Ministry of Children, Community and Social Services
2024 DS Compliance Information Sessions

Questions and Answers

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General Compliance Questions

1. What are the specifics about how transfer payment recipients (TPRs) are inspected – besides reviewing the agreement?

The ministry conducts compliance inspections of transfer payment recipients (TPRs) that receive funding under *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008* (SIPDDA), to provide services & supports to persons with a developmental disability.

Compliance inspections enable the ministry to determine whether service agencies are meeting applicable requirements set out in the quality assurance measures regulation -O. Reg. 299/10 (the QAM regulation) and policy directives, made under SIPDDA. The ministry inspects the following programs and services – support group living residence (SGLR), intensive support residence (ISR), supported independent living (SIL), host family (HF), community participation (CP), caregiver respite (RESP), employment supports (ES) and adult protective services (APS).

Compliance inspections includes a file review (staff records, medication documentation, individual support plan (ISP), behavior support plan (BSP) (where applicable) and in person inspection of the SGLR and ISR homes and programs being delivered. The ministry may review all or a sampling, depending on the type and purpose of the compliance inspection.

Where TPRs choose to contract with a third party to provide services and supports to persons with a developmental disability, e.g., outside paid resources (OPRs), the ministry will review evidence of oversight by the TPR of the third party. For example, the Ministry would review:

- any contract(s) between the TPR and the third party (OPR); and,
- the process for monitoring the performance of the contract to ensure that the third party complies with the applicable quality assurance measures.

TPR’s are solely responsible to ensure that the OPR(s) they contract with, are in compliance with all relevant QAM requirements.

2. What is the process when the Executive Director and Program Advisor disagree regarding the interpretation of a policy directive or regulation (a non-compliance) during an inspection?

If there is a disagreement between the Program Advisor and the agency over the interpretation of a guideline or regulation, there is an option for the Executive Director (ED) to seek a resolution. The Quality Assurance and Compliance Unit (QACU) has an “Issues Dialogue and Resolution” process with senior corporate team members (including the manager) to discuss any issues that arose during the compliance inspection process.

Inquiries such as this are deemed a high priority. The ED can simply inform the Program Advisor and a meeting will be scheduled, often within 24-48 hours.

If an Executive Director is still not satisfied with the response they were given at this stage, the ED must submit any inquiries in writing to DSCompliance@ontario.ca. Information should include but is not limited to:

- The regulation/guideline in question
- The circumstances of the situation (can include photos, emails, etc.)
- An explanation of what the Program Advisor stated and what/why there is disagreement.

The Quality Assurance and Compliance Unit may need to consult with the policy branch and/or legal services branch which may add more time to resolve, depending upon the complexity of the case. The manager will approve any responses at this stage.

In the event that the agency continues to disagree with the QACU team, they can submit a 'request to the Director to reconsider' any inspection non-compliance findings and/or compliance team responses.

The above process only applies during the inspection period. Please note that if an agency receives a Notice of a Proposed Compliance Order or a Compliance Order, the agency must follow the directions provided within the order.

3. Are 'recommendations' during a QAM inspection expected to be implemented? (i.e., is it a non-compliance if it is not changed by the next visit)

Recommendation(s) by the ministry's Program Advisor are provided for the service agency to consider actioning or implementing (e.g., to improve their processes or documentation to support QAM requirements). If an agency chooses not to implement any recommendation(s), it will not be deemed a non-compliance, as Program Advisors can only cite an agency if they do not meet the requirements under SIPDDA/QAM.

4. What are the compliance requirements for volunteers?

Volunteers require the same training and documentation as any staff at an agency. For more details, see the Developmental Service(DS) Compliance Inspection: Indicator List. For example:

- orientation and annual staff/volunteer training on mission, service principles and statement of rights (Staff-Volunteer Records, #1, #2 and #3)
- training on first aid and CPR, provided by third party health professionals or medical professionals (Staff-Volunteer Records, #4)
- training and annual refresh training on abuse prevention, identification and reporting for all staff members and volunteers (Staff-Volunteer Records, #7 and #8 – Abuse training and annual refresher).

- training on the service agency's policies and procedures regarding respecting privacy, confidentiality and consent to the collection, use or disclosure of personal information (Staff-Volunteer Records, #9 Privacy and confidentiality training)
- orientation, initial and ongoing training on the service agency's policies and procedures and on each supported individual's needs (Staff-Volunteer Records, #11, #12 and #13 – Orientation, initial and ongoing training)
- the service agency will arrange for a personal reference check and police records check (including a vulnerable sector screen) for all volunteers if they will have direct contact with the persons with developmental disabilities who receive services and supports from the service agency. The agency must ensure that the personal reference check and police records check are completed as soon as possible for the volunteer. Until the completion of the reference check and police records check, orientation and initial training, a staff or volunteer must only have direct contact with persons with a developmental disability only when being supervised (Staff-Volunteer Records, #15, 17-18 – References)
- volunteers are trained and training records are documented on the behaviour support plan of the persons they will support, and the behaviour interventions as outlined in person's behaviour support plan (BSP), where the service agency's policies permit volunteers to work directly with persons with developmental disability who have challenging behaviour. The service agency must ensure that staff and volunteers receive and successfully complete all components of the refresher training, as applicable. (Staff-Volunteer Records, #24, #25 and 26 – Training, Behaviour Interventions)

It is recommended that agencies also review all training requirements specifically for Host Family outlined the policy directives.

5. What is a "service record" besides the SIS, ADSS, and ISP? Is there anything else considered a "service record" that can be checked for compliance during inspection?

For the purposes of compliance, the service records include at a minimum the Supports Intensity Scale (SIS), Application for Developmental Services and Supports (ADSS) and the individual support plan (ISP). For QAM requirements, see Developmental Service(DS) Compliance Inspection: Indicator List, Individual Records, #47, #48 and #49.

6. The local fire departments are now charging for signing off on fire plans. Is there any thought to revaluating the need for this sign off and if not, to compensating TPRs for the additional expense?

The requirement for an approved fire safety plan is a requirement under the QAM regulation. This concern has also been passed on to the policy branch. ,. It is the agency's responsibility to ensure there is a signed, approved fire plan for each SGLR/ISR home. Each TPR is responsible for the costs associated with meeting the requirements.

7. Is there an update on police checks for front-line and administrative positions?

Police record checks, including Vulnerable Sector Screens (VSS), are required for all staff, including front line and administrative positions, who have **direct contact** with people receiving supports and services from the agency. The ministry recommends that your agency meet with the local police services and have written protocols in place to ensure that the type of information provided through a police records check is appropriate to the position being applied for (as per O. Reg. 299/10, section 13 (4)).

It is a regulatory requirement for a staff member to have a VSS in place or they require supervision when providing direct contact with vulnerable individuals.

8. Which indicators apply to Employment Support (ES) services?

The indicators that apply to employment supports fall under the "all" category under the 'Applicable' column on page 5 of the Developmental Service(DS) Compliance Inspection: Indicator List. Although some indicators may not relate to employment services, they would be reviewed only if they occur at the agency. For example, an ES program agency that also helps with medical appointments will be responsible for complying with relevant medication indicators.

Behaviour intervention strategies

9. Can you review how to write behavior support plans (BSPs)?

It is not the ministry's role to define how to write behaviour support plans (BSPs). It is up to the agency and the clinician or other professional writing the behaviour support plan to determine how it is written so that it meets requirements set out in the QAM regulation and Policy Directive. Requirements for what should be included in a behaviour support plan are set out in Part III of the QAM regulation (in particular, section 18) and in the Policy Directives for Service Agencies, #2 - supporting people with challenging behaviour, including:

- service agencies must develop an individual behaviour support plan (BSP) for each person with a developmental disability who has challenging behaviour. Note: It may not be called a BSP – but must include all the requirements of a BSP (see Developmental Service(DS) Compliance Inspection: Indicator List, Individual Records, #51 to #95)
- BSPs are developed with the involvement of the person with a developmental disability who has challenging behaviour, or persons acting on their behalf
- the person with the developmental disability or persons acting on their behalf provides consent to the BSP and the strategies outlined
- BSPs outline positive behaviour intervention strategies and intrusive behaviour intervention strategies, where applicable

- BSPs set out supports for the individual outlining the least intrusive to the most intrusive strategies
- BSPs address the challenging behaviour identified in the behavioural assessment of the person
- BSPs are monitored for effectiveness
- BSPs are approved by a psychologist, a psychological associate, a physician, a psychiatrist or behaviour analyst certified by the Behaviour Analyst Certification Board, where the behaviour support plan includes intrusive behaviour intervention strategies
- BSPs are reviewed by a review committee at least twice in a 12-month period.

If **intrusive behaviour interventions** are used, including PRNs, secure isolation/confinement time out, physical, or mechanical restraints, additional requirements include monitoring, approvals, notification of use, debriefing, safeguards for the prevention of misuse of the intrusive intervention, staff training on use, and the requirement for fading and elimination.

In most cases, the written BSP is generally not where most non-compliances arise. Most often it is the improper use of an intrusive measure, failure to notify or debrief after the use an intrusive behaviour intervention, lack of monitoring during the use of the intrusive behaviour intervention, or insufficient training of staff on the use of the BSP or safeguards to prevent risk to the person with challenging behaviour.

BSP reviews can be conducted in multiple ways – in a team meeting, with the BSP developer or the approving clinician, or a formal third-party review. It is important that all BSP reviews are recorded to provide evidence that the review has taken place. Often it is found that agencies review plans more than twice a year but aren't recording each time a review happens.

In addition, you may also wish to consult your local community tables or umbrella organizations such as Ontario Agencies Supporting Individuals with Special Needs (OASIS) or the DS Provincial Network to canvass any best practices, operation templates and resources. It is important to consider that BSPs should address the unique needs including the health, safety, and well-being of individuals supported.

You can also visit http://qamtraining.net, for information and resources related to developmental services quality assurance measures, such as the Behaviour Support Plan Reference Guide that can assist agencies will putting together comprehensive BSPs for people with challenging behaviour.

10. What is the requirement for clinical oversight, including review and analysis, of a behaviour support plan?

The QAM regulation requires that behaviour support plans that include intrusive behaviour intervention strategies for challenging behaviour are approved by a psychologist, a psychological associate, a physician, a psychiatrist or behaviour analyst certified by the

Behaviour Analyst Certification Board. This would include the approval for any significant changes to these intrusive measures. Clinical support is not necessarily required for the development and approval of a BSP.

The policy directives require service agencies to ensure that, where there is prescribed medication on a PRN basis to address a person's challenging behaviour, there is a protocol as part of their behaviour support plan. The service agency is also required to monitor the application and use of behaviour intervention strategies (both positive and intrusive strategies), to see that the strategies are carried out as outlined in the individual's behaviour support plan.

QAM requires that service agencies ensure that all medication prescribed to the person with a developmental disability who has challenging behaviour is reviewed by the prescribing physician and is included in the regular review of the individual's behaviour support plan. This can include documentation related to an individual's medical appointment records or medical summaries, etc.

11. Has consideration been made about allowing nurse practitioners to sign off on BSPs?

The ministry has heard from many agencies that they would like the addition of a nurse practitioner as one of the approvers for the BSP with intrusive behaviour interventions. Currently, a nurse practitioner is not one of the clinicians listed that can approve a BSP with intrusive behaviour intervention strategies. Only a physician, psychiatrist, psychologist, psychological associate, or a behaviours analyst certified by the Behaviour Analyst Certification Board is permitted to approve a BSP with intrusive behaviour interventions identified.

. This suggestion has also been passed on to the policy branch.

12. Can you explain confinement time out? In a BSP, if a person is directed "to go to their room" during challenging behavior, is that a CTO?

"Secure isolation or confinement time-out", as an example of a type or intrusive behaviour intervention in Ontario Regulation 299/10, is a "designated, secure space that is used to separate or isolate the person from others and which the person is not voluntarily able to leave."

Secure isolation or confinement time-out does not refer to a space that a person may use to "cool down" when he/she feels anxious or angry, and where the person may leave freely, or an apartment where a person may live on their own. Further clarification is provided in Directive 2.0 – Supporting People with Challenging Behaviour, in the Policy Directives for Service Agencies.

Confinement time out (CTO)/secure isolation requires the inclusion of all three key components:

1. The person is exhibiting challenging behaviour, and
2. The person is isolated away from staff and others, and
3. The person is unable to leave their space voluntarily, i.e., their doors and/or gates are locked, preventing them from exiting. This includes a locked yard.

A service agency must have policies and procedures in place regarding the use of confinement time out (CTO)/secure isolation, and it must be part of an individual's approved BSP.

When using CTO/secure isolation a service agency must ensure that all requirements as set out in the QAM regulation, and the policy directive 2.0 Supporting People with Challenging Behaviour are met.

Video monitoring can be used during CTO.

13. We had some questions regarding CTO and submitting a serious occurrence report. We historically have not submitted a serious occurrence (SO) if it was in a person person's plan.

A SOR is required only when an adult with a developmental disability is placed in a secure isolation/confinement time out room in the absence of or contrary to the individual's behaviour support plan, the provisions of Ontario Regulation 299 under the SIPDDA and/or the policy directives (2.0 – Supporting People with Challenging Behaviour) under the SIPDDA.

Policy Directives for Service Agencies: 2.0 Supporting People with Challenging Behaviour requires a service agency to report serious occurrences with the ministry as may be appropriate and as per the serious occurrence reporting procedures, after the use of a physical restraint (including physical restraint in a crisis situation), a mechanical restraint, or secure isolation/confinement time-out. The SOR manual, updated in December 2023, can be found on the ministry website: External SOR Page – EN

Individual support plan (ISP)

14. Is an individual support plan (ISP) a single document or the amalgamation of all support information?

An individual support plan can be an amalgamation of all support information. Service agencies may use different terms for an ISP or have the different areas of support information captured separately. From a compliance perspective, the ISP is compliant, as long as the information meets QAM requirements set out in section 5 of the QAM

regulation. It is strongly recommended that the ISP is written in a manner that is easy for the agency staff to review and clearly understand the needs of the individual in care (i.e., one comprehensive document).

15. Following the choking memo that was released, will there be new choking indicators added? What are inspectors looking for with regards to choking when they come visit?

Currently, there are no plans to add new indicators for choking. Eating and swallowing protocols fall under existing indicator, namely, individual support plan safeguards. (see Developmental Service(DS) Compliance Inspection: Indicator List, under Individual Records (#24))

During an inspection, the ministry will check for evidence of a swallowing assessment, for a person where there have been concerns about swallowing or eating and compare it to the eating protocol to ensure the recommendations made in the assessment are adequately reflected in the eating protocol. The ministry will also review staffing levels to ensure they are sufficient to meet the individual needs of the supported individuals.

Occasionally, when the ministry identifies health and safety trends across the province, a memo will be sent to all Executive Directors for their information. Ideally, each agency and each home should re-review their protocols and reinforce the importance of following an individual's ISP if there are specific instructions on eating and swallowing.

16. Is there a plan for MCCSS to develop templates that agencies can use for things such as bathing/ feeding protocols?

It is not the ministry's role to develop templates for protocols such as bathing/feeding.

You may also wish to consult your local community tables or umbrella organizations such as Ontario Agencies Supporting Individuals with Special Needs (OASIS) or the DS Provincial Network to canvas any best practices, operation templates and resources. It is important to consider that protocols related to the health, safety, and well-being of individuals supported should address their unique needs.

You can also visit http://qamtraining.net, for information and resources related to developmental services quality assurance measures.

17. What type of bathing protocol is necessary for an individual with a seizure disorder who is in an individual living environment that currently receives no supervision?

It is up to the service agencies to determine appropriate protocols that are aligned with QAM requirements regarding supervision to ensure the safety of the supported individual.

Agencies may wish to reach out to other agencies about their practices in this regard. For example, discuss current bathing practice with the supported individual and after assessing the safety risk of the supported individual to bath independently, risk may need to be elevated and bathing supports provided.

18. How is support from a third party (for example, personal support worker (PSW)) documented in a bathing protocol of a person in an individual living environment?

It is up to the service agencies to determine appropriate protocols that are aligned with QAM requirements regarding supervision to ensure the safety of the supported individual. Agencies may wish to reach out to other agencies about their practices in this regard. For example, a supported individual's ISP may note that bathing support is not provided by the agency directly.

Medication and medical services

19. Can you explain controlled acts, and the required training necessary to perform them?

The definition of "controlled acts" can be found in the Regulated Health Professionals Act, 1991, a piece of legislation that defines who is authorized to perform a controlled act or who has been delegated to perform a controlled act, in accordance with any regulations under the health profession act governing the member's profession.

Controlled acts include, but are not limited to, administering a substance by injection or inhalation, putting an instrument, hand or finger into an orifice of the body, such as an ear canal or nasal passage, or prescribing or dispensing a drug defined in the Drug and Pharmacies Regulation Act.

A person may assist another person with his or her routine activities of living regarding a controlled act. However, staff must be trained on how to assist the supported individuals, as applicable or needed.

Examples that would not be considered a controlled act:

- providing a rapid COVID test
- maintenance of a pre-existing of a colostomy bag on the exterior of the body
- finger prick for blood sugar reading.

The QAM regulation requires service agencies to provide training to staff on meeting the specific needs for the health and well-being of persons with developmental disabilities who are receiving services and supports from the agency, including controlled acts. (see Developmental Service(DS) Compliance Inspection: Indicator List, Staff-Volunteer Records - #5 Training, specific needs). The intent of this requirement is to ensure that the

agency provide training to staff members about how to meet the specific needs of persons with a developmental disability.

While the ministry has not identified or approved a particular training program, the QAM regulation provides service agencies with the flexibility to arrange training for their staff on the skills to address the health needs of the people supported. Examples of specific training needs may include, but are not limited to suppository training, catheter care, EPI pen use, diabetes training, or the use of nebulizers and inhalers.

Agencies may wish to reach out to other agencies that may utilise similar controlled act processes for more insight into sector wide training processes. For example, training videos developed by regulated health professionals, nursing agencies or pharmacists.

Non-specific training would be sufficient, in cases where the controlled act is a standard process i.e., performed in exactly same way regardless of the individual needs. However, if there are individual-specific processes regarding the controlled act, then the training must be specific to the supported individual's needs.

QAM does not have specific requirements on the frequency of controlled acts training. It is up to the agency to determine training requirements and ensure that these are outlined in their policies and procedures.

During an inspection, the ministry will look for evidence of training for each staff, who performs the controlled act. The ministry reviews an individual's ISP or medication administration record (MAR) and if any controlled acts are identified, the ministry will review training records for evidence to confirm compliance with controlled acts requirements.

20. How will the ministry respond to family physicians not providing annual physicals to those we support? Some physicals are over the annual due dates, some by 2 to 3 years. If an individual in group living does not have a doctor due to doctor shortages, how does the agency show compliance regarding annual appointments?

Individual Records #30. Medical and Dental Appointments requires agencies to ensure assistance is provided to the person to attend regular medical and dental appointments, as needed, and that a log is kept or documentation is kept on file with respect to the person's regular medical and dental appointments. The agency's policies and procedures should speak to the frequency of medical and dental appointments for individuals.

The QAM regulation does not require annual visits with a physician. Individuals may seek medical assistance and appointments from a nurse practitioner for general health needs.

21. What documentation is needed for people supported who have PRNs that are NOT chemical restraints? Is a PRN protocol required?

QAM requires that:

- An ISP identify any necessary safeguards to protect the health and safety of the person with a developmental disability when receiving services and supports, which could include a PRN medication
- service agencies provide information, as applicable and appropriate, to the individual regarding prescription medication. For example: medication information sheet, notation in the individual's file to indicate that information has been verbally shared with the individual.

Service agencies are required to develop their own policies and procedures regarding health promotion, medical services and medication, including (but not limited to):

  - access to and storage of the medication as well as the administration of medication, including self-administration
  - any medication errors and refusals to take prescribed medication
  - transfer of medication between different locations where the person receives services and supports, and responsibility for access, storage, and administration of medication at each of the different locations.

Service agencies must train their staff to meet the specific needs for the health and well-being of the individual receiving services and supports from the agency.

A PRN plan is recommended to ensure consistent implementation among staff, even when the PRN is not an intrusive behaviour intervention for challenging behaviour.

22. For over-the-counter medications such as Tylenol and cough and cold remedies is it necessary to have a doctor approve of a protocol for each one, or can a list of the medication be given and approved?

QAM requires that service agencies have policies and procedures, including documentation regarding administration of medication, regardless of whether these are over-the-counter medications. It is recommended that medications are reviewed regularly with the doctor as well to ensure continuous safe practice around the medication administration.

Agencies may wish to reach out to other agencies about their practices in this regard. For example, ensure is that the doctor has approved the use of these medications, clear instructions for safe administration.

23. What are QAM requirements for individuals that administer and store their own medications in their independent living environments? If a person self-administers PRN in an independent living environment how do we track the effectiveness of the PRN?

QAM requires that service agencies have policies and procedures, including documentation regarding administration of medication, even for individuals that administer and store their own medications in their independent living environments.

During an inspection, the ministry will review the service agency's policies and procedures related to self-administration of medication. The process to self-administer medication may be outlined in the supported individual's ISP.

Agencies may wish to reach out to other agencies about their practices in this regard. For example, using a checklist to monitor the individual at regular intervals, which serves as continuous documentation that the agency assessed the persons capacity to self-administer.

24. What is the kind of detail needed for a PRN protocol where the individual has a regular medication that is also used as a PRN.

It is not the ministry's role to define how to write a PRN protocol. Agencies may wish to reach out to other agencies about their practices in this regard. For example, after discussing with the physician, including considerations related to minimum time interval required between medication, maximum daily dosage or conditions when to safely administer the PRN.

Supportive Living supports and services

25. Is it a requirement or recommendation to have a daily hot water check in showering areas?

QAM requires daily temperature check of water to confirm it is under 49 degrees. The location of the daily temperature check of water may be from any faucet in the home, however it is recommended that the showering areas are tested regularly. During an inspection, the ministry will check the water temperature from any accessible faucet in the home.

26. Will there be a way for apartments that have no control over their maximum water temperature to be compliant with the hot water indicator?

QAM requires that the temperature of water from all faucets is under 49 degrees. In the case of apartments that have no control over their maximum water temperature, service agencies must have safeguards and supports in place regarding water usage to protect the supported individuals. Agencies may wish to reach out to other agencies about their practices in this regard. For example, detailed bathing safety protocols where staff set the temperature before the individual begins bathing.

27. Do you have more information on dealing with mould and mildew in a compliant manner?

QAM requires that homes are kept safe and clean. Agencies may wish to reach out to other agencies about their practices in this regard or visit the website, QAMtraining.net, for resources.

While the presence of mould or mildew is not an automatic non-compliance, the ministry will check how the agency is managing it to ensure the health, well-being, and safety of the supported individuals. If significant quantities of mould and/or mildew are present in the home, the ministry may assign an immediate non-compliance, requiring corrective action within 24 hours to ensure the health and safety of the supported individuals.

Topics not directly related to DS compliance

28. Can you share the membership of the QAM Reference Group, which EDs are on the group?

Current members from DS Provincial Network include: (as of January 2025)

- Sherri Kroll, Executive Director, Middlesex County (Chair of the Provincial Executive Directors Coordinating Committee and Provincial Executive Directors Group)
- Michelle Brooks, Executive Director, Participation House Durham (Chair of Provincial Network)
- Darlene Dale, Executive Director, Community Living Belleville and Area (Chair of Focus Group for the Hastings, Prince Edward Focus)
- Kim Daly, Executive Director, Sudbury Developmental Services
- Art Mathews, Executive Director, Salvation Army
- Regan Turner, Executive Director, Community Living & Respite Northumberland
- Heather Williams, Director, Ottawa-Carleton Association for Persons with Developmental Disabilities
- Eugene Versteeg, Senior Vice President, Karis Disability Services
- Megan Waqué, Executive Director, Community Living North Bay

Membership for the QAM Reference Group is usually for a two-year term. Sector representatives are determined by the Provincial Network.

Members:

- provide expertise, feedback and suggestions on the overall strategic direction of operational and policy items
- as well as share sector issues and advise on any program or policy changes that affect the sector.

29. Is a 3rd party contract required if someone purchases support using Passport funding? Our organization brokers these funds.

In short, no, third-party contracts are not required for compliance if services are purchased by the individual using Passport funding. QAM requirements only apply to supports and services receiving ministry funding under *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008* (SIPDDA).

The Passport program is funded under the Ministry of Community and Social Services Act, (MCSSA). Since Passport funding is individualized to the recipient, it is the individual who chooses the supports and services they would like to purchase, in alignment with the Passport guidelines. For example:

- Recipients who choose to utilize a TPR or any third party to administer their funding – negotiate the services or supports they want to purchase or receive as well as to administer funding
- Recipients choose how much of their funding they are willing to use for a 3rd party to reimburse on their behalf – including what services.

For more information about the Passport program, please visit,

- https://www.ontario.ca/page/passport-program-adults-developmental-disability
- https://passportfunding.ca
- https://www.ontario.ca/page/passport-program-guidelines

30. What are an agency's responsibilities are in regards to the TPON database?

For compliance purposes, please work with your agency or regional office colleagues to ensure that your information is **always up to date in TPON** – especially before your inspection. This includes:

- a comprehensive list of all of sites and corresponding services/programs receiving ministry funding under SIPDDA
- number of individuals supported at each site
- number of individuals with behaviour support, intrusive interventions, PRNs
- number people supported in community participation (CP), host family (HF), supported independent living (SIL), employment supports (ES), caregiver respite (RESP), and adult protective services (APS).

Remember, it is the agency's responsibility to keep TPON up to date with the above information at all times. **Please note that this is also important for DSCIS as well.** QAM leads should always have the most updated site information along with the program and services at each site. This may require you to connect with someone else in your agency, who is responsible for entering information in TPON.

31. What role does the TPA Risk Assessment play in determining compliance, if any?

The Program Advisors work closely with the agency's Program Supervisor and would be made aware of any relevant compliance issues prior to the inspection.

32. When can we expect QAMClear to be updated on the web page? Currently they are flagged "under review".

QAMClear will be updated and reposted in 2025.

Journey to Belonging

33. Will QAM compliance apply to individualized funding solutions in the future, such as passport and Journey to Belonging (J2B) in the future?

Decisions related to the design of the future system such as those related to quality, compliance, and oversight, have not yet been made. The ministry recognizes the importance of a phased, gradual transition aligned with the guiding principles of *Journey to Belonging* and will continue to engage with stakeholders as future decisions are made.