waite, Program Assistant, Group Care/PQI Facilitator (May 2011 to present)
Vi Sharma, PQI Coordinator (September 2010 to March 2011)
Dave Purpur, Program Director, Group Care Treatment
Lauren Hershfield, Clinical Director
Stewart Halper, Clinician, Group Care Treatment
Andrea McKenzie, Program Director, Treatment Foster Care
Dawn Vandal, Program Director, SAIL
Kyle Spencer, Coordinator, Treatment Foster Care

Mandate of Committee:

The mandate of the CRR committee is to regularly review, as delineated by the COA (Council on Accreditation) standards, client files to ensure compliance with COA standards and/or Knowles Centre (KC) specific policies as part of our Performance Quality Improvement (PQI) Program. KC is proud to be accredited by COA to strengthen, measure, and validate our organization's effectiveness.

Process of Committee

- The PQI Facilitator randomly identifies files from each program for review on a quarterly basis. The amount of files per program and review are based on guidelines from COA. Some reviews include active files whereas other reviews are designated for discharged files;

- The PQI Facilitator, in consultation with all other committee members, is responsible for scheduling all file reviews at the beginning of the review period;

- The PQI Facilitator identifies files to be reviewed and advises each respective Program Director and/or Administrative Assistant;

- The PQI Facilitator attends and facilitates each CRR and ensures all required documents are present. This includes a list of client names , Corrective Action Request forms, and the most updated review template for each program;

- Each committee member reviews and completes the appropriate documentation for each file that is reviewed. No member can review a file from their own program;

- Open discussion, questions, clarification, etc. is encouraged. If there is a situation where a document is missing and has not been filed for example, the committee is flexible in allowing that person to retrieve the document and put it on the file;

- The PQI Facilitator processes and distributes any Corrective Action Requests to the respective Program Directors for follow-up. There is a 30-day timeline for any Corrective Action Requests to be completed. Once the Corrective Action Request is completed, it is signed off by the Program Director and submitted to the PQI Coordinator. The PQI Coordinator then signs off on the PQI document and the file is considered complete;

- The PQI Coordinator submits a copy of each completed review template to the respective Program Directors to note findings and recommendations;

- Each Program Director provides an annual summary of the findings and recommendations regarding their respective programs for the Annual PQI report;

- While all programs started out with a consistent template, this has changed over time, to accommodate differences between programs; templates are changed on an ongoing basis as necessary;

- The SAIL program became part of the Case Record Review in this review period, 2010-11;

- All committee members are committed to improving the process as we gain experience on what is and is not effective. A significant change from the last review year was a change from simply identifying findings to implementing a corrective action process. A Corrective Action Request is completed by a reviewer when there is something about the file that is NOT in compliance with COA standards, however CAN be corrected. For example, a treatment conference report that is not on file. Something that CANNOT be changed, such as attending an admissions physical would NOT result in a corrective action, but a recommendation may be made to note on the file the rationale for why this did not occur; and

- Findings and recommendations outside of a Corrective Action Request are shared with the Program Director for consideration by the Director and their respective team. It is up to the Program's respective Director to determine whether a recommendation will be implemented.

Outcomes of the CRR Process

- The CRR process continues to highlight the excellent quality of work being done by all programs (Group Care: on-ground units and community homes; Clinical: Group Care, Day Treatment, and Sexual Abuse Treatment; SAIL; and Treatment Foster Care);

- It continues to provide insights into how we can improve the documentation of these services provided in a manner that is more in compliance with COA guidelines. In addition, it continues to assist all staff and Directors to become more familiar with COA standards;

- Improvement in files was noted as the reviews progressed. Reviews are also becoming less time consuming as files are reviewed and enhanced and reviewers are more comfortable with the process;

- It helps familiarize senior managers with all Knowles respective programs and services and assists with the identification of similarities and uniqueness;

- It assists with developing processes to ensure compliance with standards (i.e. monitoring of adherence to conference and written report deadlines);

- Discontinuation of client codes occurred during the last review as they are not deemed necessary;

- It is helpful for program directors, supervisors, and staff, to receive external feedback from someone in a different program;

- It enhances confidence in our files as an organization should there be an external review
  *An overview of program specific findings and recommendations is identified in a separate summary within this report.

Review of Recommendations from Previous Reporting year 2009-2010:

1. Define terms/categories used in the final PQI document - incomplete, no longer deemed necessary;

2. Identify the nature of the themes regarding findings, recommendations, and corrective action requests rather than only noting the number of findings, recommendations, and corrective action requests. The numbers alone may inadvertently mislead the reader to draw false conclusions about a program. For example, in one program over 50 findings were noted, however, a large percentage of them were based on 1 item (i.e. fasten documentation in the file) which, while being a helpful recommendation, does not reflect the quality of work being done or any concerns regarding complying with COA standards. This type of issue was corrected by implementing a corrective action process by Review 3. It would be even more productive to note while there were 4 corrective action requests, for example, the identified issues on 2 of the 4 CARS were related to the physical file and what is included on it and the other 2 corrective action requests were about medical documentation. In that way, the reader is aware of both the number and nature of corrective action request and can refer to the "Director's Overview of Recommended Changes" to determine how corrective action requests and other findings have been/will be addressed - complete/ongoing;

3. The CRR committee will continue to review and revise the CRR review template on an ongoing basis to best meet the needs of both the organization as a whole, and individual programs - complete/ongoing;

4. Areas to be targeted include check boxes for some categories (i.e. strengths) to enhance the identification of strengths and consistency between reviewers - incomplete, agreed this will be completed prior to the next review;

5. The PQI facilitator, in consultation with senior management and senior Administrative Assistant, will ensure reviews are in compliance with COA standards and advise of any changes required in this process - ongoing; and

6. Senior Managers continue to provide an annual overview for their respective programs regarding findings, corrective action requests, and recommendations.

Recommendations from Current Reporting Year 2010-2011:

1. To clearly determine whether files will be pulled randomly and not reviewed prior to the CRR, or if managers have the option to review them prior to the review;

2. Each program manager will provide a list from their respective program regarding what specifically is considered the "Admission information";

3. To add a prompt at the end of the review template to ensure the reviewer signs off that they have reviewed the file on the conference tracking form in the file;

4. To change the template to reduce paper waste to being double sided and less spacious AND to develop a template for files that have been previously reviewed that does not include the admission information component;

5. Develop a process to ensure files are reviewed within a year as not to accumulate extensive reports to be reviewed;

6. Add a list of strengths to the template with tick boxes that the reviewer can check off; and

7. To complete the discharge review in June of each review year.

Case Record Review
Summary

1. Open File Case Record Review – October 29, 2010

   a. Treatment Foster Care Program
      - 10 TFCP files were reviewed
      - 2 corrective actions resulted from the review of the 10 TFCP files

   b. Group Care Treatment Program
      - 5 GCTP file were reviewed
      - 4 corrective actions resulted from the review of the 5 GCTP files

   c. Day Treatment Program
      - 2 DTP files were reviewed
      - 1 corrective action resulted from the review of the 2 DTP files

   d. Sexual Abuse Treatment Program
      - 2 SATP files were reviewed
      - No corrective actions resulted from the review of the 2 SATP files

   e. SAIL
      - 2 SAIL files were reviewed
      - No corrective actions resulted from the review of the 2 SAIL files

2. Open File Case Record Review – March 11, 2011

   a. Treatment Foster Care Program
      - 10 TFCP files were reviewed
      - 3 corrective actions resulted from the review of the 10 TFCP files

   b. Group Care Treatment Program
      - 5 GCTP file were reviewed
      - 4 corrective actions resulted from the review of the 5 GCTP files

   c. Day Treatment Program
      - 2 DTP files were reviewed
      - 1 corrective action resulted from the review of the 2 DTP files

   d. Sexual Abuse Treatment Program
      - 3 SATP files were reviewed
      - 1 corrective action resulted from the review of the 3 SATP files

   e. SAIL
      - 2 SAIL files were reviewed
      - 3 corrective actions resulted from the review of the 2 SAIL files

3. Open File Case Record Review – June 16, 2011

   a. Treatment Foster Care Program
      - 12 TFCP files were reviewed
      - 5 corrective actions resulted from the review of the 12 TFCP files

   b. Group Care Treatment Program
      - 6 GCTP file were reviewed
      - 6 corrective actions resulted from the review of the 6 GCTP files

   c. Day Treatment Program
      - 2 DTP files were reviewed
      - No corrective actions resulted from the review of the 2 DTP files

   d. Sexual Abuse Treatment Program
      - 3 SATP files were reviewed
      - No corrective actions resulted from the review of the 3 SATP files

   e. SAIL
      - 3 SAIL files were reviewed
      - 2 corrective actions resulted from the review of the 3 SAIL files

4. Discharge File Case Record Review – June 6 and 8, 2011

   a. Treatment Foster Care Program
      - 5 TFCP files were reviewed
      - No corrective action resulted from the review of the 5 TFCP files

   b. Group Care Treatment Program
      - 28 GCTP file were reviewed
      - 18 corrective actions (10 of these corrective actions were that the clinical contact sheet was not on file) resulted from the review of the 28 GCTP files

   c. Day Treatment Program
      - 4 DTP files were reviewed
      - 1 corrective action resulted from the review of the 4 DTP files

   d. Sexual Abuse Treatment Program
      - 5 SATP files were reviewed
      - No corrective actions resulted from the review of the 5 SATP files

   e. SAIL
      - 11 SAIL files were reviewed
      - 1 corrective action resulted from the review of the 11 SAIL files

Case Record Review
Overview of Findings and Recommended Changes

Treatment Foster Care Program

Strengths:

1. Files are well organized; all reviewers raved about the new files and new filing system;

2. Conferences are generally held within designated time frames or a rationale is provided if this did not occur,

3. Reports are very comprehensive and well written, "Excellent continuity of assessed needs and treatment goals through all reports."

4. Overall, goals are clearly identified that relate to issues, needs, and strengths; goals are well defined,

5. Enhanced documentation requesting social history from respective placing agencies if it is not received upon admission was noted, and

6. Reviewers noted that clients had an opportunity to complete a "My Conference Report" whether they attended the conference or not, where they had the opportunity to share their thoughts and feelings.

Recommendations:

1. Changes to the Review Template
   - Change "psychiatric consultation was considered" to "counseling/therapy/specialized intervention (i.e. speech-language, O/T, etc.)was considered."; complete.

2. Changes to the Client Information Sheet
   - Ensure any change in agency worker as well as Knowles Clinical Case Manager, transfer between agencies or foster homes, etc. is clearly documented, including date of same
   - Ensure identification of CCM'S direct supervisor is noted.

3. Changes to the Conference Tracking Sheet
   - Input date of CRR directly onto conference tracking sheet rather than the tracking sheet previously utilized.

4. Changes to the Conference Report Template
   - Assessment Conference – Have a clearly designated heading for admission physical /Initial Health Screening and note COA standard; CCM's will ensure children are seen as soon as possible and note any reasons if this doesn't occur within the designated time

line; a medical appointment tracking sheet is currently being developed to place on the child's main file; medical information continues to be documented in all conference reports; all medical contact sheets are kept in the CCM's working file given the long term care and resulting numerous appointments that would be difficult to retain on the main file.

- Ensure Reasons for Referral are clearly noted. Although many RFR in treatment foster care are related to the functioning of the children's parents it is essential Presenting issues/needs are clearly identified and that goals are clearly linked to the issues and needs identified, in addition to other areas.
- Consider whether "My Conference Report" should be on the main file or CCM's working file.
- Consider whether younger children should have treatment conferences every 6 months (rather than 3 months).

Corrective Action Requests (CARS):

Issues noted on the CARS include:

- Some occasions of missing the social history, albeit there is a written request to the agency on file; make a final decision about how to address this,
- Occasional missing authorizations that have not been filed,
- Occasional conference reports not signed; this improved upon the development of a different signing sheet that is signed at the conference,
- Clarify what medical/health documentation goes on the main file, and
- 2 incidents when a report was sent out prior to edits being completed; all edits will be completed prior to supervisor signing off.

Case Record Review
Overview of Findings and Recommended Changes

Group Care Treatment Program

Strengths:

1. Files are well organized,

2. Conferences are held within designated time frames or a rationale is provided if this did not occur,

3. Reports are very comprehensive and well written,

4. Overall, goals are clearly identified that relate to issues, needs, and strengths; goals are well defined,

5. Excellent clinical work; specific summaries provide a clear picture of how certain issues and goals are being addressed.

6. Excellent clinical work that conveys origin of issues and addresses the same

7. Reports clear and easy to read.

8. Reviewing of goals is easy to find

9. Clear format

10. Goals are specific and measurable

Recommendations:

1. Include reasons for referral in all reports, and incorporate goals
   - Reasons for referral appeared in all the assessment reports, but not in all review reports. It is suggested that the Reasons for Referral be referenced in all reports.

2 Ensure that new goals are established from the concerns in the "overview" section of the report
   - When a concern is mentioned in the overview, the writer will ensure that the concern is noted in the form of a new goal

3. Ensure that assessment conferences are held 30 days after admission

4. Ensure all signatures are on clinical reports

5. Ensure clinical contact sheets indicate why sessions are being missed

6. A goal that addresses the origin of the client's issues should be considered

Corrective Action Requests (CARS):

Issues noted on the CARS include:

- 4 group care reports were not on main file
- One admission physical documentation was not on main file
- Three clinical assessment reports were not on file
- Two review conference clinical reports were not on the file
- One delayed clinical review report.

Case Record Review
Overview of Findings and Recommended Changes

Supported Advancement to Independent Living (SAIL)

Strengths:

1. Files are well organized

2. Files are structured and well laid out

3. Content in reports is "superb"

4. Goals are clearly identified and well defined

Recommendations:

1. Changes to the File
   - Place colored sheets in front of each conference report.
   - Label the conference number on each colored sheet.
   - Create a section in each file for the Program Meeting Attendance sheets.

2. Changes to the Client Information / Conference Tracking Sheet
   - Ensure conference dates are recorded on each client face sheet.
   - Indicate reason for delays in conferences on client face sheet.

3. Changes to the Conference Report Template
   - Include a recreation heading
   - Include a Family/Positive Supports heading in report template
   - Indicate reason for delays in reports/conferences on reports as required
   - Provide date conference reports were completed on report templates
   - Ensure assessment reports are clearly titled 'Assessment'

4. Changes to the Case Record Review Template
   - Consider removing the discharge portion of the templates and create a separate discharge template.
   - Reword statement regarding previous goals being addressed –take out the word 'partially'. (Section C, number III)

Corrective Action Requests (CARS):

Issues noted on the CARS include:

- One occasion of a social history not being on file. A form was developed for internal Knowles Centre clients admitted to the SAIL program. The form indicates what program file the social history can be cross referenced. All other clients must have a social history in order to be referred to the SAIL program.

- Intake forms were placed in the clients file on one occasion.

- One instance of an Assessment Conference report not placed in the file.

- One instance of admission forms not in the file.

- 2 instances of files missing a section for Program Meeting Attendance sheets.

Case Record Review
Overview of Findings and Recommended Changes

Day Treatment Program

October 2010 Case Record Review: 2 files were reviewed
February 2011 Case Record Review: 2 files were reviewed
June 2011 Case Record Review: 2 Files were reviewed
June 2011 Discharge Case Record Review: 4 files were reviewed

Strengths:

The overall strengths identified in the above mentioned Case Record Reviews included that the files presented as well organized, reports were well written and documents were easy to find.

Recommendations:

Concerns identified throughout the 4 reviews included that there were things in the main file that should not have been there (loose papers), some sheets were out of order, a discharge date was missing, psychiatric notes were not in a particular file, some reports were delayed, some conferences were delayed, no new goals were listed in one report, and an explanation as to why psychiatric consultation was not considered was not provided on one occasion. There was only one recommendation throughout the 4 reviews. This recommendation was that the goals in a particular report should have been more relevant to the reasons for referral. Since this recommendation, therapists are ensuring that goals do reflect the reasons for referral or identify that the reason for referral is no longer presenting as an issue.

Corrective Action Requests (CARS):

Throughout all 4 Case Record Reviews there were a total of 2 Corrective Actions.

1. The first Corrective Action was a result of the file not containing referral information.

2. The second Corrective Action was as a result of missing consent forms.

Case Record Review
Overview of Findings and Recommended Changes

Sexual Abuse Treatment Program (SATP)

October 2010 Case Record Review: 2 files were reviewed
February 2011 Case Record Review: 3 files were reviewed
June 2011 Case Record Review: 3 Files were reviewed
June 2011 Discharge Case Record Review: 5 files were reviewed

Strengths:

The overall strengths identified in the above mentioned Case Record Reviews included that the reports captured all relevant information, were well written and flowed well, were easy to read, and were deemed by more than one reviewer as excellent. Other strengths identified included that information was very easy to find, that the file and various reports were very well organized and the various treatment goals were well designed.

Recommendations:

Two recommendations were made throughout the year. These included:

1. The Case Record Review Template should be modified. Under A. Meets Admission Criteria, a bullet labeled Adult is needed. This modification to the template has since been made.

2. A request for a labeled divider sheet between conference reports was made. This request is being carried out by the Coordinator of the program.

Corrective Action Requests (CARS):

Please note that no concerns were identified and no corrective actions were completed.

Risk Management Summary Report

Risk Management Report

Group Care Treatment Program

Purpose:

To identify, summarize, and analyze the trends in the findings of the monthly risk management reports and make appropriate recommendations.

Trends noted:

Self-harm has been the most reported incident for 8 of the 12 months of this review period. Self-harm covers many issues, such as cutting, substance abuse, and suicide ideation. The total number of self-harm incidents reported this year was 240.

The majority of the suicide ideation incidents have involved the female clients.
Substance abuse incidents are relatively equal between boys and girls.
Cutting incidents that have been reported are almost exclusively female.

To combat the high number of self-harm incidents, we will be increasing the training of the staff by introducing training modules that deal specifically with the issues above. This will commence this year as our Clinical Director has now returned from Maternity leave.

A Youth Care Worker who is specially trained in addictions and a Unit Supervisor facilitated this years "Addictions Camp" at our Camp in the Big Whiteshell. The camp was 5 days, which covered both alcohol and drug addictions in a fun setting. The kids not only learned about the effects of substances, but also did so in combination with swimming, fishing, biking and more. The camp proved to be very successful.

All full time staff in the program are trained in ASIST, which is a suicide intervention program.

Unplanned absences are now considered incidents by the province of Manitoba (they were not prior) and rate as the second highest reported incident (201 AWOLs this past year). Many of the kids we work with have AWOLING as the number one reason for referral. We are doing our best to combat AWOLS in the following ways.

1. **Youth Care Worker Relationships –** One of the most effective ways to prevent AWOLS is to build relationships with the kids we work with. The Youth Care Workers do an amazing job of this. Most of the kids we work with have lost trust in adults, and building up this trust is a critical part in preventing AWOLS.

2. **Dr. Martha Straus Conference –** Many of the Group Care staff were sent to a conference in Kenora, ON, were they learned better strategies for working with our population of clients. We were so impressed with the conference that we are bringing Miss Straus to Winnipeg and

having her present to the rest of our staff and others in the city. The original conference was scheduled for November 2011, but due to health reasons, it was delayed until next June.

3. **Outreach Worker** – Our current outreach worker has been a catalyst in getting kids off the streets and back to the Centre. His ability to connect with our kids while they are NOT AWOL has proven to be very effective in developing relationships and trust with the kids.

4. **Recreation Specialists** – Both our recreation specialists have done an amazing job keeping kids busy. Varieties of programs are offered for the kids to participate in, which has proven effective in reducing AWOLS.

Police intervention is the third highest incident reported (188 reports this past year, many of which are missing person reports when clients go AWOL). Police intervention also includes arrests, warnings, interviews, assistance, and transport calls. One factor that is contributing to the high volume of police incidents is the fact that many of the calls are for repeat offenders. Meaning, the same kids are being arrested, picked up, and then released quickly by the courts, only to re-offend again. This is very frustrating for both Police and Knowles Centre.

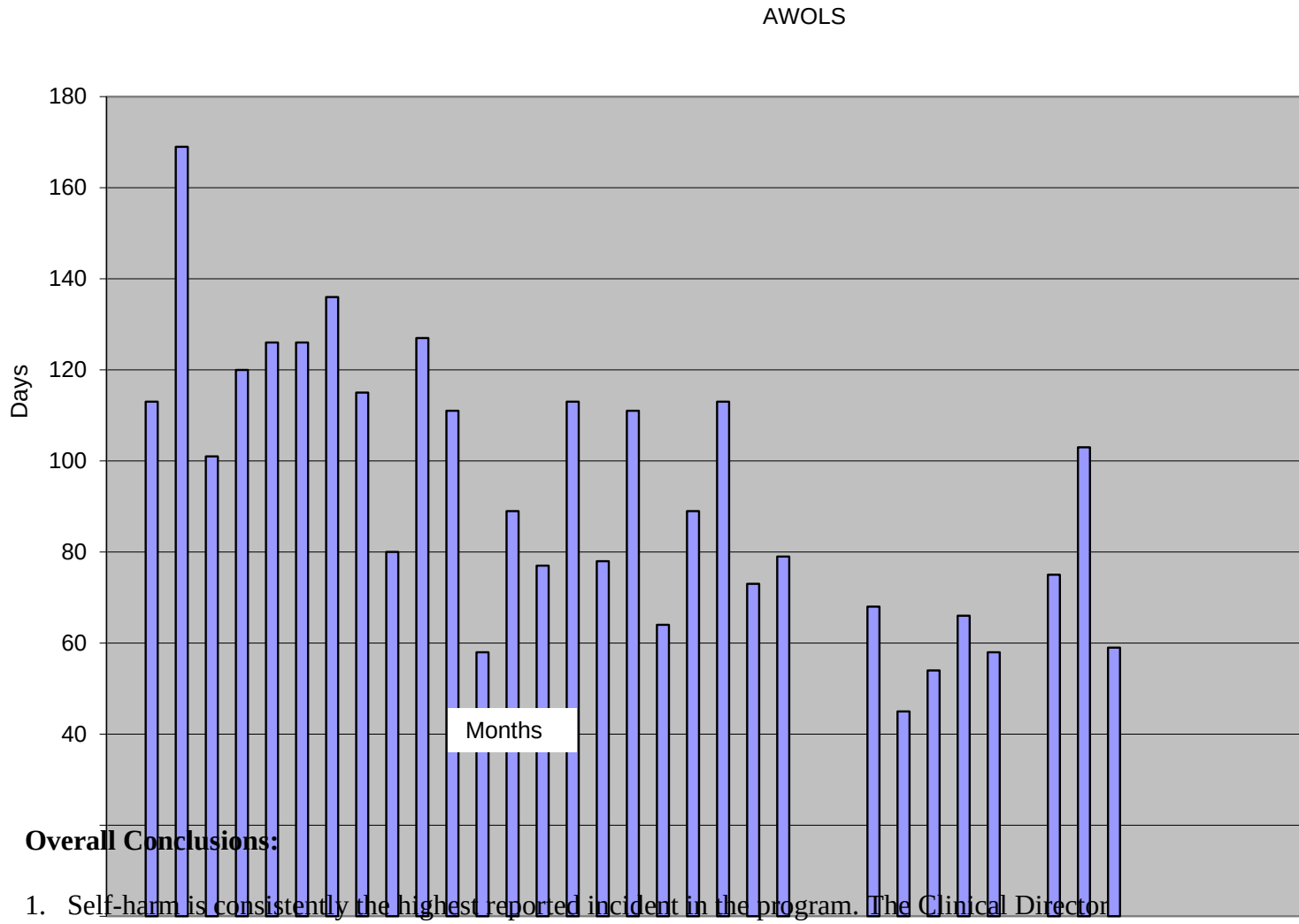
Containment/Physical Intervention incidents have remained low (11 this year). This is a major accomplishment that we are very proud of at the Centre.

This decline has been attributed to the commitment of the Centre to ensure all staff are trained regularly in CPI/NVCI techniques. Two staff trainers train all staff on a regular basis. The Director of Group Care, who is also one of the trainers in CPI/NVCI, reviews and discusses every physical intervention report with the supervisors. Unit supervisors then review every physical intervention with staff, and suggest ways they could be avoided (if possible). The two trainers were sent to Minneapolis this past year to recertify and learn new techniques in the area of NVCI.

This decline would also not be possible without the hiring of competent youth care workers. Youth care staff are well aware that physical intervention is the last resort when dealing with our clients, and have become proficient in de-escalating kids verbally.

There was no other pattern/trend with the remaining incident reports.

Following are the AWOLS from the past year:



Overall Conclusions:

1. Self-harm is consistently the highest reported incident in the program. The Clinical Director will champion a training program for Youth Care Workers in this area.

2. Self-harm appears to be a very contagious behavior for our girls. When one client starts harming, other clients follow.

3. The justice system allows repeat offenders to be released quickly, making it very difficult for police and youth care staff.

4. Our outreach worker has done a very good job helping kids return from AWOL in a timely fashion.

5. CPI training has greatly reduced the number of physical restraints and containments in the program.

Recommendations:

1. To continue to monitor incidents on a monthly basis.

2. To enhance training, specifically in the area of self harm.

3. To continue to train staff regularly in the most recent CPI techniques.

Risk Management Statistics
September 2010 – August 2011
Group Care Treatment Program

	Unit 1	Unit 2	Respect House	Clyde Road	TOTAL
Assault/Aggression					
By current staff		1			1
By former staff					0
By community member	4	2	4		10
By family member	1				1
Between clients	4	7	**1**		12
Against staff	3	1			4
Verbal threats	1	4		1	6
Past Aggression		1			1
Weapons					0
Self-harming behavior					
Inflicted by client	52	9	7	1	69
Substance abuse (on site)	7	2	2		11
Substance abuse (off site)	30	25	41	4	100
Suicide attempt	2	1			3
Suicide ideation/verbal	28	14	10	2	54
Sexual exploitation (off site)			1		1
Self-Piercing	1	2			3
Suicide gesture					0
Allegation of abuse					
By current staff	1	3			4
By former staff					0
By member of community	1	1	1		3
By family member	1				1
By another client	2	3			5
By police	1				1
Past abuse	4				4
Internet contact by adult					0
False allegation		**1**			1
Allegation of sexual abuse					
By current staff		1			1
By former staff					0
By community member					0
By family member					0
By another client	2				2

	Unit 1	Unit 2	Respect House	Clyde Road	TOTAL
Behavior management					
Involuntary containment	4	7			11
Voluntary use of containment					0
Use of isolation					0
Physical intervention/hold		1			1
Property damage	4	3	3		10
Possession of Weapon					0
Shoplifting	1				1
Acting out behavior					0
Fire					
False fire alarm (client)	**4**	**6**			10
False fire alarm (equipment)		3			3
Property damage	1	1	1		3
Fire	1				1
Police involvement					
Assistance required	17	11	2	2	32
Return of client(s)	7	6		1	14
Interview/questioning	5	12	3		20
Arrested/charged/warned	10	21	8	6	45
Other	4				4
Witness					0
PY 1	1	1			2
Medical					
Admission to hospital/emergency CSU	6	3			9
Medication error	1	1		1	3
Missed medication	2		2		4
Injury/health required medical attention	3	2	4	1	10
Refusal of Meds	4	2	2	6	14
Injury	1				1
Other					
Drug paraphernalia		1			1
Weapons	1				1
Vehicle accident	1				1
Bullets found					0
CSU					0
Other	1		1		2
SUB TOTAL					501
AWOLS					
AWOLS	68	72	49	13	202
Days absent while AWOL					0
TOTALS (Includes number of AWOL incidents but not number of days absent)	292	231	142	38	703

Risk Management Report

Supported Advancement to Independent Living Program (SAIL)

Purpose:

To identify, summarize, and analyze the trends in the findings of the monthly risk management reports and make appropriate recommendations.

Within this reporting year, there were 103 incident reports filed.

Trends noted:

- Substance abuse accounted for 27.18% of the incidents. Two clients in particular made up the majority of the incidents. This number is down from last year;
- Suicidal ideation accounted for 13.59% of all incidents. One client accounted for almost all of the incidents. This number is also down from last year;
- Hospital or urgent care accounted for 11.65% of all incidents. One client in particular made up almost half of these incidents;
- Unplanned Absences/AWOLs accounted for 10.68% of incidents;
- Assaults against clients accounted for 10.68% of incidents as well;
- There were a total of 4 reports of sexual assaults made by 2 clients during this reporting period;
- The remaining 22.34% of incidents were spread in categories such as police involvement, property damage, acting out behavior etc. and did not have any obvious trends;
- An average of 8.58 incidents are filed each month;
- 19 clients accounted for all the incident reports generated. Of those, 11 were female and 8 were male. Females accounted for a total of 76% of the reports while males accounted for 24%.

Analysis:

Substance abuse accounted for the highest number of incidents throughout this reporting year. Upon closer look, it was discovered that the majority of these incidents involved two clients in particular. These clients were admitted into the program with some known substance use. Alcohol was the typical substance used. The more serious of the two clients was connected to the

Addictions Foundation of Manitoba to receive outpatient services. The other client refused any service offered. It is important to note that incident reports are generated for clients at or over the age of majority only when evidence exists that their alcohol consumption is having a negative effect on their life or if they are an expectant mother. No report is generated if there is no concern present.

Suicidal ideation was the second highest in incidents recorded at13.59% for the year. One client accounted for 71% of the incident reports generated in this category. This client has refused additional respite services from a professional therapist employed at another organization with whom she had previously seen regularly. By the end of August this client had agreed to see a therapist and a referral was made for her. This client has always been able to contract for safety and has stated that although she expresses suicidal thoughts she doesn't have any intent to act on them. She has also stated that sometimes she says things to get attention. The majority of the support staff have been trained in suicide intervention through ASIST.

Hospital or Urgent Care was higher than anticipated with 11.65% of all incidents reported. One client accounted for almost half of the incidents with 5 trips to the emergency room via ambulance in February and March with various symptoms. He had a number of tests done and was always cleared medically. In one of his last visits the client had been informed that he had been suffering from anxiety/panic attacks. A subsequent visit to his doctor resulted in medication being prescribed to him. Extra support staffing was put in place to help the client get in the routine of taking his medication and to transport him to the emergency room should he have another anxiety/panic attack. The other hospital visits involved a variety of other clients for various medical reasons which were all addressed accordingly.

Unplanned absences (AWOL) SAIL had 11 clients living in their own apartment by the end of August with a yearly average of 9. This is over double last year's amount. As a result the number of unplanned absences also increased. There was a total of 11 AWOL reports filed (10.68% of all incidents). Three clients accounted for the majority of the absences. Two of these clients had a tendency to forget to call in on the weekends to check in and would be out with friends or their boyfriend. The third client had significantly detached herself from the program. She was discharged from care and SAIL as a result.

Assault Against Client The number of assaults against clients was high for the year. 10.68% of incidents were physical assaults on clients and fewer than 4% (4 incidents) were sexual assaults. Three female clients were involved in physical altercations with their male partners on five different occasions. The balance of the physical assaults on clients was random incidents. The four sexual assaults involved two clients on four separate instances.

Overall Conclusion:

The numbers of incidents reported remains fairly low considering the vulnerability involved for clients living on their own with limited supports. An average of 8.58 incident reports per month is reported.

1. It was anticipated that with more than double the amount of clients living in their own apartments the rates of substance use would also increase. However, SAIL reported a 12% decrease in substance use. SAIL staff were directed to only report alcohol use if the client was under 18 or if their use was having negative consequences in their life. Drug use was reported regardless of age. The majority of clients living on their own were of the legal drinking age and only one of those clients had an ongoing issue with alcohol;

2. Incidents of suicidal ideation have decreased by 6.41% compared to last year's reporting period. One would assume this number would have increased considering the number of clients has increased significantly. As mentioned previously, one client accounted for more than 70% of the incidents in this category whereas last year three clients accounted for the majority of the incidents. Emphasis placed on client safety, developing supportive relationships with clients, ongoing consultation with Case Managers, implementation of the SAIL Outreach Worker and staff advocating the CFS agency involved to fund therapy, counseling or psychiatry appears to have had a positive impact on the occurrences of suicidal ideation in our youth. Monthly group meetings with SAIL clients and staff began during this reporting period. The groups provide an opportunity for the SAIL clients to learn something from guest speakers, do something recreationally, and to help foster the feeling that they are not alone. As the program grew this year so did the amount of Support Workers who work directly with the clients. That being said, more training in suicide intervention is required as soon as Knowles has trainers within the organization or sooner if possible.

3. Two female clients accounted for 33% of all the incidents reported. Both of these clients have been assessed by psychologists recently resulting in them qualifying for Adult Services. They are currently awaiting transfer into the adult system. One of these females has also been referred to and is waiting for a psychiatrist to be assigned to her. Had the youth been assessed earlier more supports would have been advocated for and implemented prior to their move out on their own. Expectations for the clients would have been adjusted accordingly and it is likely some of the issues presented may have been reduced in frequency. The hiring of Case Managers aided in identifying issues present and advocating agencies for assessments for clients to help determine if they would qualify for services into adulthood. The CAFAS and ABASII measures being implemented in the fall should be helpful in identifying potential deficiencies;

4. Appropriate pairing of support staff to client has contributed towards stronger relationships thereby enabling clients and staff to problem solve issues before they become bigger. A good example of this is there have been no evictions of SAIL clients;

5. An outreach worker was hired in the spring to help maintain contact with clients living in apartments. Without this position the number of unplanned absences would likely be higher. The availability of the On Call worker and Outreach Worker has positively impacted the number of possible AWOL's. Clients living in apartments are required to check in with staff when absent for 24-48 hours. The Outreach Worker or On Call staff conducts safety checks in the client's home if they fail to check in or show up for a meeting;

6. Issues involving assaults on clients have dramatically increased as the number of clients moved out on their own. These issues have highlighted the need for training in healthy relationships, personal safety, and self-defense training.

Recommendations:

1. To continue to monitor incidents on a monthly basis;

2. To offer addictions related speakers to the SAIL group meetings at least once a year;

3. To promote addictions related workshops including FASD for staff to attend;

4. To provide opportunities for newly hired staff to attend ASIST training (suicide intervention);

5. To continue to advocate for psychological assessments to be conducted based on observations and outcomes of CAFAS and ABAS II;

6. To continue to advocate for therapy for clients who are seen as in need of counseling services.

7. To provide workshop opportunities for staff in mental health to better understand and work with clients;

8. To provide a group to clients on healthy relationships;

9. To provide training to clients on personal safety;

10. To provide and explain information to clients on the cycle of abuse

Risk Management Statistics
September 2010 – August 2011
Supported Advancement to Independent Living (SAIL)

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Total
Assault / Aggression													
Against client		1		3	1				2		2	2	**11**
Client to client													
Against staff/other													
Acting out behaviour							2						**2**
Verbal threats - to staff													
- To client/other													
Property damage						1			1				**2**
Sexual Assault													
Client to client													
Community member									2			2	**4**
Abuse Allegations													
Current staff						1							**1**
Former staff													
Former foster parent			1										**1**
Parent / guardian													
Other													
(Physical, emotional, sexual)													
Police Involvement													
Client behaviour					1		1				1	1	**4**
Staff related													
Other (e.g. Witness, interview)	1	1										2	**4**
Self-Harm													
Self-inflicted injury					1					1			**2**
Suicide attempt													
Suicidal gesture / ideation				1			1	1	1	7	1	2	**14**
Substance abuse		1	2	1	1	2	2	5	2	1	5	6	**28**
Drug paraphernalia													
Medical													
Hospital or urgent care	1					2	6			2		1	**12**
Injury requiring medical attention													
Public health issue													
Behaviour Management													
Restraint resulting in injury / volatile													
Other													
Client grievance													
Death of client													
Unplanned absence (AWOL)			1		2		2	1			3	2	**11**
Weapons													
Landlord / caretaker issues													
Evicted													
Other	1			1	1			2	1	1			**7**
TOTAL INCIDENTS:	**3**	**3**	**4**	**6**	**7**	**6**	**14**	**9**	**9**	**12**	**12**	**18**	**103**

Risk Management Report

Treatment Foster Care Program

Purpose:

To identify, summarize, and analyze the trends in the findings of the monthly risk management reports and make appropriate recommendations.

Trends noted:

- Within this reporting year, there were 83 incident reports filed. There was a range of 1-19 incident reports filed per month.

- Approximately 39% of the incidents were classified under the "Other" category, with the majority of those incidents being AWOLs and a few related to unauthorized and/or unsafe family contact;

- Approximately 30% of the incidents were classified as "Assault/Aggression" , primarily towards peers and siblings as well as "Acting Out Behavior" in general;

- Approximately 12% of the incidents were classified as "Self-Harm";

- Approximately 10% of the incidents were classified as "Medical";

- Approximately 6% of the incidents were regarding "Abuse Allegations", generally regarding past abuse by a birth or foster parent(s);

- Approximately 2% of the incidents were regarding "Police Involvement"; and

- Approximately 1% of the incidents were classified as "Sexual Assault";

- Many incidents involved different children (i.e. not re-occurring issues);

  Some incidents involve a few youth who have reoccurring incidents regarding the same/similar issues.

Analysis:

- The largest percentage of incidents (39%) was under the "Other" category, with AWOLS accounting for over 90% of those incidents, and the rest being related to unplanned and/or unsafe family contact. Given the histories, issues, and needs of the client population being served by the program, these numbers are not surprising. In fact, with over 70 clients being

served by the program, we experience a relatively low amount of AWOLs. The relatively low number of AWOLs is indicative that some good work is being done by the foster parents and CCM's to address behaviors that generate these types of incident reports.

- The second largest percentage of incident reports (30%) were related to "Assault/Aggression" and included physical aggression between peers and siblings, as well as acting out behavior in general as well as verbal and physical aggression towards the foster parent. Again, given the reality of the nature of the children's histories, issues and needs, these findings are not surprising. The TFC program continues to work with foster parents and foster children regarding developing healthy relationships/attachments, emotional regulation, communication, effective parenting strategies, and ensuring additional professional services are identified and accessed as required.

- With regard to "Self Harm", only 10 incidents or 12% of the incidents reports filed were under this category, with 70% of those incidents being substance use by a small number of clients.

Overall Conclusion:

Overall, the numbers of incident reports filed are relatively low for a treatment foster care program, averaging 6.9 incident reports per month. Possibilities for this include:

1. We have a lot of younger children in the program who tend to generate less incident reports overall;

2. Appropriate placement/matching between foster children and treatment foster parents contributes toward enhanced relationships; and less behavioral issues and/or ability to manage and/or reduce difficult behaviors;

3. Regular and active support and consultation between Treatment Foster Parents and Clinical Case Managers provides opportunities for relationship development, which enhances transparency of both strengths and struggles; and promotes pro-active treatment assessment, intervention, and planning;

4. Ongoing training and skill development of foster parents (and program staff) is provided in order to: a) understand and address children's issues and needs; b) focus on strengths, and c) develop positive, caring, and responsive relationships that are attuned to the child/youth's needs;

5. Regular support and supervision/consultation (peer: peer and CCM: supervisor) promotes the early identification of strengths, issues, needs and planning for same.

6. The implementation of a new resource for 3 male youth with high needs will impact incidents related to AWOLS and substance abuse.

Recommendations:

1. To continue to monitor incidents on a monthly basis;

2. To enhance training in the following areas:
   a. attachment;
   b. working with children who have experienced trauma;
   c. working with children impacted by FASD and their care providers; and
   d. substance use/abuse.

Risk Management Statistics
September 2010 – August 2011
Treatment Foster Care Program

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Total
Assault / Aggression													
Against peer/sibling		1			1	1		3					**6**
Peer to peer									1				**1**
Against staff/foster parent/other							2				2	2	**6**
Acting out behaviour									6	3			**9**
Verbal threats - to staff							1						**1**
- To other			1					1					**2**
Property damage													
Sexual Assault													
Client to client			1										**1**
Community member													
Abuse Allegations													
Current staff/foster parent				1									**1**
Past (parent/extended family)													
Former foster parent							1						**1**
Parent / guardian							1					1	**2**
Other (sexual abuse alleg.)								1					**1**
(Physical, emotional, sexual)													
3rd party allegation against foster parent													
Police Involvement													
Client behaviour								1				1	**2**
Staff related													
Other (e.g. Witness, interview)													
Self-Harm											1		
Self-inflicted injury							1						**1**
Suicide attempt													
Suicidal gesture / ideation							1						**1**
Substance abuse			1			1					5		**7**
Drug paraphernalia													
Accidental injury										1			**1**
Medical													
Hospital or urgent care			1						1	1	1	1	**5**
Injury requiring medical attention									2		1		**3**
Public health issue													
Behaviour Management													
Restraint resulting in injury / volatile													
Other													
Client grievance													
Death of client													
Unplanned absence (AWOL)		1			1	1	1	1	4	2	9	9	**29**
Mental health (hallucinations)													
Unsafe/problematic use of internet													
Unsafe and unplanned family contact	1												**1**
Unauthorized family contact													
Car accident		1	1										**2**
TOTAL INCIDENTS:	**1**	**3**	**5**	**1**	**2**	**3**	**8**	**7**	**14**	**7**	**19**	**14**	**83**

Risk Management Report

Day Treatment Program

Purpose:

To identify, summarize, and analyze the trends in the findings of the monthly risk management reports and make appropriate recommendations.

Trends and Analysis:

Within this reporting period (September 1, 2010 – August 31, 2011), there were a total of 18 incident reports filed.

Assault/Aggression was the most reported incident of the year (with a total of 13 incidences)

- 6 incidents were in the sub- category of client to client
- 3 incidents were in the sub-category of verbal threats – to other
- 2 incidents were in the sub-category of verbal threats – to staff
- 2 incidents were in the sub-category of against staff/other

To help manage and reduce the number of incidences related to assault and aggression the following strategies were utilized throughout the year:

Individual therapy focused on managing stress, problem-solving and learning and practicing anger management techniques; Debriefing of each incident with school staff and the school principal; School suspensions and re-entry meetings; Reducing contact between specific students; Recommended psychiatric consults and ultimately trials on medication; Warnings regarding possible police intervention; and one completion of a River East Transcona School Division Threat Assessment.

The only other categories containing more than one incident included **Abuse Allegations** and **Weapons.**

There were two incidents involving abuse allegations over the 2010 -2011 school year. Both incidents were in relation to the same student and were reported to his assigned social worker. The clients associated thoughts and feelings and development of coping mechanisms would have additionally been debriefed and worked on in individual therapy.

There were two incidents involving weapons within the 2010-2011 school year. One involved the use of a laser pointer on staff and the other involved a student brining a knife to school. Parents were notified of both incidents and were given the above mentioned weapons. The incidents were additionally debriefed with the students. In the case of the second incident, please note that when reported to the student's mother it was confirmed that the student had borrowed

his father's coat (which contained the knife) and the student was not aware that the knife was there.

There was one remaining incident in the category of **Substance use**

Overall Conclusions:

The vast majority of Day Treatment incident reports from the September 2010 – August 2011 school year fell in the category of Assault/Aggression.
The above mentioned strategies will continued to be utilized with students struggling in the area of anger management.

Recommendations:

1. To continue to monitor incidents on a monthly basis.

2. To continue with the above mentioned strategies to help manage and reduce incidents of assault and aggression.

3. For therapists to refer clients who are deemed appropriate to an anger management group either within or external to Knowles Centre.

Risk Management Statistics
September 2010 – August 2011
Day Treatment Program

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Total
Assault / Aggression													
Against client													
Client to client	1		3			1			1				**6**
Against staff/other	1			1									**2**
Acting out behaviour													
Verbal threats - to staff	1						1						**2**
Verbal threats - to other	3												**3**
Property damage													
Sexual Assault													
Client to client													
Community member													
Abuse Allegations													
Current staff													
Former staff													
Former foster parent													
Parent / guardian	1												**1**
Other	1												**1**
(Physical, emotional, sexual)													
Police Involvement													
Client behaviour													
Staff related													
Other (e.g. Witness, interview)													
Self-Harm													
Self-inflicted injury													
Suicide attempt													
Suicidal gesture / ideation													
Substance abuse									1				**1**
Drug paraphernalia													
Medical													
Hospital or urgent care													
Injury requiring medical attention													
Public health issue													
Behaviour Management													
Restraint resulting in injury / volatile													
Other													
Client grievance													
Death of client													
Unplanned absence													
Weapons		1	1										**2**
TOTAL INCIDENTS:	**8**	**1**	**4**	**1**	**0**	**1**	**1**	**0**	**2**	**0**	**0**	**0**	**18**

Risk Management Report

Sexual Abuse Treatment Program

Purpose:

To identify, summarize, and analyze the trends in the findings of the monthly risk management reports and make appropriate recommendations.

Trends Noted:

Within this reporting period, there were two incident reports filed. One alleged a minor of sexual abuse and the other alleged a respite worker of sexual abuse.
Both incidents were cases of alleged sexual abuse.

Analysis:

One of the focuses of the Sexual Abuse Treatment Program is on discussing past abuse, identifying thoughts and feelings and exploring safety planning. It is not uncommon for further disclosures to be made.

Overall Conclusions:

Upon disclosure of both incidents, a safety plan was developed, the clients' agencies were reported to, and continued work in these areas in therapy was pursued.

Recommendations:

1. To continue to monitor incidents on a monthly basis.

Risk Management Statistics
September 2010 – August 2011
Sexual Abuse Treatment Program

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Total
Assault / Aggression													
Against client													
Client to client													
Against staff/other													
Acting out behaviour													
Verbal threats - to staff													
- To other													
Property damage													
Sexual Assault													
Client to client													
Community member													
Abuse Allegations													
Current staff													
Former staff													
Former foster parent													
Parent / guardian													
Other	1		1										**2**
(Physical, emotional, sexual)													
Police Involvement													
Client behaviour													
Staff related													
Other (e.g. Witness, interview)													
Self-Harm													
Self-inflicted injury													
Suicide attempt													
Suicidal gesture / ideation													
Substance abuse													
Drug paraphernalia													
Medical													
Hospital or urgent care													
Injury requiring medical attention													
Public health issue													
Behaviour Management													
Restraint resulting in injury / volatile													
Other													
Client grievance													
Death of client													
Unplanned absence													
Weapons													
TOTAL INCIDENTS:	**1**		**1**										**2**

Stakeholder Satisfaction Surveys

Stakeholder Satisfaction Surveys

Group Care Treatment Program Clients

Process:

Surveys were given to all 32 clients in the Group Care Program, requesting them to respond to statements. Statements were rated on a five point scale from strongly agree to strongly disagree.

When a client could not complete survey on his/her own, unit staff provided assistance.

Findings:

- We received 17 responses out of a possible 32 clients.
- The majority of clients rated the program favorably on eleven of fourteen statements (strongly agree – agree). However, three items failed to reach this majority level of endorsement (5,12,13)

Recommendations:

1. Unit staff will regularly ask the kids for their input regarding the units.

2. The CEO and Group Care Director will meet with the kids in each unit to discuss ways to improve the unit.

Stakeholder Satisfaction Surveys

Group Care Treatment Program Clients Questionnaire Results

Note 17/32 GCTP clients completed the survey

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	I was given written information about my rights and responsibilities as a consumer/client.	6	5	3		2
2.	The people who work at the organization treat me with respect and courtesy.	6	5	2	2	2
3.	The staff is respectful of my confidentiality and privacy.	6	3	4	1	3
4.	I know where to go at the organization or whom to speak to if I have a complaint.	9	4	2	0	2
5.	The organization asks me about my ideas on how to improve its services.	3	5	3	1	5
6.	The organization is easy for me to get to.	1	10	3	1	2
7.	The organization's services are available at times that are good for me.	2	7	4	1	3
8.	The organization's building and offices are clean.	7	6	2	0	2
9.	I feel safe while at the organization and on its property.	5	7	3	0	2
10.	I help plan my services and set my goals.	5	5	3	1	3
11.	I was able to receive services from the organization without too much waiting time.	4	5	3	2	3
12.	I would recommend the organization to my family and friends.	4	3	2	3	5
13.	If I needed help or services again I would come back to the organization.	3	3	3	2	6
14.	Overall, I am satisfied with the services that I am receiving.	5	5	3	1	3

Stakeholder Satisfaction Surveys

Treatment Foster Care Clients

Process:

- A Client Satisfaction Survey developed by COA was utilized for TFC clients (children and youth) 12 years of age and over; it consists of a survey with 14 statements in which the client can indicate whether they "strongly disagree", "disagree", are "uncertain", "agree", or "strongly agree" with a statement;

- A memo went out to all foster parents explaining the purpose of the client satisfaction surveys and requesting their assistance and support in bringing their foster child(ren) to the TFC office for the purpose of the children completing the survey. They were provided with a general guideline of how to prepare their child(ren) for this process that would contribute toward them feeling comfortable ;

- 2 separate dates were scheduled after school hours in an attempt to make this available for as many people as possible; a light snack was provided;

- 13 out of 24 clients who met the criteria (12 years of age or older) attended to complete the survey;

- A program staff representative was present with each client who attended while they completed their questionnaire in a private office without their foster parent, Clinical Case Manager or any other staff present;

- The staff representative gave the children the option of completing the questionnaire on their own or with her assistance; she used a brief script to prepare each client in the same manner; she remained present to clarify any question the child may have;

- Each child was asked to place their completed survey in an envelope and seal it.

Findings:

Overall, the results indicate that the children and youth in the TFC program are satisfied or very satisfied by the care they are receiving, indicated by the majority of the responses to the questions being in the "Agree" or "Strongly Agree" categories. There was one question, however, that did not reach this threshold, which was "I was given written information about my rights and responsibilities as a consumer/client." The program is currently in the process of developing a client's rights and responsibilities hand-out for clients.

- Some rural foster parents found it difficult to attend the office at the designated times offered;

- The administrator's feedback included that some questions felt more "group care" than treatment foster care, and should be adjusted accordingly;
- The administrator indicated that most of the children utilized her presence to clarify the meaning of some of the questions.

Recommendations:

1. Add a line on the survey for the child/youth's name to allow follow up if necessary;

2. Consider modifying the questions to make them more appropriate for treatment foster care clients,

3. Complete the development and implementation of a client rights and responsibilities form;

4. Develop a clear process to elicit feedback from clients on how to improve our services;

5. Continue to utilize a neutral administrator who remains present to respond to any questions the child/youth may have; and

6. The TFC team will consider whether there are other means to administer the questionnaire if they do not attend the office (i.e. if they live outside of Winnipeg) and how to increase participation in the process.

Stakeholder Satisfaction Surveys

Treatment Foster Care Program Clients Questionnaire Results

Note 13/24 TFCP clients completed the survey

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	I was given written information about my rights and responsibilities as a consumer/client.	3	1	6	3	
2.	The people who work at the organization treat me with respect and courtesy.	6	7			
3.	The staff is respectful of my confidentiality and privacy.	7	3	3		
4.	I know where to go at the organization or whom to speak to if I have a complaint.	4	8	1		
5.	The organization asks me about my ideas on how to improve its services.	3	6	3	1	
6.	The organization is easy for me to get to.	1	7	3		2
7.	The organization's services are available at times that are good for me.	2	6	4	1	
8.	The organization's building and offices are clean.	8	5			
9.	I feel safe while at the organization and on its property.	7	5	1		
10.	I help plan my services and set my goals.	3	7	3		
11.	I was able to receive services from the organization without too much waiting time.	6	3	2	2	
12.	I would recommend the organization to my family and friends.	4	5	3		
13.	If I needed help or services again I would come back to the organization.	4	8	1		
14.	Overall, I am satisfied with the services that I am receiving.	7	5	1		

Stakeholder Satisfaction Surveys

Supported Advancement to Independent Living (SAIL) Clients

Process:

- Client Satisfaction Surveys were distributed to all 16 clients in the program.
- The survey consists of 14 statements rated in a 5 point scale from strongly agree to strongly disagree.
- Survey questions were reviewed with S.A.I.L. Case Managers and Support Staff during the team meeting prior to a monthly group meeting.
- Clients were given the surveys at the monthly group meeting. Time was set aside for clients to fill out their survey and return it in the sealed envelope provided.
- Staff were available to assist clients when they filled out their surveys in the event they did not understand any of the statements.
- Clients who were not in attendance at the group meeting were given the survey during their regular meeting time with their S.A.I.L. support worker. Clients were given time to fill out their surveys on their own with the expectation to return it sealed within the provided envelope at their next meeting with staff.

Findings:

- 10 out of 16 clients completed the survey.
- The majority of clients rated the program favorably (either strongly agree or agree) on all 14 items
- Statements 5, 7, 8, 9, 11, and 12 show only 9 responses although there were 10 clients who filled out and returned the survey
- There were 2 clients with known developmental delays who did not ask for assistance and may not have fully understood the written statements
- 3 clients were uncertain if they received information about their rights and responsibilities as a client

Recommendations:

1. Utilize a monthly Case Manager/client one on one meeting to fill out surveys to increase participation in the process;

2. Case Managers to solicit client feedback regularly during monthly one on one meeting to ensure client's needs are being met and rights respected;

3. Support Staff and Case Managers will ensure copies of client rights are given out at each case conference instead of at admission only.

Stakeholder Satisfaction Surveys

SAIL Clients Questionnaire Results

Note 10/16 SAIL clients completed the survey

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	I was given written information about my rights and responsibilities as a consumer/client.	4	3	3		
2.	The people who work at the organization treat me with respect and courtesy.	6	2	1	1	
3.	The staff is respectful of my confidentiality and privacy.	4	3	2	1	
4.	I know where to go at the organization or whom to speak to if I have a complaint.	4	4	1		1
5.	The organization asks me about my ideas on how to improve its services.	4	4	1		
6.	The organization is easy for me to get to.	7	3			
7.	The organization's services are available at times that are good for me.	5	3	1		
8.	The organization's building and offices are clean.	6	3			
9.	I feel safe while at the organization and on its property.	7	1	1		
10.	I help plan my services and set my goals.	5	3	1	1	
11.	I was able to receive services from the organization without too much waiting time.	4	4	1		
12.	I would recommend the organization to my family and friends.	5	2			2
13.	If I needed help or services again I would come back to the organization.	6	2			2
14.	Overall, I am satisfied with the services that I am receiving.	6	2	1	1	

Stakeholder Satisfaction Surveys

Sexual Abuse Treatment Program Clients

Process:

Surveys were given to all 12 clients in the SATP. This survey requested that they answer 14 questions on a 5 point scale from Strongly Agree to Strongly Disagree.

Findings:

- 10/12 SATP clients completed the survey. One client responded that she was too new to the program to answer the questions.

- 100% of the responses were in the positive range (Strongly Agree or Agree)

Recommendations:

1. The Coordinator and therapist of the program will continue to seek feedback from her clients and clients' guardians (when relevant).

2. An annual client satisfaction survey will continue to be administered in order to ensure continued satisfaction with the program.

Stakeholder Satisfaction Surveys

SATP Clients Questionnaire Results

Note 10/12 SATP clients completed the survey. One respondent responded that she was too new to the program to each question

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	I was given written information about my rights and responsibilities as a consumer/client.	4	5			
2.	The people who work at the organization treat me with respect and courtesy.	7	2			
3.	The staff is respectful of my confidentiality and privacy.	6	3			
4.	I know where to go at the organization or whom to speak to if I have a complaint.	5	4			
5.	The organization asks me about my ideas on how to improve its services.	5	4			
6.	The organization is easy for me to get to.	5	4			
7.	The organization's services are available at times that are good for me.	4	5			
8.	The organization's building and offices are clean.	7	2			
9.	I feel safe while at the organization and on its property.	8	1			
10.	I help plan my services and set my goals.	7	2			
11.	I was able to receive services from the organization without too much waiting time.	4	5			
12.	I would recommend the organization to my family and friends.	7	2			
13.	If I needed help or services again I would come back to the organization.	8	1			
14.	Overall, I am satisfied with the services that I am receiving.	7	2			

Stakeholder Satisfaction Surveys

Day Treatment Program Clients

Process:

Surveys were given to 9 clients in the Day Treatment Program (at the time of the administration of the survey only 9 of 12 spaces were filled in the program). The surveys requested that the clients respond to 14 statements on a 5 point scale from Strongly Agree to Strongly Disagree.

Findings:

- We received 4 responses out of a possible 9 clients.

- The majority of the clients rated the Day Treatment Program favorably on 12 of the 14 items surveyed. There was only one item/question that failed to reach this threshold (#3). There was also one item/question (#12) where favorable and unfavorable responses were equal.

Recommendations:

1. Day Treatment staff will ask the kids and involved family members regularly for their input regarding the program.

2. An annual client satisfaction survey will continue to be administered in order to ensure continued satisfaction with the program.

3. Therapists will review confidentiality with their clients in order to address any concerns and to ensure they have a good understanding of what is and what is not kept confidential.

Stakeholder Satisfaction Surveys

Day Treatment Program Clients Questionnaire Results

*Note 4 out of 9 DTP clients completed the survey. *

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	I was given written information about my rights and responsibilities as a consumer/client.	2	1	1		
2.	The people who work at the organization treat me with respect and courtesy.	2	1	1		
3.	The staff is respectful of my confidentiality and privacy.	1		1	1	1
4.	I know where to go at the organization or whom to speak to if I have a complaint.	2	2			
5.	The organization asks me about my ideas on how to improve its services.	3	1			
6.	The organization is easy for me to get to.	1	2		1	
7.	The organization's services are available at times that are good for me.	2	1	1		
8.	The organization's building and offices are clean.	2	1		1	
9.	I feel safe while at the organization and on its property.	2		1	1	
10.	I help plan my services and set my goals.		2	1	1	
11.	I was able to receive services from the organization without too much waiting time.	1	1	1	1	
12.	I would recommend the organization to my family and friends.	1	1		1	1
13.	If I needed help or services again I would come back to the organization.	1	1	1		1
14.	Overall, I am satisfied with the services that I am receiving.	2	1		1	

Stakeholder Satisfaction Surveys

Foster Parents

Process:

- The PQI Facilitator mailed out foster parent satisfaction surveys with 17 statements that had to be rated on a scale with the categories including: “strongly agree”, “agree”, “uncertain”, “disagree”, and “strongly disagree”;

- 12 out of 34 foster parents completed and returned the surveys (35%);

- Foster parents completed the surveys independently and mailed back their responses in a sealed envelope, in confidence, to the PQI Coordinator.

Findings:

The majority of treatment foster parents that completed the survey present as satisfied or very satisfied with the support and services provided to them and their foster children as indicated by the overwhelming number of responses under the “strongly agree” or “agree” categories for all 17 items.

Recommendations:

1. Provide a line for the foster parent to have the option of identifying themselves so that follow-up may occur regarding any questions/concerns identified;

2. To consider strategies to increase response rate;

3. To improve communication with foster parents about our recruitment and retention strategies as this was the response with the most disagreement; albeit, there were only 3 people who identified with this category.

Stakeholder Satisfaction Surveys

Foster Parent Questionnaire Results

Note 12/34 foster parent surveys were completed.

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	I participate in service planning for my foster child.	6	6			
2.	The organization provided me with specific information about the child prior to placement in my home.	3	8	1		
3.	The organization responds proactively to challenges and conflicts associated with the placement.	4	8			
4.	I am given adequate notice when I am to receive a child and when a child is to be removed.	4	4	3		
5.	My foster child maintains relationships with family members, friends and their community through visits and/or activities.	7	5			
6.	The organization ensures my foster child receives needed services identified in the service plan, such as: counseling, support, and education services.	7	4			1
7.	My foster child has opportunities to participate in ethnic, cultural, and/or religious activities consistent with his/her cultural or native traditions.	7	5			
8.	My foster child receives needed medical, dental, developmental and mental health services.	8	3			1
9.	I received information about my foster child's healthcare needs.	3	8	1		
10.	I have access to a caseworker whenever I need information and assistance.	9	3			
11.	I have a private visit with the caseworker at least once a month.	10	2			
12.	Foster parents are involved in the organization's foster parent recruitment and retention efforts.	4	3	3	1	1
13.	The training I received from the organization has effectively prepared me to be a foster parent.	7	5			
14.	I have been informed of my rights and responsibilities as a foster parent.	5	7			
15.	I have access to services to prevent/reduce stress, such as childcare, respite care, counseling, peer support, or recreational activities.	8	3	1		
16.	The organization provided or helped me develop a plan for responding to emergencies such as accidents, run away behaviour, serious illness, fire, and natural disasters.	4	7		1	
17.	The organization assesses the safety of my home.	10	2			

Stakeholder Satisfaction Surveys

Community

Process:

The PQI Facilitator mailed a cover letter and survey to 81 community stakeholders, comprised of social workers of clients from KC's various programs (Group Care, Treatment Foster Care, Independent Living) and representatives of funders (United Way of Winnipeg for the Sexual Abuse Treatment Program, River East Transcona School Division for the Day Treatment Program, Provincial Central Placement Desk for the Group Care Program). The cover letter requested that the stakeholders rate anonymously KC on various items and return their completed surveys within the provided stamped envelopes, and mail them to the KC PQI Facilitator within a specified time period. A total of 26 community stakeholders (32%) responded.

Findings:

The majority of stakeholders rated KC favorably on 14 of 17 items surveyed (responding either strongly agree or agree). The remaining 3 items just missed reaching this majority threshold of endorsement because a large number of stakeholders was "uncertain" about how to respond to items #2, 9, and 13. There was also a fourth item (#14), where a significant number of respondents was "uncertain" about how to respond.

Recommendations:

1. Concerning item #2, KC will ask future stakeholders if they have visited the KC campus, as we are unable to determine what percentage of present stakeholders has actually visited KC. Most of KC is accessible for people with disabilities.

2. Concerning #9, KC is planning to market KC to other agencies in 2012, which should enhance its presence within the community.

3. Concerning item #13, the onus is on stakeholders to find other agencies' per diems and to compare them to KC. However, per diems can be misleading, as each program is unique and offers different services as part of its per diem.

4. Concerning item #14, KC will make stakeholders aware that the annual audited financial statement is on the KC website.

Stakeholder Satisfaction Surveys

Community Questionnaire Results

Note 26/81 community surveys were completed.

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	The organization's facilities are clean and well maintained.	8	16	2		
2.	The organization's services are accessible to persons with disabilities.	2	9	12	2	
3.	The organization's services are conveniently located and accessible to public transportation.	3	19	2	2	
4.	The organization does not discriminate in the provision of its services.	9	15	2		
5.	Information about the organization's services and eligibility criteria are made available to the community.	5	14	5	2	
6.	The organization provides culturally sensitive services.	10	15	1		
7.	The organization respects the confidentiality of the persons it serves.	10	16			
8.	The organization is known for its integrity and ethical practices.	11	11	3	1	
9.	The organization conducts a public education program to make its presence known in the community.	4	6	15	1	
10.	The organization works with other community organizations to advocate on behalf of the people it serves.	5	14	7		
11.	The organization promptly screens applicants and persons referred for its services.	9	10	7		
12.	Waiting periods for services are responsible.	7	12	6	1	
13.	Fees are reasonable and fair.	4	8	13	1	
14.	The organization is fiscally responsible.	5	10	11		
15.	The organization's reputation with the community is favorable.	6	14	5	1	
16.	Personnel are qualified and competent in the performance of their jobs.	9	12	3	2	
17.	The organization is in compliance with all applicable laws and regulations.	7	12	7		

Stakeholder Satisfaction Surveys

Knowles Centre Personnel

Process:

The PQI Facilitator distributed a cover letter and survey to 52 permanent full-time and part-time staff within KC's various programs (within their pay envelopes). The cover letter requested that staff rate anonymously KC on various items and return their completed surveys within the provided envelopes to the PQI Facilitator by a specified date. A total of 26 staff (50%) responded.

Findings:

The majority of staff rated KC favorably on 15 of 16 items surveyed (responding either strongly agree or agree). There was only one item (#10) that just failed to reach this majority threshold of endorsement because of the significant number of staff who were "uncertain" about how to respond to this question.

Recommendations:

KC management will continue to encourage staff to share their input, as part of the decision-making process at KC. However, KC management does pride itself on its efforts to solicit staff feedback as part of its decision-making process. Examples of soliciting staff feedback include: a) the development of KC's strategic plan document (organizational and departmental goals); b) the development of KC's PQI plan; c) the semi-annual all-staff meeting; and d) all managers have an open door policy allowing staff to bring their questions, concerns, and suggestions forward. Moreover, all minutes from regular meetings are distributed among staff (e.g., weekly senior management minutes, monthly CEO report and board minutes).

Stakeholder Satisfaction Surveys

Knowles Centre Personnel Questionnaire Results

Note 26/52 personnel completed the survey

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	My job responsibilities are clearly outlined in my job description.	5	14	3	3	
2.	I received an orientation within the first three months of beginning work with the organization.	9	11	1	4	
3.	I have an up-to-date copy of or can access the personnel handbook.	4	13	3	2	3
4.	I am aware of the organization's grievance procedures and know how to make a complaint.	7	17	1		
5.	I am notified when positions that I may be qualified for become available within the organization.	7	11	6	2	
6.	I can access my personnel record.	6	12	6	2	
7.	I receive annual performance evaluations.	4	12	3	2	5
8.	I receive regular supervision.	6	16	1	2	1
9.	At least annually, employee satisfaction is assessed by the organization.	5	11	8	2	
10.	The organization implements changes based on the feedback received from personnel.	4	7	8	5	1
11.	I participate in quality improvement activities within the organization.	5	14	2	4	
12.	I received information on program outcomes that is useful to me in working with persons served.	4	11	8	3	
13.	I have participated in on-the-job activities that enhance my knowledge and skills.	6	16	2	1	
14.	Case records of persons that I serve are readily available or accessible to me.	6	11	5	1	1
15.	I participate with others at my organization in quarterly review of my client's progress toward achieving this goals.	5	11	3	3	
16.	I am aware of the organization's policies regarding:					
	1. Harassment	12	14			
	2. Discrimination prohibition	12	12	2		
	3. Prohibition of corporal and degrading punishment of consumers	11	11	2	1	
	4. Confidentiality	13	12	1		

Stakeholder Satisfaction Surveys

Knowles Centre Supervisors/Managers

Process:

The PQI Facilitator distributed a cover letter and survey to 13 supervisors and managers (within their pay envelopes). The cover letter requested that supervisors and managers rate anonymously KC on various items and return their completed surveys within the provided envelopes to the PQI Facilitator by a specified date. A total of 10 supervisors and managers (77%) responded.

Findings:

The majority of supervisors and managers rated KC favorable on all 17 items (responding either strongly agree or agree).

Recommendations:

KC will continue with this annual survey as the results reassure us that we are on the right track with the supervisors and managers within the various programs.

Stakeholder Satisfaction Surveys

Supervisors / Managers Questionnaire Results

Note 10/13 supervisors/managers completed the survey.

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	The organization has an effective quality improvement program.	3	6	1		
2.	I participate in the organization's quality improvement activities.	6	3		1	
3.	The organization regularly examines its internal access and service delivery processes.	5	3	1		
4.	The organization conducts quarterly reviews of accidents, incidents, and grievances.	8		2		
5.	Outcome data is used to improve services for consumers.	5	4	1		
6.	I am aware of the organization's conflict of interest policy.	5	5			
7.	The organization does not discriminate in hiring/promoting.	5	2	1	1	
8.	I receive an annual performance evaluation.	2	5	2	1	
9.	The organization is prepared to respond to natural disasters and other emergencies.	1	8		1	
10.	The finances of the program in which I work are managed by the organization with integrity and according to sound business practices.	6	3	1		
11.	The organization's services are well coordinated.	3	5	1	1	
12.	The organization facilitates timely and easy access for consumers.	2	6	2		
13.	Access to emergency and crisis intervention services is available for consumers.	2	6	2		
14.	I have time to conduct supervision with my staff.	3	6		1	
15.	The organization monitors its relationship with contractors who provide services to consumers.	4	3	3		
16.	The organization's governing body and the CEO/Executive Director have an effective working partnership.	5	3	2		
17.	I am aware of the organization's confidentiality policy and procedures.	7	3			

Stakeholder Satisfaction Surveys

Board of Directors

Process:

Both the PQI Facilitator and the Senior Administrative Coordinator facilitated board members completing this survey at a regular monthly board meeting (board members who were unable to attend this board meeting also had the opportunity to complete this survey). A total of 7 of 9 board members (78%) completed this survey.

Findings:

The majority of board members rated KC favorably on all items (responding either strongly agree or agree).

Recommendations:

Next year, question #15 will have the response option of either “yes” or “no”, which is more appropriate for this question than a 5-point rating continuum.

Stakeholder Satisfaction Surveys

Board of Directors Questionnaire Results

Note 7/9 board members completed the survey.

		Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1.	As a member of the governing body (GB), we effectively conduct/participate in long term planning.	4	3			
2.	As the GB, we effectively develop and approve policies.	3	4			
3.	As the GB, we establish resource development targets and goals.	2	4	1		
4.	We regularly review fiscal/financial reports.	7				
5.	We approve the organization's annual budget.	7				
6.	As the GB, we review and formally accept the annual audit.	6	1			
7.	As a member of the GB, I review and provide input regarding the organization's quality improvement activities/initiatives.	3	3	1		
8.	As a member of the GB, we receive information on the organization's program outcome and outcomes for persons served.	5	2			
9.	The organization's GB and the CEO/Executive Director have an effective working relationship.	4	3			
10.	At least annually as members of GB, we assess areas of risk to the organization.	2	4	1		
11.	We receive quarterly reports of immediate and ongoing risk within the organization.	4	3			
12.	The organization collaborates with the community to advocate for issues of mutual concern.	2	3	2		
13.	I received an orientation as to my GB responsibilities.	4	3			
14.	The organization's GB is representative of the community it serves.	4	3			
15.	To your knowledge, within the last four years, have any of the following occurred? a. Allegations or findings of professional misconduct, Financial malfeasance, c. failure to comply with laws and regulations governing equal opportunity and workforce administration, d. investigations by regulatory or other monitoring bodies which have identified significant problems at the organization. **Four respondents responded "NO" to this question**			1		2

Client Outcome Measures

Client Outcome Measures

Treatment Foster Care Program

Clients are referred to the Treatment Foster Care Program when their parents are unable to provide safe and appropriate care for them and/or children's behaviors are beyond the care and control of their birth or alternative care providers. In addition to possessing numerous strengths, the children we serve may suffer from of a variety of issues including past trauma, grief and loss, and various developmental, attachment, emotional and behavioral issues and needs. Treatment foster care is designed to provide safe, stable relationships in order to promote healthy functioning and to decrease the severity of emotional and behavioral issues. Consequently, a clinical measure was implemented to monitor the change in emotional and behavioral functioning over time.

The TFC Program utilized 2 measures within this review period, the Nipissing Developmental Screen and the Child Behavior Checklist (CBCL); however, only the CBCL is a formal outcome measure in the program at this time. The Child Behavior Checklist (CBCL) consists of 113 behavioral symptoms, rated on a 3-point scale. The CBCL is completed by the children's foster parents, at times with the support of their Knowles Centre TFC Clinical Case Manager, and at times independently. The CBCL measures and compares children's behavioral functioning in numerous areas against those of similar aged peers across different interactional partners. The competency section includes items that address children's activities, social relations, and school performance, whereas the syndrome scale identifies specific emotional and behavioral issues.

The CBCL is administered upon being in the program for 60 days (time 1/pre-test) and every 6 months thereafter (time 2, time 3, and so forth) until they are discharged from the program. At each testing, a total competency score and a total problem score (syndrome scale) is generated for each client, which is converted to a t-score, which allows the client's behavior to be classified as functioning in the normal, borderline, or clinical range.

Data Analysis

CBCL data was collected on only 34/71 clients for various reasons: a) some clients were too young to have the CBCL completed; b) some clients were discharged from the program before the time 2 testing; and c) some case managers were unable to complete the time 2 testing for various reasons. There was also one other extraneous variable that needs to be noted. Specifically, some clients had different case managers at time 1 and time 2 because of growth within the program and redistribution of case managers' caseloads. The possible implication is that different case managers may have interpreted questions differently at time 1 and time 2.

There were 34 clients who had both time 1 and time 2 data on the competency scale: 23 (68%) showed no change, 7 (21%) showed improvement, and 4 (12%) showed regression. It is worth noting that 19 clients (56%) scored in the normal range at time 2.

There were also 34 clients who had both time 1 and time 2 data on the syndrome scale : 24 (71%) showed no change, 6 (18%) showed improvement, 4 (12%) showed regression. Once again, it is worth noting 16 clients (47%) scored in the normal range at time 2.

The finding of no change from time 1 to time 2 on both scales for the majority of clients could be due to the fact that many clients have been in the program for one or more years, and their behavior has stabilized within the normal range. However, there were also some examples of clients who were stable, but became less stable as they entered adolescence.

Recommendations:

1. The program director will meet with her staff to look at the results more closely to determine why some clients showed improvement, regression, or no change.

2. Knowles Centre will implement a new client outcome measure for the 2011-12 year for TFC. The Child and Adolescent Functional Assessment Scale (CAFAS) will replace the CBCL, as the former is deemed to be a more sensitive measure for assessing client emotional and behavioral functioning over time. The Adaptive Behavior Assessment System-II (ABAS-II) will be implemented to assess clients' gains on developmental milestones.

3. A system will be developed to ensure more data is collected and to assist with data analysis.

Client Outcome Measures

Group Care Treatment Program

Clients are referred to the GCP because of the severity of their emotional and behavioral problems. KC's intervention/treatment is designed to decrease the severity of their emotional and behavioral problems. Consequently, two standardized outcome measures were selected to monitor this change in behavioral and emotional functioning over time. The Beck Depression Inventory – Revised (BDI-II) was selected to monitor emotional functioning and the Child Behavior Checklist (CBC) was selected to monitor behavioral functioning.

The BDI-II is a self-report measure consisting of 21 items assessing depressive symptoms; each item is rated on a 4-point scale for severity. Clients complete this measure at pretest/time 1 (generally within the first 6 weeks following admission) and at posttest/time 2 (six months after the pretest), and every six months thereafter while they remain in the program. At each testing, a total score is calculated. Clients' responses can fall into one of four categories (minimal, mild, moderate, severe).

The CBC consists of 113 behavioral symptoms rated on a 3-point scale. The CBC compares children's behavioral functioning in numerous areas against those of similar aged peers. The competency section includes items covering children's activities, social relations, and school performance, whereas the syndrome scale describes specific behavioral and emotional issues. KC staff rated clients using this checklist within clients' first two months in the program, which constituted pretest/time 1. KC staff rated clients six months later, which constituted posttest/time 2. The CBC is re-administered every six months thereafter while clients remain in the program. At each testing, a total competency score and a total problem score (syndrome scale) are generated for clients, which are converted to a T-score, allowing clients to be classified as functioning in the normal, borderline, or clinical range.

Extraneous Variables:

It should be noted that both for BDI-II and for CBC, data could not be analyzed for many clients for various reasons: a) clients were discharged prior to the six month posttest period being reached; b) clients had yet to reach the posttest period; c) clients refused to complete a measure (BDI-II); or d) staff were unable to complete the posttest for various reasons. There were 22 such examples of pretest data existing, but not posttest data.

There were two other mitigating factors that should be noted. First, there were examples of the gap between pretest and posttest being longer than six months, due to the busy schedules of staff members. Second, different staff often completed the CBC at time 1 and time 2 for various reasons. Consequently, there are reservations about the reliability of the CBC data, as different staff may have: a) interpreted questions differently; b) held different perceptions of children's functioning; or c) changed their perceptions of similar behavior between testing periods.

Data Analysis:

There were 15 clients who completed the BDI-II at both time 1 and time 2: 7 improved (47%), 6 showed no change (40%), and 2 regressed (13%).

There were 12 clients for whom the CBC competency section at both time 1 and time 2 were completed: 10 showed no change (83%), 1 improved (8%), and 1 regressed (8%). There were 16 clients for whom the syndrome scale at both time 1 and time 2 were completed: 9 showed no change (56%), 4 improved (25%), and 3 regressed (19%).

In conclusion, a number of clients showed some improvement on the BDI-II, but the majority showed no change on the CBC.

Recommendations:

As a result of the CBC revealing that the majority of clients showed no change from time one to time two, we felt the need to determine what effect our treatment is having. As of December 2011, this writer has begun to track discharges from the group care program and classify each discharge as to whether the discharge was planned or unplanned and whether the discharge was deemed as positive (client showed progress and some success) or whether the discharge was negative (client did not make gains and/or regressed). The clients' gender and the unit they are placed in is also being tracked to help determine who we have success with and who we have greater challenges with. This information will provide us with insight as to which population we require more training and support with.

KC will be introducing a new client outcome measure for the 2011-12 school year for the GCP. More specifically, the Child and Adolescent Functional Assessment Scale (CAFAS) will replace the CBC. It is our feeling at KC that the CAFAS will be a better overall fit for KC and more sensitive at detecting changes in client functioning (the BDI-II will be retained). Consequently, it's anticipated there will be more data to analyze in next year's PQI report, and this data will be a more reliable indicator of change in client functioning.

Client Outcome Measures

Day Treatment Program

Clients are referred to the DTP because of the severity of their emotional and behavioral problems, and their struggles to function within the regular school system. KC's intervention/treatment is designed to decrease the severity of their emotional and behavioral problems. Consequently, two standardized outcome measures were selected to monitor this change in behavioral and emotional functioning over time. The BDI-II was selected to monitor emotional functioning and the CBC was selected to monitor behavioral functioning. Both of these measures have already been described in the GCP section.

Extraneous Variables:

Once again, there was very little data to analyze in the DTP for various reasons. First, there was very little turnover of clients in the program, so there were few new clients to measure. Second, there was a turnover of therapists in the program, which likely impacted data collection. Other contributing factors included: a) some clients were discharged from the program before reaching the six month posttest period; b) some clients had yet to reach the six month posttest period during this reporting period; c) some clients refused to complete a measure (BDI-II); and d) some clients were missed because of staff oversight.

Data Analysis:

There were three clients who completed the BDI-II at both time 1 and time 2: two showed no change and one improved.

There were two clients for whom the CBC competency scale was completed at both time 1 and time 2: one improved and one regressed. There were also two clients for whom the CBC syndrome scale was completed at both time 1 and time 2: both showed no change over time.

The lack of data precludes drawing any conclusions or inferences.

Recommendations:

The recommendation contained in the Group Care Program also applies to the DTP (i.e., replacing the CBC with the CAFAS next year).

Client Outcome Measures

Sexual Abuse Treatment Program (SATP)

For victims of sexual abuse, the program is designed to decrease their trauma symptomatology, improve their emotional functioning, and reduce the likelihood of any re-victimization. Consequently, two outcome measures were selected to monitor changes in the first two areas:

1. The Trauma Symptom Child Checklist (TSCC) is a self-report measure for children and adolescents assessing trauma symptomatology. The Trauma Symptom Inventory (TSI) is used with adults (18 years and older). Both scales generate a total score, which is converted into a T-score with a cut-off score, indicating whether a score is clinically significant or not.

2. The Child Depression Inventory (CDI) is used with clients 12 years and younger, whereas the Beck Depression Inventory-Second Edition (BDI-II) is used with clients 13 years and older. These measures assess for symptoms of depression.

Concerning the issue of re-victimization, it should be noted that the Children's Knowledge of Abuse Questionnaire Revised III (CKAQ-R-II) is no longer being used for PQI purposes. The reason for this decision is that this measure is only used at intake and at discharge, not at six month intervals.

Data Analysis:

Concerning TSCC, three subscales were analyzed for PQI purposes (Post Traumatic Stress/PTS, Disassociation/DIS, and Sexual Concerns/SC), as they were deemed most relevant to the work being done in the SATP. Although six clients completed the TSCC at both time 1 and time 2, data for three clients had to be excluded from analysis because their scores were deemed invalid due to under-reporting. For the remaining three clients, there was no overall change from time 1 to time 2 on the three subscales (however, one client reported a slightly elevated score on the DIS subscale).

Concerning TSI, three subscales were analyzed for PQI purposes (Intrusive Expressions/IE, Disassociation/DIS, and Sexual Concerns/SC), as they were also deemed most relevant to the work being done in the program. There were two clients who completed these measures at both time 1 and time 2: both showed no change over time.

There were seven clients who completed the CDI at both time 1 and time 2: four improved, two showed change, and one regressed.

There were also two clients who completed the BDI-II at both time 1 and time 2: one showed improvement and one showed no change.

In summary, a number of clients reported improvement on depressive symptomatology, but clients reported no change on trauma symptomatology. There are a number of viable explanations for the lack of change in trauma scores on the TSCC and TSI:

1. Symptom reduction may require longer term treatment for some clients, hence longer term analysis (longer than one year). Therefore, the program may need to evaluate change over time a longer timeframe.

2. Some symptoms may be more resistant to treatment; consequently, some clients may show a lack of improvement.

3. Clients must confront their trauma in order to overcome it; consequently, some deterioration may be expected at the outset of treatment (i.e., the "reverse sleeper effect").

4. Some of the data analyzed were for clients who were younger than 8 years old when they began therapy, but were administered the TSCC after their 8th birthday. For these clients therapy had already commenced and may have impacted their trauma score.

5. Some of the clients showed no significant symptoms of trauma both at time 1 and time 2 (they were asymptomatic).

Recommendations:

1. It is hoped that next year there will be a larger sample, which would allow for greater generalization of results.

2. The plan is to examine change over a longer interval (longer than one year), as symptom reduction may require longer treatment for some clients. Client outcome data will continue to be completed every six months; however, clients that remain in the program for a longer period of time will have all of their data compared.

3. The program will consider the merit of implementing the Trauma Symptom Checklist for Young Children (TSCYC), a 90 item caretaker instrument that measures trauma symptoms in children 3 to 12 years old.

Client Outcome Measures

Supported Advancement to Independent Living (SAIL)

As a new program, the SAIL program only started collecting client outcome measures this school year (2011-12). The program selected Child & Adolescent Functional Assessment Scale (CAFAS) and Adaptive Behavior Assessment System - 2nd Edition (ABAS II) as its client outcome measures. This data will be analyzed and reported in the 2011-12 PQI report.

John G. Stewart School Annual Community Report

John G. Stewart School Report (2010-2011)
(River East Transcona School Division)

Mission Statement

The John G. Stewart School provides an opportunity for at-risk students to engage in a positive educational experience designed to enhance their self-esteem as well as develop the academic and interpersonal skills necessary for a successful integration into the community.

Belief Statements:

- ✓ *All students want to be successful in school*
- ✓ *All students perceive their degree of success in school as a measure of their self-worth*
- ✓ *There is always a way to engage students in a school community*
- ✓ *Students and staff should be able to function in a safe environment*
- ✓ *Students must feel accepted and part of the school community in order to engage and be successful*
- ✓ *Students need to be empowered by participating in the planning process in order to be successful*
- ✓ *Students need to feel there is hope and that they can have control over their future*
- ✓ *Every student is valued and should be part of the school community*
- ✓ *All staff at John G. Stewart School need to be 100% committed to our mission statement in order that they and the students are successful*

2010-2011 Annual Community Report
John G. Stewart School
"Creating Success for Youth"

The indicators of program success for John G. Stewart School were mutually determined by the John G. Stewart School Student Support Team, Knowles Centre Clinical Team and the Special Education Review Initiative Team and supported by the River East Transcona School Division Student Support Services Department.

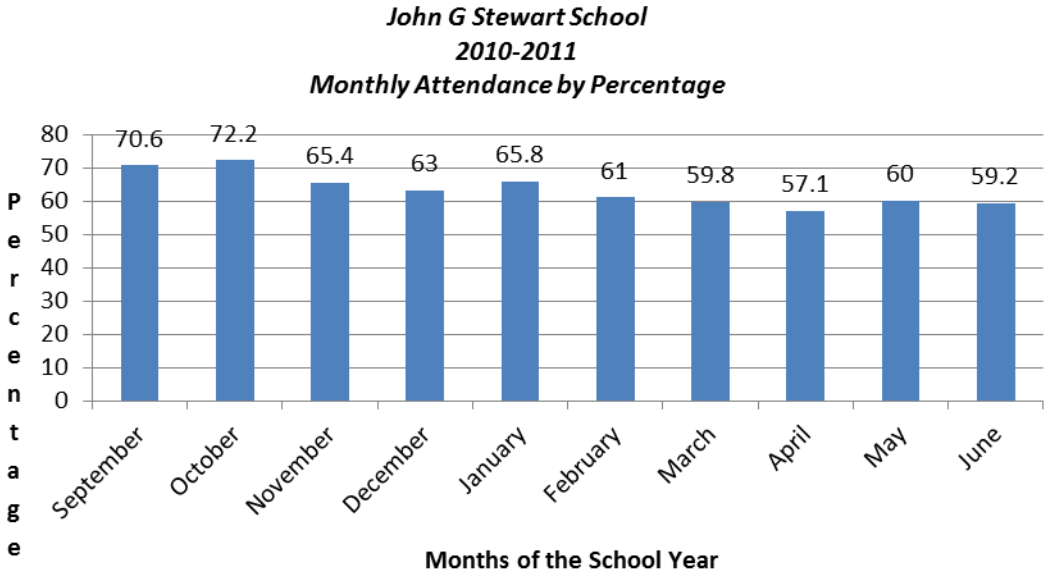
INDICATORS OF PROGRAM SUCCESS

- ☐ Attendance (reported monthly to M.E.C.Y. and annually in the John G. Stewart Community/Annual Report)
- ☐ Behaviour Tracking (through daily charting and tracking)
- ☐ Academic Growth (through pre and post assessments of students)
- ☐ September 30 – One year follow-up of previously enrolled students (provided by M.E.C.Y. in October of the following year)

In 2010-2011 the Personal Outcome Performance reported in previous years was replaced by a Discharge Summary and an Absentee Summary. The Discharge Summary will compare the number of positive or planned discharges to the unplanned discharges. The Absentee Summary will provide a detailed account of the reasons students are absent from school.

Student Attendance:

John G. Stewart School
2010-2011



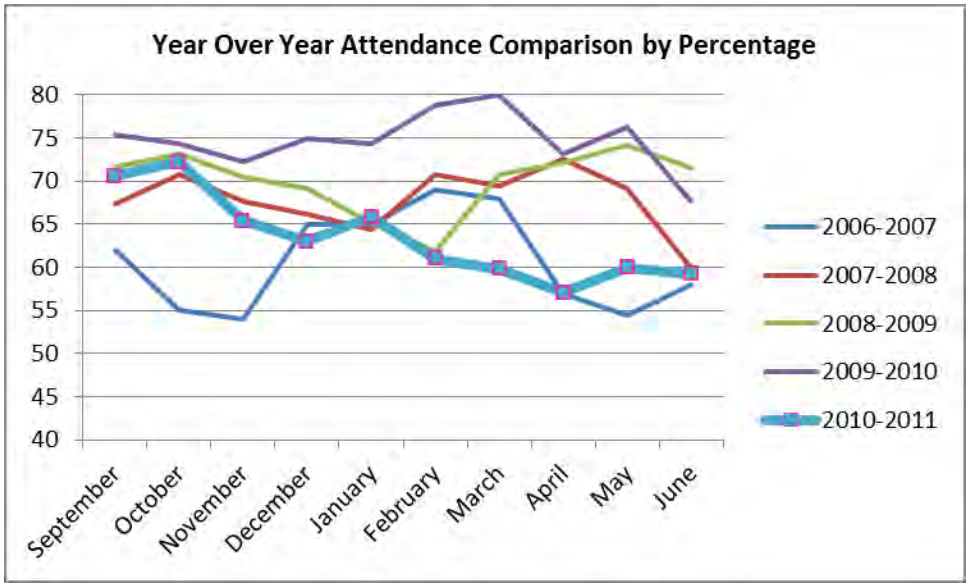
The first two months of the school year started really well. We were able to maintain our 70% attendance rate during these months. The rest of the year we were unable to accomplish our goals. There were several contributing factors to the decline in attendance this year. The first was we carried 4 RETSD students who rarely attended at all. Three by choice and one was hospitalized since late November. With less than 50 students registered that accounts for an 8% decline in attendance. The Knowles Centre clientele became much older in age. We had many more 16 and 17 year old students than any other year. The older students chose to be truant more often, be AWOL from Knowles for longer periods of time and were sentenced to longer periods of incarceration. This year's 16 and 17 year olds accounted for 380 days of truancy. This is more than last year's entire school total of 350. The number of 16 and 17 year old students AWOL from Knowles Centre this year totaled 143 days compared to last years' entire total of 285. On a brighter note, despite having 16% fewer students on average in the building each day, the students that did come achieved even more Eagle Awards for completing 85% or higher classes completed for an entire school week. The previous year's total was 427 Eagle Awards and this year we reached a record high of 430 all with less students in the building.

The trend of the Central Placement Desk using Knowles Centre to house older children in care certainly carried on for 2010-2011. Older teenagers with a longer history of criminal activity tend to get longer sentences than younger less criminally active teenagers. Social workers and agencies also know that finding places for older teens is a difficult task and find it in their best interest to continue to pay the daily per diem to Knowles even though the child is in the Youth Centre. This allows for a secure placement for the child once released from the Youth Centre.

Another disturbing trend that has continued this year is youth crime being more violent. Assaults with weapons and armed robbery are becoming more common in our city and the justice system is keeping those responsible incarcerated for longer periods of time. Some of our students definitely were incarcerated for long periods of time!

With violent crime becoming a 2011 Provincial election issue, it will be interesting to see if this trend of longer sentences continues.

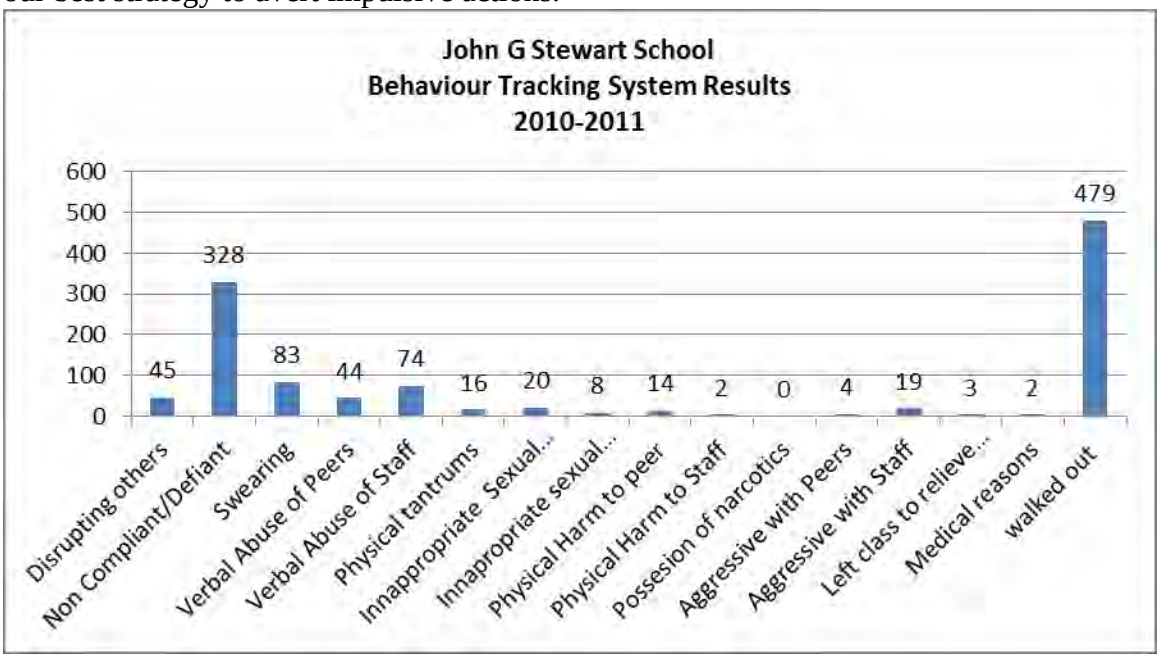
With the Provincial government changing the age of mandatory school from 16 years of age to 18 we anticipate an ever increasing number of older students in our school. Both River East Transcona School Division and Knowles Centre will be challenged with programming for older students. Moving forward, I believe that John G. Stewart will have to prepare to accommodate for this older population.



November 2010 saw the end of a 17 month streak of 70% or better attendance. The longest in the history of the school!

Student Behaviours:

The Behaviour Tracking System graph below shows all behaviours that are tracked and is used as a school wide tool by our staff. It is a good visual indicator that most of the student's behaviours are impulsive in nature. The staff continues to work hard to eliminate any unnecessary stimuli that may invoke an impulsive remark or action. Close adult supervision, good differentiated instruction, and relationship building with individual students continues to be our best strategy to avert impulsive actions.



For the 2010-2011 school year we created 6 major changes to the service delivery model that we felt would be effective in reducing the number of times students walked out of class. The changes in delivery included optional courses for our grade 9 and 10 students, an all girl's Phys. Ed. class each afternoon and expanding the number of grade 9/10 classrooms from 2 to 3.The impact of these changes was enormous! We had a grand total of 1486 referrals out of class. Students walking out of their classes represented 479 of those referrals. This was a decrease of 61% over the previous year.

The areas that showed the greatest improvement were the creative arts area and the grade 9/10 academic classrooms. Providing the older children with the option of going to creative arts meant only motivated students were attending while the others chose options more in line with their aptitudes and interests. By creating a third grade 9/10 classroom and a Culinary Arts program we were able to bring the number of students in learning environments down to an average of 5 per area compared to the 10 per area last year. Smaller numbers meant more space and fewer interactions amongst students and increased interactions with staff. A third but not so significant change came in the area of gym class. The creation of unisex Phys. Ed. classes each afternoon saw a small decrease in the number of girls walking out. However the reasons the girls gave for walking out changed from not wanting to participate to "I am sweating too much". This made us feel like we had made significant strides in this area.

Academic Achievement for 2010-2011:

We are very proud of the results we can report each year that our students have improved their academic skills and this year is no exception.

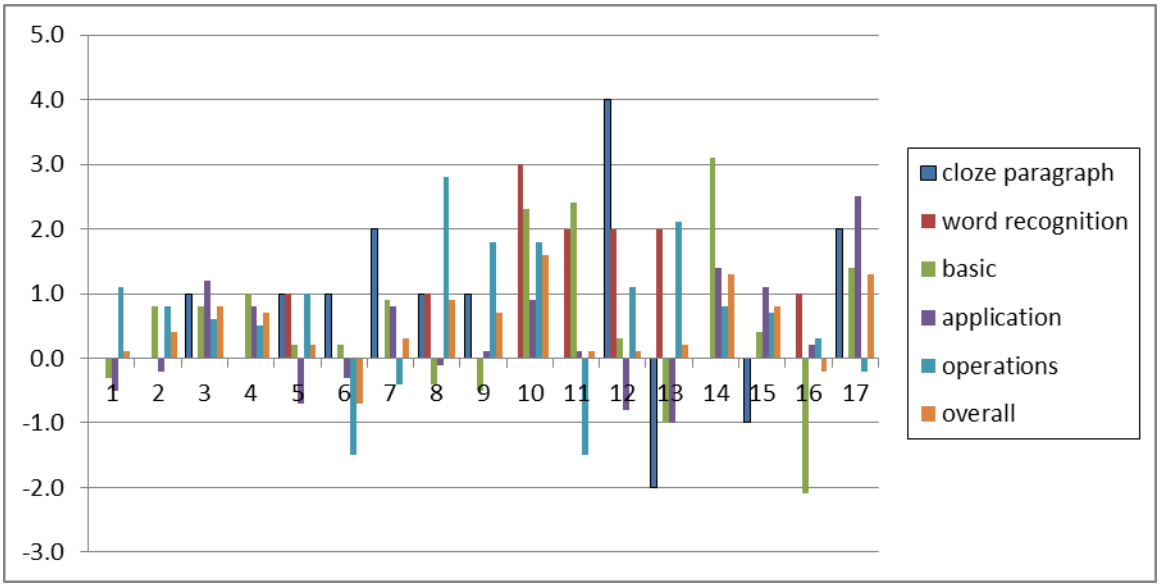
For many students, living at Knowles Centre provides them with their first stable home environment with structure and routine. With their needs being met by Knowles Centre, school becomes a place where they begin to risk learning new things and feel confident enough to challenge themselves to do better. The small class size and intimate classroom settings also contribute to the academic improvement.

Our greatest disappointment came with our individualized reading program. The data we collected, pre and post tests, indicated that only three of the students showed a reading increase of more than one grade level over the year. The other 14 students involved in the program all had positive results but the increase in their reading abilities were limited to .1 to .3 grade level improvement. Student engagement was tallied on a scale of 1-5 for each session with an overall average of 4.23 being attained. Despite the high engagement of students the results we were looking for were not achieved.

With our high school population we continue to offer two courses per 13 week term. This addresses the needs of a transient population and many students arriving after the start of the school year. We are very proud to say that 111.5 credits were earned by our high school students this year. That is only 3.5 credits less than the previous year. This is another indicator that though we had fewer students, the students attending were definitely engaged in their learning!

Academic growth Chart:

John G. Stewart School 2010-2011



Discharge Summary:

During 2010-2011, there were 27 students discharged from the school. Twenty-one of these students were clients of Knowles Centre and six were students attending through River East Transcona School Division. A planned discharge is where students have left the school as part of a planned exit. Some examples of this would be when students transfer out of John G. Stewart to attend other schools in the River East Transcona School Division, or are registered in alternative programs such as Training Resources for Youth, Workmates or Independent Living courses or moving in with foster parents. Non planned discharges range from students being incarcerated for lengthy periods, being discharged from Knowles because of absenteeism and Social Workers no longer willing to pay daily per diems for empty beds.

Of the 6 RETSD students, 3 were discharged to attend other schools and 3 were discharged because of non-attendance. Of the 21 Knowles clients, 8 were discharged with good plans, mostly to foster homes or returned to family members while 13 were discharged either because of absenteeism or lengthy incarcerations.

Absentee Summary:

Reason For Absence	***Number of Occurrences***	***Reason For Absence***	***Number of Occurrences***
Student AWOL	514	Medical Appointment	18.5
Court Appearances	11	Parent Request for Absence	64.5
Incarcerated	360	Knowles Residents Refusing to go to school	234
Held Back in Unit	384.5	Student involved in half-day specialized programming	209.5
On Home Visits	158.5	Out of School Suspensions	203.5
Student Ill/Hospitalized	204	Truancy	971.5
On Program with Knowles Centre	78.5		

Staff Retention Data

Staff Retention Data

Breakdown by Department
September 1, 2010 – August 31, 2011

		Admin	SAIL	TFC	Group Care	Mtnce	Clinical
# current full and part time staff	77						
# of Applicants Hired	12	2	1	3	3	1	2
# total full and part time staff	89						
# of FT/PT that Left Employment	6	1			3		2
# of FT/PT Retirements	1	1					
Turnover %	8%						
Total FT/PT Staff	**82**						

Summary:

Sept.1/10 - Aug.31/11: During this time Knowles Centre's turnover rate has decreased by 5 % from the previous year (2009-2010).

Staffing Level changes by department:

Administration
1 full-time Human Resource - hired - new position
1 full-time Development Coordinator- hired to fill position
1 part-time (.8 eft) Executive Secretary position - filled with .9 eft

SAIL
1 full-time Case Manager - hired - new position

TFC
3 full-time Clinical Case Managers -hired - new positions

Group Care
3 full-time Youth Care Workers - positions filled

Maintenance
1 full-time - hire-new position

Clinical
1 full-time - hired to fill current position / 1 part time - .6 EFT -hired-new position

Reasons for staff leaving:

The 3 employees that left Group Care were all voluntary, and the 2 clinical staff left for the following reasons: one left for a position which deals directly with her educational background, and the other was a in a term position and found a permanent position prior to the term ending.

The .5 EFT administration position was a voluntary leave and the position then was deleted, the .8 EFT Executive Secretary was due to retirement.

Financial Report

(March 31, 2011)

AUDITORS' REPORT

To the Directors
Knowles Centre Inc.

We have audited the accompanying financial statements of Knowles Centre Inc., which comprise the statement of financial position as at March 31, 2011, and the statement of changes in fund balances, statement of revenues and expenditures and statement of cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian generally accepted accounting principles and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified audit opinion.

Basis for Qualified Opinion
In common with many charitable organizations, the Centre derives revenue from donations and fundraising, the completeness of which is not susceptible of satisfactory audit verification. Accordingly, our verification of these revenues was limited to the amounts recorded in the records of the Centre and we were not able to determine whether any adjustments might be necessary to donations and fundraising revenues, excess of revenues over expenses, current assets and net assets. In addition, the Centre does not accrue vacation pay in their year-end payables. The accounting policy for vacation pay is not in accordance with Canadian generally accepted accounting principles. If vacation pay were accrued annually, accounts payable would have been increased and operating net assets decreased as described in Note 3.

Qualified Opinion
In our opinion, except for the possible effects of the matter described in the Basis for Qualified Opinion paragraph, the financial statements present fairly, in all material respects, the financial position of Knowles Centre Inc. as at March 31, 2011 and its financial performance and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Winnipeg, Manitoba
June 15, 2011

CHARTERED ACCOUNTANTS

KNOWLES CENTRE INC.

STATEMENT 1

STATEMENT OF FINANCIAL POSITION

MARCH 31

	Operating Fund	Capital Fund	Scholarship Fund	TOTAL 2011	TOTAL 2010
ASSETS					
CURRENT					
Cash	$	$ 34,700	$	$ 34,700	$ 99,146
Investments		409,516		409,516	413,131
Accounts receivable	889,396	5,867		895,263	657,297
Prepaid expenses					4,800
Interfund balances	-	89,885	105,160	195,045	145,134
	889,396	539,968	105,160	1,534,524	1,319,508
CAPITAL ASSETS *(Note 3)*	-	1,670,162	-	1,670,162	1,555,039
	$ 889,396	$ 2,210,130	$ 105,160	$ 3,204,686	$ 2,874,547
LIABILITIES					
CURRENT					
Bank indebtedness	$ 352,060	$	$	$ 352,060	$ 91,431
Accounts payable	281,346	1,200		282,546	388,010
Deferred revenue	364,399			364,399	292,132
Interfund balances	195,045			195,045	145,134
Current portion of long term debt	-	17,730	-	17,730	13,561
	1,192,850	18,930	-	1,211,780	930,268
LONG TERM DEBT *(Note 6)*	-	204,651	-	204,651	282,383
FUND BALANCES					
FUND BALANCES *(Statement 2)*	(303,454)	1,986,549	105,160	1,788,255	1,661,896
	$ 889,396	$ 2,210,130	$ 105,160	$ 3,204,686	$ 2,874,547

Approved on behalf of the Board

Wayne Benson

.....
Director

.....
Director

HMA

KNOWLES CENTRE INC.

STATEMENT 2

STATEMENT OF CHANGES IN FUND BALANCES

YEAR ENDED MARCH 31

	2011	2010
OPERATING FUND		
BALANCE, *beginning of year*	$(247,284)	$(286,922)
Excess of revenue over expenditures *(Statement 3)*	1,600	39,638
Interfund transfer - Capital Fund	(57,770)	-
BALANCE, *end of year*	$(303,454)	$(247,284)
CAPITAL FUND		
BALANCE, *beginning of year*	$ 1,805,346	$ 1,802,239
Excess of expenditures over revenue *(Statement 3)*	127,048	4,282
Transfer of realized gains to investment income		814
Interfund transfer - Operating Fund	57,770	
Net change in unrealized fair value of investments	(3,615)	(1,989)
BALANCE, *end of year*	$ 1,986,549	$ 1,805,346
SCHOLARSHIP FUND		
BALANCE, *beginning of year*	$ 103,834	$ 99,767
Excess of revenues over expenditures *(Statement 3)*	1,326	4,067
BALANCE, *end of year*	$ 105,160	$ 103,834
TOTAL FUND BALANCES	$ 1,788,255	$ 1,661,896

KNOWLES CENTRE INC.

STATEMENT OF REVENUE AND EXPENDITURES

YEAR ENDED MARCH 31

	Operating Fund	Capital Fund	Scholarship Fund	2011	2010
REVENUE					
Group care treatment	$ 2,515,875	$	$	$ 2,515,875	$ 2,688,718
Other income *(Schedule 3)*	4,438,166			4,438,166	2,860,842
Province of Manitoba grant	632,300			632,300	632,300
Thomas and Beatrice Gilroy Trust		5,050		5,050	5,559
A.R McNichol Fund		1,984		1,984	2,189
C.H. Bowie, C.A. Bowie, and A.W. Gibson Memorial Fund		4,333		4,333	4,693
Investment income		18,425	5,933	24,358	25,779
Insurance proceeds	56,653			56,653	
Fundraising					10
Replacement reserve contribution					30,000
Furniture donations		47,119		47,119	
Capital campaign	-	136,136	-	136,136	-
	7,642,994	213,047	5,933	7,861,974	6,250,090
EXPENDITURES					
Staff remuneration *(Schedule 1)*	6,663,453			6,663,453	5,400,866
Maintenance and repairs *(Schedule 1)*	311,731			311,731	255,726
Administration and general *(Schedule 1)*	225,417			225,417	145,700
Food, clothing, welfare and activities *(Schedule 2)*	440,793			440,793	339,930
Amortization		65,319		65,319	49,892
Interest on long term debt		15,857		15,857	4,738
Miscellaneous		4,823		4,823	3,477
Fundraising and public relations					910
Loss on sale of investments					814
Scholarships	-	-	4,607	4,607	50
	7,641,394	85,999	4,607	7,732,000	6,202,103
EXCESS OF REVENUE OVER EXPENDITURES (EXPENDITURES OVER REVENUE)	$ 1,600	$ 127,048	$ 1,326	$ 129,974	$ 47,987

1. DESCRIPTION OF OPERATIONS

Knowles Centre Inc. is a private, not-for-profit agency established in 1907 and incorporated in 1910. The Centre is a registered charity under the provisions of the Income Tax Act, Canada. The Centre serves as a community resource for children and families in Manitoba and Northwestern Ontario who require intensive therapeutic intervention in order to reach their personal and social potential.

2. CHANGES IN ACCOUNTING POLICIES

Financial Instruments

The Centre adopted the following recommendations of CICA Handbook:

a) Section 3855, Financial Instruments - Recognition and Measurement. This section describes the standards for recognizing and measuring financial instruments in the balance sheet and the standards for reporting gains and losses in the financial statements. Under the new standard, financial assets and liabilities are initially recorded at fair value. Subsequently, financial instruments designated as held for trading are carried on the balance sheet at fair value and all periodic changes in fair value are recorded in income. Financial assets designated as available for sale are carried on the balance sheet at fair value and all unrealized periodic changes in fair value are recorded directly in the Statement of Changes in Fund Balances and reclassified to net income when realized. Other financial instruments are measured at amortized cost using the effective interest method.

b) Section 3861, Financial Instruments - Disclosure and Presentation. This Section establishes standards for presentation of financial instruments and non-financial derivatives, and identifies the information that should be disclosed about them.

c) Section 3251, Equity - This Section establishes standards for the presentation of equity and changes in equity during the reporting period.

The Centre has classified its financial assets and liabilities as described in Note 3.

These new standards were applied retroactively as of April 1, 2007 without restatement of the prior year's amounts. The adjustment made to the balance sheet as of April 1, 2007, upon the adoption of the new standards, resulted in an increase of $67,940 in the carrying value of investments.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

FINANCIAL ASSETS AND FINANCIAL LIABILITIES

Financial assets and financial liabilities are initially recognized at fair value and their subsequent measurement is dependent on their classification as described below. Their classification depends on the purpose, for which the financial instruments were acquired or issued, their characteristics and the Centre's designation of such instruments. Settlement date accounting is used.

Classification

Cash	Held for trading
Investment in money market funds	Available-for-sale
Investment in bonds	Available-for-sale
Accounts receivable	Loans and receivables
Bank indebtedness	Other liabilities
Accounts payable	Other liabilities

Held for trading

Held for trading financial assets are measure at fair value at the balance sheet date. Fair value fluctuations including interest earned, interest accrued, gains and losses realized on disposal and unrealized gains and losses are included in investment income.

Available-for-sale

Available-for-sale financial assets are carried at fair value with unrealized gains and losses recorded directly in the Statement of Changes in Fund Balances until realized when the cumulative gain or loss is transferred to investment income.

Interest on interest-bearing available-for-sale financial assets is calculated using the effective interest method.

Loans and receivables

Loans and receivables are accounted for at amortized cost using the effective interest method.

Other liabilities

Other liabilities are recorded at amortized cost using the effective interest method and include all financial liabilities, other than derivative instruments.

3 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES *(continued)*

FUND ACCOUNTING

The accounts for the Centre are maintained in accordance with the principles of "fund accounting". Fund accounting is a procedure whereby a self balancing group of accounts is provided for each accounting fund established by the Centre.

For financial reporting purposes, the accounts have been classified into three funds. The activities carried out by each fund are as follows;

Operating fund

The Operating Fund accounts for the Centre's program delivery and administration activities. This fund reports unrestricted resources and operating grants.

Capital fund

The Capital Fund is utilized by the Centre as a building fund. All capital expenditures, including facility construction and expansion, and vehicle purchases are funded through this fund.

Scholarship fund

The Arthur Prior Estate Scholarship Fund was established as a result of a bequest. This fund is to be used as a scholarship fund for the further education of graduates or students of the Centre.

REVENUE RECOGNITION

Restricted contributions on account of group care treatment and other income are recognized as revenue of the Operating Fund in the year in which the related expenses are incurred.

Capital Fund revenue is recognized as follows:

Interest and investment income are recorded on an accrual basis. Fundraising and donations are recorded as revenue when received. Restricted contributions are recorded as revenue in the same period as they are received.

Interest income is recorded on the accrual basis in the Arthur Prior Estate Scholarship Fund.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES *(continued)*

CAPITAL ASSETS

Replacement of furnishings and equipment and ground improvements are recognized as operating expenses. New additions of fixed assets are capitalized and are funded by the capital fund at cost less government assistance.

Amortization of fixed assets is not recognized as an operating expense item that is recoverable from government agencies. It is provided for by a reduction in the capital fund as follows:

Buildings	2-1/2%	declining balance method
Program building	5%	declining balance method
Campsite conservation	10%	declining balance method
Ground improvements	2-1/2%	declining balance method
Furniture, equipment, vehicles	20%	declining balance method

DONATED MATERIALS AND SERVICES

During the year, the Centre received a significant amount of donated materials and services from volunteers, for which there has been no amount recorded in the financial statements.

FINANCIAL INSTRUMENTS

Interest rate risk
Financial risk is the risk to the Centre's earnings that arise from fluctuations in interest rates and the degree of volatility of those rates. The Centre does not use derivative instruments to reduce its exposure to interest rate risk.

Credit risk
Credit risk arises from the potential that a counterparty will fail to perform its obligations. However, due to the nature of the receivables and the composition of its investment portfolio, this risk is minimized.

Fair value
The fair value of cash, accounts receivable, bank indebtedness, and accounts payable is approximately equal to their carrying values due to their short-term maturity.

VACATION PAY

The Centre does not accrue for vacation pay but rather expenses these costs as incurred. Limitations are placed on the number of vacation days that staff are allowed to carry-forward to the following fiscal year, and these vacation days are included in that year's budget which is approved by the Board of Directors. Management estimates that the unaccrued vacation pay liability at March 31, 2011 would approximate $261,000 (2010 - $215,000). Had the vacation pay liability been accrued, accounts payable would have increased by $261,000 (2010 - $215,000) and the ending balance in net assets would have decreased by $261,000 (2010 - $215,000).

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES *(continued)*

USE OF ESTIMATES

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statement and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from these estimates.

4. CAPITAL ASSETS

	Cost	Accumulated Amortization	Net Book Value 2011	Net Book Value 2010
Land	$ 17,719	$	$ 17,719	$ 17,719
Buildings	2,540,025	1,019,888	1,520,137	1,472,597
Ground improvements	26,042	17,075	8,967	9,197
Campsite conservation	179,869	167,009	12,860	14,289
Furniture and equipment	363,909	284,901	79,008	1,897
Tractor	15,824	15,732	92	115
Tractor loader	14,695	11,761	2,934	3,668
Camp equipment	33,745	33,495	250	313
Vans	182,384	154,189	28,195	35,244
	$ 3,374,212	$ 1,704,050	$ 1,670,162	$ 1,555,039

Land was revalued by directors' resolution in 1955. The stated amount of $17,719 consists of $7,650 cost and $10,069 appraisal increase.

5. BANK INDEBTEDNESS

The Centre has available a maximum credit facility of $300,000. The credit facility bears interest at prime plus 1.00%.

6. LONG TERM DEBT

	2011	2010
Mortgage payable, bearing interest at 5.60% per annum, payable in monthly installments of $2,467, secured by land and buildings, general security agreement and assignment of fire and liability insurance, due November 1, 2014.	$ 222,381	$ 295,944
Less: Current portion	17,730	13,561
	$ 204,651	$ 282,383

Principal repayment terms are approximately:

2012	$ 17,730
2013	18,609
2014	19,678
2015	20,809
2016	22,004

7. GOVERNMENT ASSISTANCE

During the year, the Centre received operating grants of $632,300 (2010 - $632,300) from the Province of Manitoba - Department of Family Services which is included in operating fund revenue.

8. PENSION PLAN

The employees of Knowles Centre Inc. are members of the United Way Agencies Pension Plan, a multi-employer, defined benefit pension plan, which is accounted for as a defined contribution plan. Knowles Centre Inc.'s matching contributions for the year were $149,444 (2010 - $163,419) and have been expensed during the year.

In 2009 the Centre was notified by the Pension Plan's Trustees that the plan potentially had a solvency shortfall. An actuarial report was completed in September 2010, which showed that the plan was underfunded. The required employee and employer contribution rates were increased as a result in order to bring the plan up to a fully funded status. The Province of Manitoba agreed to fund the increased contribution rates for the participants in the plan and deposited the necessary amount in December 2010. As a result, Knowles Centre Inc. is no longer obligated to cover the funding shortfall.

An accrual for $36,495 was set up in the prior year based on the estimated liability. The $36,495 accrual has been reversed in the current year which has reduced accounts payable by $36,495 and reduced operating expenditures by $36,495.

9. COMPARATIVE FIGURES FOR THE PRIOR YEAR

Certain 2010 comparative figures have been reclassified in order to conform with the financial statement presentation adopted for 2011.

KNOWLES CENTRE INC.

SCHEDULE 1

SCHEDULE OF OPERATING FUND EXPENSES

YEAR ENDED MARCH 31

	2011	2010
STAFF REMUNERATION		
Salaries	$ 3,511,311	$ 3,098,442
Foster Care	2,513,253	1,728,394
Canada Pension Plan	145,411	122,536
United Way pension fund	149,445	163,419
Employee group insurance benefits	112,579	93,152
Employment insurance	82,919	74,940
Manitoba payroll tax	78,379	66,622
Workers compensation	70,156	53,361
	$ 6,663,453	$ 5,400,866
MAINTENANCE AND REPAIRS		
Autopac and insurance	$ 63,324	$ 57,021
Building repairs	130,125	50,403
Equipment repairs and replacement	29,481	36,899
Heating fuel	11,140	16,398
Hydro and electrical	29,932	27,431
Maintenance and household supplies	33,560	24,009
Municipal taxes	6,957	5,913
Replacement reserve allocation		30,000
Water	7,212	7,652
	$ 311,731	$ 255,726
ADMINISTRATION AND GENERAL		
Advertising and miscellaneous	$ 56,275	$ 17,955
Accreditation	9,400	6,600
Bank charges and interest	6,613	6,952
Dues and subscriptions	5,779	7,037
Meetings	8,283	3,572
Office supplies	50,952	35,126
Payroll service charge	638	1,549
Postage	6,906	5,270
Professional fees	24,069	19,040
Public relations	7,845	4,272
Staff development	16,992	10,028
Telephone	31,665	28,299
	$ 225,417	$ 145,700

KNOWLES CENTRE INC.

SCHEDULE 2

SCHEDULE OF OPERATING FUND EXPENSES

YEAR ENDED MARCH 31

	2011	2010
FOOD, CLOTHING, WELFARE AND ACTIVITIES		
Bedding and clothing	$ 30,082	$ 28,165
Food	143,061	139,525
Medical, dental and optical	4,834	5,376
Personal supplies	1,428	918
Program activities	40,397	35,921
Program supplies	27,421	22,029
Residents' gifts	3,117	4,763
Residents' transportation	14,181	10,079
SAIL Stage 2 - client living expenses	78,370	
School supplies	682	1,646
Spending allowances	15,220	16,962
Summer outdoor education program	3,317	2,900
Transportation - general	73,839	69,395
Volunteer activities	4,844	2,251
	$ 440,793	$ 339,930

KNOWLES CENTRE INC.

SCHEDULE 3

SCHEDULE OF OTHER INCOME

YEAR ENDED MARCH 31

	2011	2010
OTHER INCOME		
Foster care	$ 3,475,962	$ 2,317,644
SAIL Program	572,144	162,245
River East School Division	199,124	179,586
Outreach program	57,550	48,260
Sexual abuse treatment program	71,100	69,700
Donations	2,122	58,645
Miscellaneous	58,120	22,972
Rentals	2,045	1,790
	$ 4,438,167	$ 2,860,842