



2009/10 Accessibility Plan

30 September 2009

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Introduction

Aims and Objectives

The two main aims of Toronto Rehab's 2009/10 Accessibility Plan are:

- to provide an update on the current status of barrier removal projects from previous Accessibility Plans (2008/09), and
- to present the Accessibility Plan for 2009/10.

Consistent with the requirements of the *Ontarians with Disabilities Act, 2001 (ODA)* and pending structures and guidelines within the more recent *Accessibility for Ontarians with Disabilities Act (AODA)*, this plan:

- outlines past and ongoing barrier removal initiatives;
- describes the process for barrier identification;
- lists and sets priorities for barriers to be addressed in 2009/10; and
- presents recommendations for the ongoing process for barrier identification and removal.

Commitment to Accessibility Planning

The Toronto Rehabilitation Institute (Toronto Rehab) is committed to making its services and facilities as accessible as possible for all Ontarians. Formed in 1998 through the amalgamation of the Rehabilitation Institute of Toronto, the Toronto Rehabilitation Centre and Lyndhurst Hospital, Toronto Rehab is Canada's largest academic hospital specializing in adult rehabilitation, complex continuing care and long-term care. Our focus is to help those who experience disabling illness or injury to rebuild their lives. We are fully affiliated with the University of Toronto (U of T) and play a leadership role in the Greater Toronto Area (GTA) Rehabilitation Network.

Facing serious injury or illness, our patients know firsthand what it means to experience barriers to access. We serve adults with neurological, musculoskeletal, cardiac and spinal cord conditions. We also work with geriatric, complex continuing care and long-term care patients. Through innovative patient care, education and research, we empower our patients to return to living life to the fullest extent possible.

As outlined in the accompanying *Guidelines for Accessibility Planning*, we recognize and acknowledge a wide variety of barriers including physical/architectural, information/communication, technical, attitudinal and policy/practice.

The Working Group

Formal accessibility planning began at Toronto Rehab in 2002/03 with the formation of the Accessibility Planning Committee (APC). Its mandate was to respond to accessibility issues raised within the Toronto Rehab community by staff, patients, families and visitors and to meet accessibility planning requirements under the *Ontarians with Disabilities Act, 2001*. Today, members of the APC continue to oversee the accessibility planning process at Toronto Rehab, providing recommendations to senior leadership on accessibility issues and developing the annual Accessibility Plan. See Appendix I for a list of APC members.

Report on Barriers

Methodology for Identifying Barriers

Accessibility planning is fully integrated into Toronto Rehab's annual Operating Plan process. Each year, the hospital's departments and clinical programs consult with employees, patients, families and visitors prior to development of the Operating Plan to identify and prioritize barriers to accessibility. Accessibility issues are then reviewed, prioritized and addressed within available resources as part of the Operating Plan process. See Appendix III for a copy of the Operating Plan template.

Toronto Rehab's *Guidelines for Accessibility Planning* (Appendix IV) clarify the milestones for successful plan development as well as the execution, tracking and reporting of barrier removal initiatives.

Prioritizing Barriers

The following criteria were used to prioritize barriers for the 2009/10 Accessibility Plan after evaluating and modifying weighted criteria used in previous years:

1. Barrier has an impact on the safety of patients or staff. Weight = 3
2. Barrier presents as a high degree of inaccessibility. Weight = 3
3. Barrier is feasible to remove. Weight = 3
4. Barrier has an impact on and is relevant to our primary populations. Weight = 2
5. Removal of the barrier will impact a significant number of people. Weight = 2
6. Barrier does not meet current code or regulation. Weight = 2
7. There are no present or future approved plans already developed to address this barrier. Weight = 1

The barrier priority list for 2009/10 was further refined based on the following planning assumptions:

- Accessibility standards mandated by the *Accessibility for Ontarians with Disabilities Act (AODA)* are included in the plan
- Consideration of the APC ranking criteria, as outlined above
- Indication that a barrier presents a safety issue
- Consideration of the priority rating given to the issue by a Functional Centre (department/program)
- Consideration of barriers that have been identified in previous years
- Barrier-removal plans that were identified in previous years' Accessibility Plans assumed to be on target and not identified in the 2009/10 barrier list
- Funds are allocated to specific barriers according to priority
- Additional contingency funds are allocated for unanticipated costs of barrier-removal plans to address those barriers where costing was not completed and to address priority barriers that arise in the course of 'usual' business.

Based on these assumptions, four (4) categories of barriers were identified for 2009/10:

1. Prioritized barriers (two-tiered in order of priority)
2. Low-cost barriers that should be considered
3. Barriers that require further information and follow-up, and
4. Barriers that were not accessibility issues and were referred to the appropriate department or clinical program for attention.

2008/09 Accessibility Plan

The following is an update on progress that has been made in addressing the 21 barriers outlined in the hospital's 2008/09 Accessibility Plan.

Barrier	Site	Status	Comments
1. Communication devices to make lecture hall and conference rooms more accessible for those with loss of hearing	RC	Completed	
2. Elevator B doors close too fast	LC	Completed	
3. Accessible Elevator push pad for patients in wheelchairs	BC	Completed	Research concludes no such device currently exists. Project cancelled.
4. Insufficient number of call bells with 'soft touch' for patients who lack dexterity	HC	Completed	
5. Lighting across wheelchair pathway	LC	In progress	Pathway barrier was addressed by cutting curb and bringing crosswalk closer to entrance. Improved lighting installed along pathway.
6. Telephones with large buttons and volume controls for patients with low vision and or hearing loss	HC	Completed	As per reported at APC Meeting of 11/20/09
7. Computer workstations not all accessible to wheelchairs	BC	Completed	Wheelchair accessible workstations installed in Patient Resource Centre
8. Curtained washroom cubicles difficult for patients in wheelchairs	LC	Completed	Curtains replaced with walls and doors

Barrier	Site	Status	Comments
9. ATM Machine buttons difficult to access due to height of machine	LC	Deferred	This issue will be addressed through the 2009/10 Accessibility Plan
10. Wayfinding signage for clinical practice room (326)	UC	In progress	Temporary solution being pursued with Marketing & Communications, with permanent solution tied to corporate-wide wayfinding plans
11. Current lighting in patient rooms not adequate for those with low vision	HC	Completed	Brighter bulbs installed. Permanent solution will be addressed through redevelopment projects and the intended transfer of HC services to UC
12. Current lighting in patient rooms not adequate for patients with low vision increasing risk for falls	UC		
13. Improve lighting in Room 326 for patients with low vision	LC		
14. Poor/dim lighting impacting patients' ability to see educational information	UC		
15. Business office counter is not sufficient depth to allow patient to access by wheelchair when conducting transactions	BC	Completed	
16. Hospital-wide internet access for patients	LC	Completed	Patient computer stations with internet access installed on main floor
17. Motion sensors in elevators to improve elevator access	UC	Completed	Doors were closing too quickly for patients – doors were adjusted to address issue
18. Summoning help from the parking lot	LC	Completed	Possible options were reviewed, but given there is currently no existing technology or processes to support this, the project was cancelled

Barrier	Site	Status	Comments
19. Token slot in token machine is too low to the ground for wheelchair users	LC	Completed	Raising machine raises a safety issue. Replacement machine was investigated but alternative technology does not exist at this time
20. Wheelchair access to food items in Café is difficult for wheelchair users due to height of counter and shelves	LC	Completed	Furniture in Café was reorganized to address accessibility issue
21. Shelving in clients' closets is too high for those in wheelchairs	UC	Completed	This issue will be addressed as part of the UC redevelopment project

2009/10 Accessibility Plan

Over the past five years, the Accessibility Planning Committee (APC) has been proactive in identifying and removing a number of physical barriers that impede access to Toronto Rehab services and/or facilities. With the recent introduction of transitioned comprehensive standards of accessibility under the AODA, the APC is broadening its focus beyond physical barriers to include attitudinal, cultural and other barriers to accessing our goods, services and facilities.

Given our specialized patient populations and our reputation as a leader in rehabilitation care and science, Toronto Rehab continues to be committed to meeting or surpassing minimum accessibility standards as outlined in provincial legislation.

Nowhere is this more apparent than in the redevelopment projects that are currently underway at the hospital's Lyndhurst, Bickle and University Centres. A significant number of physical and architectural barriers identified in advance by the APC have been taken into consideration and are expected to be eliminated through completion of these redevelopment projects over the next few years.

Strong emphasis this year will be on complying with the new Accessible Customer Service Standard under the AODA. Extensive awareness and educational activities have been scheduled throughout the Fall of 2009 to ensure compliance with this standard by January 1, 2010 (see Appendix V for details). A consistent approach is being applied to the roll-out of each of the AODA standards including comprehensive communication and training to support staff, physicians, volunteers and students.

This year's Operating Plan process resulted in the approval and funding for seven new accessibility initiatives (Appendix II) with a primary focus on improving accessibility at the Lyndhurst Centre which houses Toronto Rehab's Spinal Cord Program. These

initiatives have a total budget of \$77,880.00 and most strategies to address them are already in progress.

Communications

Communication remains at the forefront in accessibility planning at Toronto Rehab. Copies of the hospital's accessibility plans are posted in dedicated Accessibility sections on both our intranet and internet sites. This provides everyone with an interest in Toronto Rehab with quick access to our plans for improving accessibility to facilities and services, and showcases what strides have already been made in this regard.

With the Accessible Information and Communication Standard under the AODA set to roll-out in 2010, efforts are already underway to enhance communications at Toronto Rehab for improved accessibility.

Appendix I: 2009/10 Accessibility Planning Committee

Chair

Chris Pickard, Director, Capital Planning and Project Management

Membership:

Lynn Bullock, Manager, Occupational Health & Safety

Katarina Busija, Patient Safety Officer

Leanna Graham, Director of Health Disciplines

Joanne Kwong, Occupational Therapist, Musculoskeletal Rehabilitation

Rhoda Lordly, Risk Manager & Patient Relations Representative

Robert Purdy, Director, Environmental Services

Audra Sher, Physiotherapist, RGP Day Hospital

Munazza Siddiqui, Planner

Narin Silver, PTA/OTA, Rumsey Centre

Martha Strong, Manager, Cardiac Rehabilitation & Secondary Prevention Program

Senior Sponsor :

Susan Mikulicic, Vice President, Finance & Planning & Chief Financial Officer

Appendix II: Barriers Identified in 2009/10 Accessibility Budget

The following are the accessibility issues identified, approved and funded for 2009/10, with the greatest emphasis on improving accessibility at our Lyndhurst Centre which houses Toronto Rehab’s Spinal Cord Program.

Barrier Identified	Site	Summary	ED/VP Responsible
1. ATM machine	LC	Patients with limited hand function and limited mobility have difficulty taking funds out of the machine.	Susan Mikulicic
2. Wheelchair access to bathroom stalls	RC	There is inadequate room for wheelchair access to individual washroom stalls in both male and female patient washrooms on the first floor.	Karima Velji/Gaetan Tardif
3. Parking token machine	LC	Patients with limited hand function and limited mobility have difficulty paying for and retrieving parking tokens.	Susan Mikulicic
4. Parking lot	LC	People in wheelchairs must travel a fairly long distance from the disabled parking spaces to the front entrance. This is particularly challenging in bad weather (e.g. snow). As well, people with decreased upper extremity function cannot effectively access the coin slot.	Susan Mikulicic
5. Lyndhurst Centre Café	LC	The self-serve nature of the Café makes it challenging for patients with limited balance or upper extremity function to safely and independently access hot food. There is a risk of food spilling and being contaminated.	Susan Mikulicic

Barrier Identified	Site	Summary	ED/VP Responsible
6. Public washrooms	LC	The universal design of the washrooms does not meet the diverse functional needs of the patients who access services at Lyndhurst.	Susan Mikulicic
7. Customer Service Standard (AODA)	Corporate-Wide	This initiative will address compliance with the new accessible customer service legislation in Ontario. It includes the development of new policies and procedures related to accommodating service animals, support personnel and assistive devices, implementing mechanisms for customer feedback, and providing education and training for staff, physicians, volunteers and students.	Karima Velji
8. Automatic door access	BC	The doors to lounges (rooms 411 and 511) do not have automatic door operators. This makes it difficult for patients to access these rooms.	Susan Mikulicic

Appendix III: Annual Accessibility Planning Template

Toronto Rehab is committed to ensuring our services and facilities are as accessible as possible for all members of our community. Consistent with the Accessibility for Ontarians with Disabilities Act (AODA), Toronto Rehab develops an annual Accessibility Plan to identify and prioritize barriers and outline the steps that will be taken to remove barriers in our organization.

We need your help in successful accessibility planning!

Using the definitions below*, please consult with your respective teams and people with disabilities who access your services (patients, families, staff, etc.) and list any identified accessibility barriers in the accompanying Accessibility Plan template. You may need to consult with others (i.e. Plant Operations and Maintenance, etc.) to provide cost estimates for removal.

NOTE: The Accessibility Planning template will be provided to you by the Finance department for completion. If you have not received a copy by the fall of '09, please contact Finance Manager immediately. Please see the attached (blank) sample.

***What is a Barrier?**

“A barrier is anything that prevents a person with a disability from fully participating in all aspects of society because of his/her disability” and can include physical, architectural, informational, communicational, attitudinal, technological or policy/practice.

***Definition of Disability**

The definition of disability includes: 1) any degree of physical disability; 2) a condition of mental impairment or developmental disability; 3) a learning disability or dysfunction of the processes involved in understanding or using symbols or spoken language, or 4) a mental disorder.

Appendix IV: Toronto Rehabilitation Institute Guide to Accessibility Planning

GUIDE TO ACCESSIBILITY PLANNING

This document provides a high-level map to Accessibility Planning at Toronto Rehabilitation Institute. It aims to clarify the milestones to successful plan development as well as the execution, tracking and reporting of barrier removal initiatives.

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Overview

Toronto Rehabilitation Institute (Toronto Rehab) was formed in November 1998 with the amalgamation of Lyndhurst Hospital, the Rehabilitation Institute of Toronto and the Toronto Rehabilitation Centre was mandated to provide patient care and engage in education and research in the field of adult rehabilitation, complex continuing care and long-term care.

In the year 2002/03, Toronto Rehab began the formal process of accessibility planning as required by the Ontarians with Disabilities Act, 2001. The Accessibility Planning Committee (the Committee) was created and with representation from the individual programs and several service areas, they were charged with responsibility for overseeing the process including creation of the annual Accessibility Plan.

Since its inception the Committee has provided leadership for the removal of countless barriers and is committed to the elimination of all barriers faced by clients with disability. The “Accessibility for Ontarians with Disabilities Act, 2005” calls for total accessibility by 2025.

As a member of this committee you would work with the other members – including professionals and current or past-patients from several other Programs - to review a list of accessibility barriers that has been identified by our various programs and services and, as a group, make recommendations of priority barriers that should be addressed by Toronto Rehab in the upcoming Accessibility Plan.

Roles and Responsibilities

Senior Sponsor – provide direction and leadership to the Accessibility Planning Committee. The Sponsor is the Senior Management Champion for accessibility planning and will work with the Co-Chairs to ensure organizational barriers to the process are overcome.

Chair – provides leadership to the Accessibility Planning Committee, including facilitating all meetings of the committee, finalize agenda, recruit members, establish communication and project plans as well as manage issues related to approved projects.

Admin – provides administrative support to the Committee, including scheduling meetings, setup teleconference, preparing agenda, taking minutes as well as collating the barrier submission and entering the tally in a spreadsheet.

Member – represent those with disabilities who access your program or service area on the Committee and participate in reviewing the identified barriers and their prioritization (ranking) for submission in the final recommendation to Senior Management. Additionally, you will review and provide comment on new regulation and legislation related to accessibility.

Patient – represent the patient community on the Committee as a member. Your role would be the same as any other member.

Program / Service Unit Leader – identifies and prioritizes all department level barriers as well as includes them on the Accessibility Planning template. He/She also leads the implementation of the Senior Mgmt approved barrier removal initiative(s) for their department.

1. Initiation phase

1.1. Review previous year's plan (early September)

All stakeholders to the accessibility planning process, including the program and service unit leaders are encouraged to review the previous year's plan with the intent of identifying any outstanding commitments outlined in the plan. Since this plan will serve as input to the new plan a reasonability check of outstanding barriers will help assess further pursuance for removing these barriers or simply taking them off the upcoming plan.

1.2. Review the Plan template (early October)

The Accessibility Plan (the Plan) template should be reviewed each year by the Accessibility Planning Committee (APC) to ensure that it still relevant to the planning process.

2. Planning phase

2.1. Distribute templates (early November)

Once the template has been reviewed and approved by the APC, it is recommended that it be forwarded to the Finance Manager for inclusion with the template package that is sent to the Operational groups.

2.2. Confirm APC membership - incl. Patient (early November)

The APC comprises of members from various program and service areas and patient care populations within Toronto Rehab. The members' participation must be confirmed each year and where possible should include someone from the patient community or those with disabilities within the hospital or community who access our services or sites...

2.3. APC kick-off meeting (late November)

Once membership has been confirmed, the committee Chair must schedule a 60-90 minute introductory kick-off meeting to apprise the Committee members of their roles and responsibilities as well as review the process.

2.4. Receive template submission - operational groups (late December)

The operational groups are instructed to have all templates, including the Accessibility Planning template completed and returned to the APC (Admin) by years end. who collates all of the templates when they are submitted as part of the Op Plan?

2.5. Review submitted templates (early January)

Once received, it is the responsibility of the APC to review all operational submission for completeness, correctness and accuracy. Ensure that the Committee has a good understanding of the barrier(s) proposed, the strategy for removal and the elements that make of the cost estimate. It is the Committee's responsibility to prioritize the barriers identified.

2.6. Develop recommendation for Senior Mgmt team (early February)

The APC will submit final recommendation to the Senior Management team for consideration and approval. The recommendation should include; the list of barriers with their priority, the budget for each and the proposed removal timelines.

2.7. Create dashboard of approved projects (March)

The Senior Management approved list of barriers for removal must be captured on a project dashboard for ongoing tracking and monitoring.

2.8. Commence drafting the Accessibility Plan (April)

Using the previous year's plan as a guide, update the new plan to reflect the approved list of barriers to be removed and new process if necessary. Ensure that any decision affecting how and when the barriers will be removed is captured in the document. This plan should be completed by the Chair or someone tasked by the APC.

3. Implementation phase

3.1. Issue Management

An issue management process must be in place to deal with unplanned occurrences that can potentially affect the final outcome of the removal process outlined in the Plan. This will be the responsibility of the Chair to liaise with the program / service unit leaders to ensure projects are on track.

3.2. Schedule quarterly or bi-annual APC status meeting (early January)

As an ongoing measure for managing each removal initiative, it is recommended that the APC schedule a quarterly status meeting to ensure all approved projects still on track.

4. Closeout phase

4.1. Official announcements (April)

Once the Accessibility Plan has been vetted and approved it should be posted on the Toronto Rehab internet site and an announcement to staff must be communicated.

4.2. Lessons learned (mid April)

While going through the process of initiating, planning, implementing and closing out the plan, one must be mindful of the lessons learned. Create a list of all issues that can be considered learning for future Accessibility Planning process.

4.3. Document archiving (mid April)

Archive all documents associated with the Accessibility Planning process in the folder for that year's plan.

Appendix V: AODA Accessible Customer Service Standard

The work plan to address Toronto Rehab compliance with the Accessible Customer Service Standard under the AODA will address the following requirements by January 1, 2010:

1. Development of related policies and procedures
2. Development of a communication plan
3. Development of a training and education plan and supporting materials

Awareness of the standard will be addressed through presentations to staff and volunteers across the facility including:

- Every program group at their monthly business meeting at each hospital site
- Research group
- Manager and coordinators of Volunteer Services
- Building Maintenance
- Corporate Professional Affairs Committee
- Nursing Professional Affairs Committee
- Senior Management Committee
- Medical Advisory Committee
- Board of Directors
- Education Office
- Management Forum
- Marketing & Communications
- Best Practice Group
- Bickle Centre Therapy Group

An e-learning module will be developed to support the self-directed training of staff supported by an accessibility resource guide.

An annual Accessibility Report will be completed and submitted to the Accessibility Directorate of Ontario.