Dental Hygienists and Radiography

The Power of Peer Mentoring

Seniors and Access to Care
The mission of the College of Dental Hygienists of Ontario is to regulate the practice of dental hygiene in the interest of the overall health and safety of the public of Ontario. La mission de l’Ordre des hygiénistes dentaires de l’Ontario consiste à réglementer l’exercice de la profession d’hygiène dentaire de sorte à favoriser l’état de santé global et la sécurité du public ontarien.
We are now well into 2013 and it is an exciting time to be part of the College of Dental Hygienists of Ontario. The Council and staff are dealing on a daily basis with many issues that impact the Dental Hygiene profession and the public.

The College is progressing with a number of initiatives including the following:


- Responding positively to the invitation from the Ministry of Health and Long-Term Care to participate in their review of the Healing Arts Radiation Protection (HARP) Act and are involved in discussions with the Ministry of Health and Long-Term Care to determine the requirements for a dental hygienist to be authorized to take radiographs under this Act and the issues involving required training and competency.

- Preparing the submission of the proposed Drug Regulation for Prescribing, Dispensing and Compounding of Specified Drugs for the Ministry of Health and Long-Term Care that will eventually allow dental hygienists who are appropriately trained and regulated to be able to carry out these functions.

- Establishing guidelines around advertising that will guide dental hygienists’ decisions on advertising their practices. This is a complex issue because it requires the balancing of the registrants’ right to advertise with the need to ensure that what is put out there is not misleading to the public or unprofessional in its content.

- Promoting activities that advance public awareness and good oral health for the people of Ontario, and enhance better access to care for those people in areas that require it. There has never been a time when expectations for public accountability from our College and all other Health Regulatory Colleges have been higher. We see this every day in media reports involving the actions or non-actions taken that involve various health issues which cover a number of areas. We have been fortunate as a College that we have not had to deal with any high profile issues that have become significant media issues. I like to think this is because we have a very dedicated profession with an equally dedicated College that has the well being and protection of the public as its number one priority. However, we are also well aware that we have to be diligent to not get blindsers on when it comes to performing the various functions mandated under the Health Regulated Professions Act and other statutes, to ensure that we can always carry out our duties in a fair and transparent manner.

We continue to further the strategic direction established by Council this year through a very effective system of Council Committees. They are the ones who do the bulk of the work which eventually makes its way to Council. At the Committee level is where the heavy lifting is done to flesh out those changes to standards, proposed initiatives involving the regulation of the profession and the regulatory requirements such as dealing with complaints and discipline issues mandated by the Regulated Health Professions Act.

Finally, I want to take the opportunity to acknowledge the accomplishments of Evelyn Waters, our former Deputy Registrar who has taken a position with the College of Massage Therapists of Ontario. Evelyn has been here from the beginning and has been an instrumental part of this organization. She will be very much missed and I would like to take the opportunity to wish her well in her new position.
The traditional role of a health professional regulatory college is relatively well understood in Ontario. A college is the monitoring agent to ensure that its members are qualified to deliver clinical service and that the care they deliver is done so safely. From a practical perspective this is borne out in the organizational structure of colleges. At CDHO, the statutory committees cover all of the traditional regulatory college bases, e.g., Registration Committee is mandated to ensure that only qualified individuals are granted a certificate of registration and Quality Assurance Committee is mandated to ensure that registrants maintain the quality of their professional practice.

I am proud to serve as the Registrar of CDHO for many reasons but one of them is that the College does a first class job of executing its traditional responsibilities. These responsibilities are clearly articulated in the legislation that constitutes Ontario’s health professional regulatory colleges. A review of that legislation, however, does reveal additional responsibilities for regulatory colleges that tend not to be classified under the traditional role. The salient section of the legislation, i.e., the Health Professions Procedural Code of the RHPA, is noted below.

**Duty of College**

2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

**Objects of College**

3. (1) The College has the following objects:

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the Regulated Health Professions Act, 1991 and the regulations and by-laws.

2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.

3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.

4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.

4.1 To develop, in collaboration and consultation with other colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance inter-professional collaboration, while respecting the unique character of individual health professions and their members.

5. To develop, establish and maintain standards of professional ethics for the members.

6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the Regulated Health Professions Act, 1991.

7. To administer the health profession Act, this Code and the Regulated Health Professions Act, 1991 as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.

8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.

9. To promote inter-professional collaboration with other health profession colleges.

10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.
11. Any other objects relating to human health care that the Council considers desirable. 1991, c. 18, Sched. 2, s. 3 (1); 2007, c. 10, Sched. M, s. 18; 2009, c. 26, s. 24 (11).

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest. 1991, c. 18, Sched. 2, s. 3 (2).

You will likely have noticed that the legislation defines the duty of the college in two different areas and in two different ways. A careful comparison of these two duties yields some striking insights. In the first instance, the duty holds the College responsible for ensuring – in consultation with the Minister – that Ontario has access to adequate numbers of dental hygienists. It’s a curious responsibility since the College does not have any capacity to educate dental hygienists, nevertheless, it is a clearly articulated responsibility.

Following that duty is the schedule of objects which are the traditional stuff of a regulatory college – with one exception, i.e., object 11. This final object allows for great latitude in terms of the work that a college might see fit to do.

Following the schedule of objects the duty of the College is articulated again. That duty is certainly more in keeping with the traditional role of a regulatory college and it is a role that CDHO embraces with great energy. What about that first duty? Why does the legislation spell it out in two different ways? They are most certainly not repeats or echoes of each other. The two positions, however, are mutually supportive. The critical connector comes in the definition and interpretation of the phrase ‘protect the public interest.’

There are at least two ways of protecting the public interest.

1. **Direct protection:** the College’s direct responsibility for monitoring a registrant’s professional behaviour as an agent of service delivery.

2. **Indirect protection:** the College’s responsibility for monitoring the health system in keeping with the first duty articulated in the Health Professions Procedural Code under RHPA and in keeping with the final object in the schedule of objects for all colleges.

So what does indirect protection mean in a practical sense? It means that if a regulatory college has a concern about the people of Ontario and their access to care, in this case their access to dental hygiene services, it has a legislative responsibility to a) investigate that concern, b) document that concern in the form of evidence, and c) bring that evidence-informed concern to the attention of the various authorities who share that responsibility.

I submit that regulatory colleges do have a role to play in the shaping of public policy. While that role is a somewhat different role from the one they have traditionally played – certainly that is the case for CDHO – perhaps it is time for that tradition to change.

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**A New Practice Advisor Joins the Team**

The College welcomes [Cathy Goldberg](mailto:cgoldberg@cdho.org) to the Professional Practice Team. As Manager of Programs and Examinations, Cathy will manage the peer mentoring program and the written and clinical examinations. A dental hygienist with over twenty years of experience in clinical, public health and educational practices, Cathy will join Robert Farinaccia in offering practice advice to CDHO registrants. Cathy is a past graduate of Algonquin College (Dip. D.H.), recent graduate of Brock University (B.Ed. Adult) and has been a Quality Assurance Assessor for the College for the past seven years. Friends describe Cathy as caring, artistic and creative. She shares her passion for dental hygiene with a passion for stained glass and animals.

Cathy looks forward to sharing her experience and insight with others and welcomes calls for practice advice, the peer mentoring program and examinations. You can reach her through email at cgoldberg@cdho.org or by calling 416-961-6234 (1-800-268-2346), ext. 238.
Mr. Mike Connor, President of Council, called the meeting to order in Toronto, Ontario. Mr. Connor noted that Lisa Taylor had been a regular attendee to Council as Associate Registrar but welcomed her to the meeting in her new incarnation as the Deputy Registrar.

Mr. Blair MacKenzie of Hilborn LLP explained the external audit process for the College and presented the Auditor’s Report to Council.

Executive Committee brought forward a proposed amendment to the Standard of Practice for Delegation (see page 7). The amendment would allow potential registrants who have failed CDHO’s clinical examination to access a clinical training refresher or remediation program in a more timely way.

Executive Committee also brought forward an update on the College’s proposed Drug Regulation. The sixty-day consultation period had expired and the changes to the proposed regulation resulting from the consultation were not substantive enough to warrant recirculating the proposed regulation anew. Accordingly Council directed the Registrar to prepare the regulation for submission to the Ministry of Health and Long-Term Care for processing.

The Investigations, Complaints and Reports Committee presented Proposed Guidelines for Advertising. It was agreed that a broader review of the issue in the form of a regulation would be prudent but that the Guidelines would be approved as presented. Council referred the issue of a broader review to Executive Committee for their deliberations.

Mr. Brad Sinclair, Registrar, presented a brief administrative report that provided an update on a number of items including:

- The National Standardized Clinical Examination Report;
- The ODHA/CDHO Sponsored Educator’s Forum;
- CDHO’s most recent clinical competency evaluation; and
- Two cases of illegal practice.

Mr. Connor presided over the presentation of a commemorative plaque to Mr. Eliot Feldman. Mr. Feldman has accepted a new position in the USA and as a result will no longer be able to serve on Council. Mr. Connor thanked Mr. Feldman for his time and contribution to Council.

Mike Connor, President, presenting Evelyn Waters with a farewell gift on behalf of Council.

Left to right:
Heather Blondin – Vice-President of CDHO
Inga McNamara – Council Member
Evelyn Waters – Former Deputy Registrar
Mike Connor – President of CDHO
Delegation: Limited to Clinical Competency Evaluations and Clinical Competency Preparatory Courses

Introduction

College publications contain practice parameters and standards which should be considered by all Ontario dental hygienists in the care of their clients and the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

This Standard applies to CDHO registrants who delegate the controlled act of “scaling teeth and root planing, including curetting surrounding tissue” for the purpose of assessing individuals in the course of a clinical competency evaluation or assisting individuals preparing for the clinical competency evaluation. This Standard should be read in conjunction with the CDHO Standard of Practice for Self-Initiation and the CDHO Dental Hygiene Standards of Practice.

The objective of this Standard of Practice is to communicate the professional standards and the College’s expectations for CDHO registrants involved in such delegations.

Legislation

The CDHO is governed by the Regulated Health Professions Act, 1991 (RHPA), the Dental Hygiene Act, 1991 (DHA) including subsequent amendments. Controlled acts are procedures that could cause harm if they are not performed safely, appropriately and effectively by individuals with the requisite knowledge, skill and judgment. “Scaling teeth and root planing, including curetting surrounding tissue” and any other procedure performed below the surface of the teeth, are controlled acts under the RHPA.1 Dental hygienists are specifically authorized to perform “scaling teeth and root planing, including curetting surrounding tissue” through the Dental Hygiene Act, 1991, in one of two ways: (i) through self-initiation, subject to certain conditions, or (ii) where there is an ‘order’ of a registrant of the Royal College of Dental Surgeons of Ontario (RCDSO)2. In addition, dental hygienists can also perform the controlled act if an exception applies or if they receive a delegation from another practitioner who is authorized to perform it.

1 See paragraph 2 of subsection 27(2) of the RHPA.
2 See section 5(1) of the DHA.
Exceptions Under *RHPA*

The *RHPA* allows individuals fulfilling the requirements to become a registrant of a health profession to perform controlled acts that fall within the scope of practice of his or her future profession, as long as those acts are done under the direction and supervision of a registrant of the profession. This is what occurs in the academic setting. In addition, an individual who is fulfilling a requirement for registration such as a clinical competency evaluation may perform the controlled act in a specific supervised setting for the purpose of evaluation of that applicant’s skills. This exception does not apply to individuals who have completed their schooling and wish to prepare for a clinical competency evaluation.

**Delegation**

There are a number of significant barriers to delegating the controlled act of “*scaling teeth and root planing, including curetting surrounding tissue*” by a dental hygienist. Firstly, it is only potentially available for dental hygienists who are authorized to self-initiate the controlled act; it is not available for those authorized by an order of a dentist or through an exception to the controlled acts rules. Secondly, the delegating dental hygienist is responsible to ensure that none of the specified contraindications are present before or during the procedure. It is the CDHO’s view that this duty is personal to the delegating dental hygienist. Thirdly, the delegation must comply with accepted standards of practice.

Therefore, delegation of the controlled act of “*scaling teeth and root planing, including curetting surrounding tissue*” is generally not available, with one narrow exception.

**Indications for Use of this Standard of Practice**

A dental hygienist who is authorized by CDHO to self-initiate “*scaling teeth and root planing, including curetting surrounding tissue*” may delegate these procedures, in whole or in part, under the following circumstances:

- The individual who is receiving the delegation must have completed all other requirements for registration with CDHO
- The delegator is either a full-time or part-time dental hygiene educator who has previous clinical teaching and evaluation experience with dental hygiene students
- The delegation is part of a structured program acceptable to CDHO
- The delegation is to facilitate applicants who require clinical practice prior to the CDHO’s clinical competency evaluation
- The delegator is a registrant in good standing with CDHO and is authorized to self-initiate
- The delegator personally reviews the client’s medical history and the treatment plan developed by the applicant
- The delegator supervises the treatment in a manner consistent with all of the circumstances, evaluates the outcomes and provides feedback to the applicant
- Record keeping is in line with the CDHO Records Regulation

The CDHO views this narrow exception to be necessary to enable applicants to prepare for registration. This exception is particularly important to enable CDHO to meet its obligations to international applicants in a manner consistent with the *Fair Access to Regulated Professions Act, 2006* amendments to the *Regulated Health Professions Act* as monitored by the Office of the Fairness Commissioner.

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1 See section 29(1)(b) of the *RHPA*. 
Performance Expectations for the Delegating Dental Hygienist

A dental hygienist, delegating the authorized act of “scaling teeth and root planing, including curetting surrounding tissue”, demonstrates the standard by:

Assessment

1. Prior to delegating the authorized act, the registrant:
   • makes sufficient inquiries of the applicant to ensure that s/he is competent to perform the delegated act,
   • reviews the treatment plan,
   • personally reviews the client’s medical history.

Risk

2. Prior to delegating the authorized act, the dental hygienist:
   • assesses the risks of delegating the authorized act and ensures that the risks are relatively low and that the applicant is safe to proceed.

Authorization

3. Prior to delegating the authorized act, ensuring that s/he is authorized to self-initiate the act through the authorizing mechanisms available in the RHPA and DHA.

Competence

4. Being able to demonstrate her or his competence to delegate the authorized act through authorization from the CDHO to self-initiate and through evidence of clinical teaching experience in a CDAC accredited school.

Accountability

5. Assuming accountability for decisions and actions related to the performance of the authorized act.
6. Assuming responsibility for the performance and outcome of the authorized act.

Professional Responsibilities

7. Delegating the authorized act in accordance with applicable legislation, regulations or standard of practice of the profession, including:
   (a) **transparency** – informing the client that the procedure is being performed under delegation and the authority for that delegation,
   (b) **consent** – obtaining informed consent, which may include a requirement that the client be advised of the registration status of the person who is performing the procedure, and
   (c) **recordkeeping** – recording the fact and details of the delegation including the name of the registrant delegating the procedure and the name of the individual performing the procedure.

*Approved by CDHO Council: October 2009*
*Amended by CDHO Council: May 31, 2013*
The College is looking for dental hygienists who have been authorized to self-initiate, to mentor other dental hygienists under our mentorship program. This is a volunteer position, however, the College will provide you with free training and time spent in training and in mentoring may be used to meet your professional portfolio requirements. You would be responsible for any costs incurred to attend the training workshop.

Interested dental hygienists must be willing to complete approximately 25 hours of learning through a combination of on-line modules, self-reflective assignments and a full-day workshop (sometime this Spring or Summer). Workshops will be booked in locations through Ontario as determined by demand.

Interested dental hygienists must meet the following requirements:

1. Be registered and in good standing with the CDHO.
2. Have practised clinical dental hygiene for at least five (5) years.
3. Have practised while authorized to self-initiate in Ontario for a minimum of two (2) years.
4. Have completed the CDHO mentorship course and workshop.
5. Be willing and able to participate in a mentoring relationship as a volunteer.
6. Have a positive attitude for the profession and its standards.
7. Be willing to have your name and contact email on the CDHO website under Find a CDHO-Peer Mentor.

If you are interested in being part of this exciting opportunity, please e-mail cgoldberg@cdho.org with an expression of interest and a brief note explaining how you meet the criteria. Questions about the program are welcome via the same email address.

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**Did You Know?**

Did you know that 38% of Ontario dental hygienists are authorized to self-initiate?

It is true that 38% of registrants are now authorized to self-initiate. However, the percentage of those who are authorized to those who are potentially eligible in each district* varies. Congratulations to district 8! Over half of registrants in this district have been authorized to self-initiate!

*For a breakdown of the districts, please view the table on page 26.
The concept of a mentor is woven all through history. Socrates was a mentor to Plato. Aristotle was a mentor to Alexander the Great. Gopal Krishna Gokhale was a mentor to Mahatma Gandhi. Mahatma Gandi was a mentor to Martin Luther King Junior and Nelson Mandela. Historically, a mentor has been a trusted teacher or counselor who plays an influential role in a person’s life. The practice of mentoring has evolved over centuries yet the intent to facilitate human growth still remains true.

Today, mentoring has evolved into a collaborative process that is recognized as a viable strategy for professional growth and leadership in health professions. Formal mentorship programs are becoming increasingly popular in institutions educating health care professionals and in workplaces inside and outside the health care field. Some of the best mentors of students are other students, and within health professions, some of the best mentors are peers within the professions.

The CDHO recognizes that mentoring relationships can be especially meaningful to new registrants and has designed the peer mentorship program to support registrants seeking authorization to self-initiate. Peer mentors are seen to be especially important because they share common experiences in day-to-day clinical practice. An experienced dental hygienist who qualifies as a CDHO peer mentor can give personal support to a new practitioner who is adjusting to the fast-paced, high-stress work of caring for clients.

A peer mentor will be a knowledgeable and experienced guide, a trusted ally and advocate, and a caring role model. They have enthusiasm about the profession and about improving the oral health of those under their care. Most importantly, they are willing to inspire and share in the professional growth of another. Those they mentor will gain experience in collective decision making, develop a habit for a collaborative approach to client care and gain confidence in practice. Imagine how empowering it would be to be searching for professional guidance and suddenly finding someone offering the insights you have been craving.

In today’s mentoring, paradigm learning is acknowledged as a powerful growth experience for both mentor and mentee. Modern mentoring sees mentors and mentees as learning partners who are exposed to new ideas, other perspectives, and intellectual stimulation brought into the relationship by both parties. Mentors and mentees learn through a parallel journey described aptly by an old African proverb “If you want to travel fast, travel alone; if you want to travel far, travel together”. This adage is the essence of what today’s mentoring paradigm is: travelling far, together, in a relationship of mutual learning.

If you have five years of clinical practice experience, have been authorized to self-initiate for at least two years in Ontario, have a positive attitude for the profession and its standards, and are willing to volunteer your time to help another dental hygienist, the College welcomes you to apply to become a CDHO Peer Mentor. In turn, the College will provide you with the necessary training, on-going support and recognition for contributing to the professional growth of your peers. As an additional bonus, time spent in training and in mentoring may be used to meet your professional portfolio requirements. For additional information on the CDHO Peer Mentorship Program, contact Cathy Goldberg at cgoldberg@cdho.org

*Did you know that the Peer Mentorship Program does not mean job shadowing?*

Peer mentoring does not even have to take place in the same location or face-to-face. Technology allows mentoring to take place through telephone, email, and even video conferencing venues such as Skype. There is no need to observe mentees in practice.
Could you imagine sending a letter out to all your clients advising them that they may have been exposed to an infectious disease in your office? In a recent news release, the public learned of an Oklahoma dentist who treated clients under unsafe and unsanitary conditions. The clinic was found not to have a written infection control protocol, and more shockingly, had not been appropriately cleaning dental equipment. Investigators found rusty instruments, potentially contaminated drug vials and improper use of a sterilizer. As a result, the Health department sent letters to approximately 7000 of the clinic’s patients informing them of a possible infection risk and recommending that they be tested.

While full details of the Oklahoma investigation may never be made public, as of May 9, 2013, the Tulsa Health Department reported that their ongoing investigation has so far identified 70 individuals who have tested positive for hepatitis C and 4 individuals who have tested positive for hepatitis B. Positive results for HIV infection have also been reported for 3 individuals. This news was as appalling to dental hygienists as it was to the public for whom we provide dental hygiene care.

The executive director of the Oklahoma Board of Dentistry reported that the agency does onsite inspections only if the agency receives a complaint against a particular dentist. This is particularly surprising when you learn that the Oklahoma Department of Health’s consumer protection division conducts restaurant inspections on a regular basis and lists the results on their website. If “imminent health hazards” exist, the establishment must cease operating until cleared. Does this mean it is safer to visit a restaurant in Oklahoma than a dental office?

In the practices of Ontario dental hygienists, inspections regularly occur as part of the CDHO Quality Assurance Program. Dental hygienists are required to record their infection prevention measures as part of their professional portfolio and questionable practices are followed up with an onsite visit. The cumulative results of CDHO portfolio and practice reviews provide overwhelming evidence that dental hygienists in the province are dedicated to meeting the expectations of their clients in regards to infection control procedures and sterilization/sterilizer monitoring.

The College’s promise to dental hygiene clients states that the public can expect to receive quality preventive oral hygiene care from registered dental hygienists in the province. This includes following a scientifically accepted, evidence-based infection control policy as required by the College’s published Standards of Practice. The CDHO has prepared a “Questions to Ask Your Dental Hygienist About Infection Control” fact sheet to help inform your clients of acceptable practices. Being open and transparent about your infection control practices and addressing any questions from your clients will reassure them that you care about their safety and that your office protocols are designed to prevent the spread of infection.

Did you know that critical and semi-critical instruments that will be stored should be wrapped or placed into containers before sterilization?
After thorough cleaning and drying of instruments, critical and semi-critical instruments that will be stored before use should be wrapped or placed into container systems prior to heat sterilization. This step protects items from contamination after the sterilization cycle and during storage.

Photo: © Andrey_Papov/Shutterstock.com
Five Questions to Ask Your Dental Hygienist About Infection Control

1. **How do you sterilize your instruments after use?**

   Current infection control guidelines recommend that instruments that penetrate or contact oral tissue be sterilized using equipment called an autoclave that uses steam and pressure to kill all infectious material. Some may also use sterilizers that use chemicals or dry heat. This process must always be performed before instruments are used on another person. Most dental instruments including handpieces (or dental drills) are designed to withstand repeated sterilization.

2. **How do you know that your sterilizer works properly?**

   Most practices use several methods to tell if their sterilizer is working. The first is by watching the gauges and readouts for proper temperature and pressure. The second is by using a colour-change indicator on their instrument wrapping or packaging. Instruments should be sealed in bags or cassettes with an indicator that changes colour after exposure to high heat, high pressure or other accepted sterilizing conditions. These indicators also tell the office staff that a package has been sterilized. Storing instruments in pouches or wraps ensures that the instruments remain free of any bacteria or germs until use. Your dental hygienist should be opening a new package just for you and will be able to show you these indicators on their packaging. The third test is using a vial or envelope that contains living spores which are then put in a regular sterilizer cycle. This test provides the best guarantee that a sterilizer is working. It can be performed right in the office, but may also be sent out to be checked. Ask to see the records showing that the spore test or biological monitoring has passed. Current guidelines require that a sterilizer that fails a biological monitoring test not be used until it has been shown to be working correctly.

3. **Do you change your gloves for every client?**

   New gloves should be used for all clients. You should see your dental hygienist taking them out of the glove dispenser, not from an unsterilized countertop. Your dental hygienist will take a new pair of gloves if she/he leaves the room or if anything other than sterile instruments or your mouth is touched.

4. **How do you clean the room before I arrive?**

   Between patients, your dental hygienist should disinfect all the surfaces they are likely to touch during treatment. You may also find that some surfaces such as light handles, tubing or control switches are covered with a plastic barrier. These barriers should be removed and discarded between clients. Both of these methods help to eliminate the possibility of transferring germs from a contaminated surface to you. You may find that your dental hygienist uses a combination of disinfecting and barriers to ensure that surfaces in the treatment room are not contaminated.

5. **What if I see you do something that I’m not sure about?**

   If you are unclear on, or uncomfortable with, any of the precautions your dental hygienist takes to protect you, speak up. If necessary, ask to see the office’s sterilizing area. The overwhelming majority of dental hygienists work very hard to ensure that you are protected against cross-contamination during treatment and will be happy to show you what they do to ensure that you are receiving safe care. Feel free to ask questions and communicate any concerns.
The Healing Arts Radiation Protection (HARP) Act, and the X-ray Safety Code (Regulation 543) cover the use of x-rays for the irradiation of human beings in the province of Ontario. These regulations govern radiographic equipment, their operation, and the qualifications of individuals operating them. Section 5(2) of the HARP Act lists members of the College of Dental Hygienists of Ontario (CDHO) as persons deemed to meet the qualifications prescribed by the regulations. This means that even though dental hygienists complete radiography training in a dental hygiene program, they are not considered HARP certified until they are registered with the CDHO. The HARP Act does not approve or certify dental hygiene radiography programs. Only the CDHO has the authority to grant HARP certification to dental hygienists in Ontario. Dental hygienists who currently hold a general or specialty certificate of registration are deemed to be HARP certified. Those who have resigned, are suspended or revoked from the College are not considered HARP certified. The Act also states that an inspector may enter and inspect the premises and require the production of proof that any person who operates an x-ray machine meets the qualifications and requirements. A ministry inspector will accept a dental hygienist’s certificate of registration (or CDHO wallet card) as proof that they meet the requirements.

Dental Hygienists and Radiographic Equipment

Currently in Ontario, a dental hygienist may own an X-ray machine provided they have a designated Radiation Protection Officer (RPO) for their facility. The RPO is responsible for ensuring that the X-ray machine in the facility is maintained in safe operating condition, as well as for other matters related to the safe operation of each X-ray machine in the facility as are prescribed by the regulations. While dental hygienists can take a course that would fully qualify them to be an RPO, according to the HARP Act, they are not listed as a practitioner that is deemed eligible in Ontario. Currently, members of the Royal College of Dental Surgeons of Ontario can be RPOs for a dental facility.

No Supervision Required

Deemed by the HARP Act as a practitioner qualified to operate an x-ray machine, dental hygienists do not require supervision to take radiographs. The Act requires that a client-specific prescription be obtained by an appropriate prescriber for every radiograph that is taken. This implies that radiographs must not be taken on a time-dependent basis (i.e., every six months or every year). This also means that dental hygienists may not take radiographs on a standing order or protocol at any time as this is contradictory to the
Act. Occasionally, clients may present with pain or visual evidence of an oral infection and the dental hygienist would like to take a radiograph of the affected area. However, without a client-specific prescription, the dental hygienist may not proceed to take the radiograph until that radiograph has been prescribed by an appropriate prescriber. Written evidence of any radiographic prescription must be recorded in the client’s record, whether by the prescriber or the dental hygienist. The following are examples of notations that the CDHO would deem acceptable by dental hygienists to meet the requirement of the recordkeeping regulation when recording evidence of a radiographic prescription:

- FMX (12 PA’s) as per Dr. X
- 2 BW’s as per Dr. X

The CDHO does not require its registrants to record the rationale for the radiographs they take unless the prescriber indicates otherwise. Although dental hygienists do not currently have radiographic prescribing rights, dental hygienists are educated and skilled to interpret radiographs and use their findings in dental hygiene treatment planning. The College expects that dental hygienists will record their radiographic interpretations within the client record. For example: radiograph shows evidence of advanced bone loss on 36D.

**Refusal of Radiographs**

Clients at times may refuse the radiographs that have been prescribed. In cases like this, the decision to proceed with dental hygiene treatment requires the dental hygienist to evaluate whether or not the risks of treating without a radiographic assessment outweigh the benefits to treatment. Either way, the dental hygienist would be wise to ensure the client fully understands the need for the radiographs and record the client’s informed refusal.

**Use of Dosimeters**

The College receives a lot of calls regarding dosimeters and whether or not they are mandatory. A dosimeter is a device used to measure an accumulative amount of ionizing radiation the wearer has been exposed to. In Health Canada’s *Radiation Protection in Dentistry: Recommended Safety Procedures for the Use of Dental X-Ray Equipment (Safety Code 30)*, it is very strongly recommended that all operators of dental x-ray equipment wear personnel dosimeters. However, in Ontario, the HARP Act does not require this, and the use of dosimeters while advised is not mandatory.

**References**


**RDH Expertise for RDHs**

CDHO practice advisors provide confidential consultations to dental hygienists who seek assistance with issues that directly or indirectly affect the delivery of safe, competent, ethical dental hygiene care.

To reach a CDHO practice advisor by phone or e-mail:

**416-961-6234 or 1-800-268-2346**

**Robert Farinaccia**, RDH ext. 237
rfarinaccia@cdho.org

**Cathy Goldberg**, RDH ext. 238
cgoldberg@cdho.org
Update on 2013 Portfolio Assessments

In January 2012, letters were sent to 1633 registrants requesting their portfolio submission by January 31, 2013. Of the 1633 portfolios requested, 1397 registrants have completed their assessment and have met the assessment guidelines. This includes registrants who have resigned from the College and those who have been exempted or who have been deferred to the next assessment period. There are 236 registrants still in the assessment process. This includes registrants who have additional information to submit to the Committee, those who are awaiting a second assessment and those who have received time extensions for submissions.

Of the portfolios that did not meet the guidelines on the first assessment, there were a number of common deficiencies that should be easily corrected in future submissions. Common deficiencies found in the portfolios included: insufficient time spent on continuing quality improvement activities; completing activities listed as unacceptable in the Continuing Competency Guidelines; and not providing an explanation of how learning benefitted clients. Many portfolios were also submitted that were missing forms or required information. There were also a number of registrants who reported expired CPR certification. Registrants who are not familiar with the Continuing Competency Guidelines will find them to be very helpful in guiding continuing quality improvement activities and recording learning outcomes. The majority of people who did not meet the guidelines were unfamiliar with them and/or had not viewed the portfolio tutorial. The guidelines and tutorial are on the USB memory stick the College provided all registrants and can also be accessed on the CDHO website.

Preliminary Results of the Registrant Survey

In the fall of 2012, the CDHO commissioned Testing for Competence and Dr. Marla Nayer, PT, PhD, to conduct a survey of registered dental hygienists in the province to get feedback on their experiences with the current Quality Assurance Program. Approximately 4700 dental hygienists voluntarily responded to the survey and provided valuable input for the Committee’s consideration in their evaluation of the program. The preliminary results of the survey were received by the Committee and will be considered along with other data collected to date from various sources and stakeholders. This data includes that collected from a public opinion poll, a QA Assessor survey, a review of college documentation and the QA database. A complete analysis of the collected data will be performed and the full report of the Committee’s evaluation of the program will be available in the fall.

Did you know that the College has a list of topics for learning goals?

The Guidelines for Continuing Competency (Section F of the portfolio package) suggests clinical practice learning goals and learning activities that would satisfy the Quality Assurance Program. Some suggested topics for learning goals include: dental hygiene science, dental hygiene practice, ethical and legal obligations, communication, cultural awareness and inclusive practice, infection control, record keeping, self-initiation, access to care, inter-professional collaboration, radiography, WHIMIS and process of care.

Did you know that 81% of people would be less inclined to visit a dental hygienist who did not participate in on-going education and training?

According to a 2011 Ipsos Reid public opinion poll, Ontarians feel that continuing education is important for dental hygienists. In fact, 81% of those polled reported that they would be less inclined to seek care from dental hygienists who did not participate in on-going education and training.
**Question:** Overall, do you consider the current CDHO Quality Assurance Program to be acceptable?

- Yes: 63%
- No: 37%

**Question:** In 2010, the Quality Assurance Committee addressed concerns expressed by registrants that a one-year “snapshot” of their learning activities did not always provide a true picture of continuing competency activities over time by giving registrants a full years’ notice and by asking them to submit three years’ worth of continuing education activities in portfolio submissions. Does the three-year submission provide you with a better opportunity to demonstrate competency over time and accommodate high and low activity years?

- Yes: 43%
- No: 57%

**Question:** How much time did it take for you to create your first portfolio (not including time spent doing continuing education activities)?

- 1-5 h: 6%
- 6-10 h: 11%
- 11-15 h: 13%
- 16-20 h: 14%
- 21-30 h: 9%
- 30+ h: 7%

**Question:** Do you feel that reporting on your continuing education activities on Forms 6, 7, and 8 allowed you to demonstrate that you were maintaining their competency?

- Yes: 66%
- No: 27%
- N/A: 7%

**Question:** Overall, do you consider the current CDHO Quality Assurance Program to be acceptable?

- Yes: 47%

**Question:** Do you feel that the “Typical Day” allows you to demonstrate that your practice meets standards?

- Yes: 34%
- No: 60%
- N/A: 6%
**Question:** In the last year, how long did it take you to maintain your portfolio?

<table>
<thead>
<tr>
<th>h = hours</th>
<th>1-2 h</th>
<th>3-4 h</th>
<th>5-6 h</th>
<th>7-8 h</th>
<th>9-10 h</th>
<th>10+ h</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>5%</td>
<td>9%</td>
<td>11%</td>
<td>10%</td>
<td>7%</td>
<td>49%</td>
</tr>
</tbody>
</table>

**Question:** Is it easy to complete the supplied portfolio forms on the computer?

<table>
<thead>
<tr>
<th>Did not use</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>9%</td>
<td>49%</td>
</tr>
</tbody>
</table>

**Question:** Do you find the CHDO Portfolio Guide to be helpful in creating and/or maintaining your portfolio?

<table>
<thead>
<tr>
<th>I was not aware of the Guide</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>15%</td>
<td>58%</td>
</tr>
</tbody>
</table>

**Question:** Have you contacted the CDHO with questions about the QA program?

<table>
<thead>
<tr>
<th>I was not aware of the Guide</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>35%</td>
<td>65%</td>
</tr>
</tbody>
</table>

**Question:** Do you complete the self-assessment tool annually?

<table>
<thead>
<tr>
<th>I was not aware of the Guide</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>59%</td>
<td>41%</td>
</tr>
</tbody>
</table>

**Question:** Do you find the self-assessment tool to be helpful in establishing your learning goals for your professional portfolio?

<table>
<thead>
<tr>
<th>I was not aware of the Guide</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>33%</td>
<td>67%</td>
</tr>
</tbody>
</table>
Question: What barriers (if any) limit your ability to participate in the required CQI activities?

- No barriers: 17%
- Time: 65%
- Cost: 36%
- Ability to travel: 16%
- Other: 6%

Question: Do you feel that the decision regarding your assessment was clear?

- Yes: 11%
- No: 89%

Question: Would you prefer to select your continuing education activities from a list restricted only to approved courses or activities?

- Yes: 56%
- No: 44%

Question: Would you prefer to write a multiple-choice exam instead of recording your typical day in your portfolio?

- Yes: 66%
- No: 34%

Question: Would you prefer to be randomly selected to complete an onsite assessment instead of recording your typical day?

- Yes: 10%
- No: 90%

Question: Would you prefer to be randomly selected to be examined on a one-to-one basis with one or two examiners and either real or simulated clients instead of recording your typical day in your portfolio?

- Yes: 6%
- No: 94%
Is it mandatory to take my client’s blood pressure? A question that is very familiar with the Practice Advisors at the College and a question that warrants some discussion.

First, let’s explain what hypertension is and why being familiar with a client’s risk of hypertension is important for oral health professionals. Hypertension refers to a condition where blood pressure persistently exceeds specified limits.1 If there is no identifying cause to the hypertension, it is referred to as primary (essential) hypertension and most people diagnosed with hypertension fall into this category. If there is an identifiable cause, then it is referred to as secondary hypertension. Some of the conditions that can cause secondary hypertension are malfunctioning bodily organs, malfunctioning bodily systems, drugs and drug interactions.

In determining whether someone is hypertensive, blood pressure needs to be evaluated. Blood pressure can be defined as the force on the walls of the arteries as the blood circulates. It is measured with two different values, systolic pressure and diastolic pressure.

A systolic value represents the pressure on the walls of the arteries when the heart is contracting. More specifically, it signifies the maximum arterial pressure during contraction of the left ventricle. Diastolic values on the other hand, represent the pressure on the walls of the arteries when the heart is in a state of relaxation and is filling with blood. The numbers are written as systolic/diastolic and the unit of measurement is millimetres of mercury (mmHg). The higher one’s systolic or diastolic pressure is and the longer these numbers are high, the more damage occurs to the blood vessels.2

Hypertension is one of the leading health problems in Canada and can cause strokes, heart attacks, heart failure, kidney failure, and also contribute to dementia and sexual problems.3 Discovering and ensuring that high blood pressure is treated early can help prevent these potential problems.

More than one in five Canadian adults currently suffer from hypertension and the lifetime risk of developing hypertension is approximately 90%.4 Hypertension may remain an asymptomatic disease with the only sign being elevated blood pressure, and for this reason, it is known as “the silent killer”. With the absence of symptoms, screening for hypertension falls to the health care community. Since many people attend dental appointments at least once or more every year, oral health professionals have the perfect opportunity to play a vital role in the detection and management of hypertension.

Through their education, dental hygienists are taught that a thorough medical history is required to determine the client’s health status, risks, disease severity, contraindications to care, the necessity for medical consultation and considerations for medical emergency prevention. Dental hygienists recognize that the timing of dental hygiene care is significantly influenced by the client’s health status. As part of taking a thorough medical history, evaluating a client’s blood pressure is often overlooked. We must ask ourselves why. Is it because a client on hypertensive medication is already being monitored by their physician? Or is it because time is limited and obtaining a measurement of blood pressure may not be feasible with an already condensed appointment schedule?
Is it mandatory to take my client’s blood pressure?

All dental hygienists need to ensure that they are not putting their clients at risk while providing dental hygiene treatment. The College of Dental Hygienists of Ontario (CDHO) requires that blood pressure be taken on clients whose medical history indicates a need (i.e., clients with known hypertension, cardiovascular disease, diabetes, and chronic kidney disease, and this list is not exhaustive). The Hypertension Advisory on the CDHO’s Knowledge Network not only provides information on conditions which may cause hypertension, but also contains a table that has the Canadian Hypertension Education Program (CHEP) Recommendations and CDHO advice regarding appropriateness of treating clients who present with various blood pressure ranges. This table lists systolic and diastolic ranges and provides advice on how a dental hygienist should proceed given the result of a client’s blood pressure measurement. Treating a client with an elevated blood pressure can increase the client’s risk of experiencing a hypertensive crisis (where a severe increase in blood pressure can create an emergency) and possibly lead to a cerebrovascular accident (stroke) or myocardial infarction in the dental chair. If the presence of hypertension is suspected, the dental hygienist should make an appropriate referral to the client’s primary care provider and should proceed only after medical consultation with the primary care provider establishes that it is safe to do so.

For clients whose medical history is clear, the CDHO encourages dental hygienists to take a blood pressure reading as part of their baseline assessment. If the client’s blood pressure is within the normal range, it may not be necessary to take that client’s blood pressure every appointment. However, in the interest of being proactive, it would be prudent to periodically monitor the client’s blood pressure to ensure that there have been no significant changes since it is well known that hypertension can be asymptomatic.

References

Did you know that a target blood pressure differs for diabetics and the very elderly?

According to the Canadian Hypertension Education Program (CHEP), target blood pressure should be less than 140/90 mmHg in most patients, including those with chronic kidney disease. In patients with diabetes, blood pressure targets are less than 130/80. In the very elderly (age 80 years or greater), the systolic target is 150 mmHg.
On February 2, 2009 the College of Dental Hygienists of Ontario’s (CDHO) Knowledge Network was born. With this initiative, the CDHO took a historic step in providing dental hygienists, other health professionals and the general public, access to a tool that assisted dental hygienists in navigating scientific medical knowledge into point-of-care decisions.

Advisories were developed for medical conditions that many clients presented with. In just four short years, the Knowledge Network grew from 23 comprehensive advisories to over 60. The intention of the advisories and the format they are presented in is primarily to provide current evidence-based medical research to dental hygienists in a well-organized and effective format so that they can apply relevant medical knowledge to client care. The College has allowed open access to the advisories so that they can be used as references by the dental hygiene community, dental hygiene clients, members of the public and other health care professionals.

The College has recently added quick reference Factsheets to the Knowledge Network. The Factsheets provide less detail than the advisories, making them a “quick read” for dental hygienists and their clients who are collaborating on:

- whether a medical consultation is advised;
- whether medical clearance is required;
- whether antibiotic prophylaxis is advised; and
- whether postponing treatment is advised.

The Factsheets will also provide information on the signs and symptoms, the oral manifestations and the oral management implications associated with a particular condition.

**How to Find and Use the New Factsheets**

The Factsheets can be accessed by visiting the Knowledge Network web page. If a Factsheet has been created, it will be listed alphabetically by condition. The following Factsheets are now available:

- Chickenpox
- Crohn’s Disease
- Head Lice
- Impetigo
- Measles
- Mononucleosis
- MRSA (Methicillin Resistant Staphylococcus Aureus Carriage/Infection)
- Mumps
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Rubella (German Measles)
- Shingles (Herpes Zoster)
- Strep Throat (Group A Strep)
- Tuberculosis
- Ulcerative Colitis

The new Factsheets are not intended to replace the current Knowledge Network advisories but rather, to be a quick chair-side reference available to dental hygienists while they are treating their clients. Dental hygienists are welcome to print the Factsheets and keep them chair-side if they wish.

http://www.cdho.org/Advisories/CDHO_Factsheet_Mononucleosis.pdf
LETTER OF APOLOGY

From time to time, your colleagues make decisions that require an intervention by your regulatory college. Ideally, this would never happen but none of us lives in an ideal world. In some cases, a registrant recognizes the error of their ways and seeks to atone for their errors and get on with the professional responsibilities of a dental hygienist. See below for a public apology that represent a new start for such a registrant.

Josiane Mwanga
3031 Raudot
Montreal, Qc
H4E 2R5

College of Dental Hygienists of Ontario
69 Bloor Street East, Suite 300
Toronto, ON
M4W 1A9

Letter of apology

To the College of Dental Hygienist of Ontario

I apologize to the College Of Dental Hygienist of Ontario for my error of non-payment of annual membership fee and practicing when certificate of registration was inactivated.

I have been made fully aware of my responsibilities to the college, its registrants and the public. I will continue to hold myself accountable for my actions.

I understand the duty of the College to uphold the rules and regulations of the Dental Hygiene Act and the Regulated Health Professions Act. I will comply with such rules and regulations going forward.

Respectfully,

Josiane Mwanga
2. People with this disease are more likely to have periodontitis than people without it, probably because they are more susceptible to contracting infections.

4. Type of radiograph that is best for interpreting posterior alveolar bone levels.

7. A space between two adjacent teeth.

10. Inflammation of the operculum or tissue flap over a partially erupted tooth.

11. More reliable marker for disease progression than probing depth measurements (3 words).

13. A fluid substance formed within tissues as a result of inflammation.

14. Term used to describe 3-4 mm of clinical attachment loss.

16. Inflammation of the gingiva without involvement of the underlying bone or periodontal attachment.

17. Space between the tooth and the marginal gingiva in gingival health.

19. Type of periodontitis formerly known as adult.

20. Chemical wearing away of a tooth.

21. Connective tissue covering the outer surface of bone.

24. Type of periodontitis formerly known as localized juvenile (2 words).

25. Class of broad spectrum antibiotic used for periodontal infections.

27. The length of the gingival connective tissue and the junctional epithelium (2 words).

29. Localized purulent inflammation in the periodontal tissues (2 words).

31. Type of periodontitis formerly known as early onset.

32. The use of plastic and _____-coated curettes is recommended to protect the titanium implant surface and the titanium abutment from contamination by other metals.

33. Name of procedure for gingiva taken from an area in the patient’s mouth, usually the palate and used to increase the amount of attached gingiva (3 words).

35. Term used to describe an area of isolated bone loss.

36. The study of supporting structures of teeth, diseases, and the conditions that affect them.

37. The excision or removal of the soft tissue walls in order to eliminate a pocket.

38. Bone loss of less than 20% is usually classified as _____ bone loss.

39. A valley-like depression of the interdental gingiva (just below the contact of the tooth) that connects the facial and lingual papillae.

40. The primary component of the connective tissue of the periodontium.

41. Caused by dental or medical treatment; abnormal condition induced by a clinician.

42. The thin, calcified tissue of ectomesenchymal origin covering the roots of teeth in which embedded collagen fibers attach the teeth to the alveolus.

Did you know that comprehensive periodontal evaluations should be part of an on-going diabetes management program?

The American Academy of Periodontology (AAP), in collaboration with the European Federation of Periodontology (EFP), recently published a series of consensus reports that analyze the scientific evidence linking periodontal disease, specifically periodontitis, to other systemic diseases, including diabetes. One of the conclusions in the report stated that “…there is an independent association between moderate to severe periodontitis and an increased risk for the development or progression of diabetes. Periodontal interventions may provide beneficial effects on diabetes outcomes in some patients, so regular comprehensive periodontal evaluations should be part of an ongoing diabetes management program.”
The answers to this Crossword Puzzle will be posted on the last page of our July 2013 online issue of Milestones at www.cdho.org
As oral health care providers, dental hygienists and dentists know that oral health plays a vital role in overall health. The 2008 Canadian Dental Association’s Report on Seniors’ Oral Health Care recognized that many seniors face substantial barriers and profound disparities in accessing needed dental services, resulting in poor oral and general health outcomes. The report recommended, among others, that an increased focus was needed in education, and delivery of care models.¹

On a national and provincial level, dental hygienists’ associations and educational institutions have also recognized this need and have been actively promoting education in geriatrics and alternative dental hygiene delivery models. But are individual dental hygienists thinking about the needs of a rapidly growing sector of society?

There are many barriers to oral health care in Ontario such as financial, cultural, organizational and social that affect how and if segments of populations will access oral health care. That means that access measured in terms of utilization is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply.² With an estimated current population of over 13.5 million people dispersed rather disproportionately, will Ontario have an adequate number of oral health care professionals willing and able to provide quality services to its aging population in an effective, accessible and affordable manner?

The number of seniors aged 65 and over is projected to more than double from 1.9 million, or 14.2 per cent of the population in 2011, to

Did you know several regulated health professions are permitted to perform acupuncture?
Several other Ontario regulated health professions are permitted to perform acupuncture as long as they are practising in accordance with the rules and regulations of their respective colleges. This includes chiropody, chiropractic, dentistry, massage therapy, nursing, occupational therapy, physiotherapy and naturopathy.
4.2 million, or 23.6 per cent, by 2036. By 2017, for the first time, seniors will account for a larger share of population than children aged 0–14 partly because Ontario has one of the highest levels of life expectancy in both Canada and among the countries of the developed world. By 2036, life expectancy is projected to reach 85.3 years for males and 87.8 years for females. This means total gains of 6.3 years for males and 4.4 years for females between the years 2007 and 2036.³

Ontario seniors are living longer than before and as a result, many are keeping their teeth longer as well. Oral care will be needed more than ever to help these seniors not only live healthy lives but also to help them maintain proper oral function. While some seniors grow old without any medical complications, many will require medications to treat different ailments and conditions. Some may have compromised immune systems making oral care that much more important in helping to prevent oral infections.⁴ Frailty and physical disabilities can also play a significant role at this stage of life. Some seniors may no longer be able to get to a setting where oral care is traditionally offered. Many seniors who are residents of long-term care homes and/or have mobility issues may find getting oral care services in their place of residence difficult.

The change in legislation that allowed dental hygienists to be authorized to self-initiate validates the position of the CDHO and the conclusion made by the Health Professions Regulatory Advisory Council in 1996, that the removal of the order requirement from the Dental Hygiene Act, 1991 satisfies the public interest in terms of access to care. Dental hygienists who are authorized to self-initiate may choose to provide dental hygiene care to seniors (and many do) through mobile dental hygiene services travelling to private and community homes. Getting the necessary legislation in place to permit dental hygienists to work without an order from a dentist is one way the College has worked to increase access to oral care services for seniors. Dental hygienists can play an important part in the solution to eliminate the barriers and assure quality oral health care for all seniors. As regulated health professionals, dental hygienists are competent to provide services to seniors in a variety of settings more accessible to clients such as residences of the homebound, public health, community clinics, and more.⁵

### Did you know that April 1, 2013 changed who could legally provide acupuncture or use the title acupuncturist?

Legislation in Ontario is now in place that protects the title “acupuncturist”, a variation or abbreviation or an equivalent in another language. Anyone claiming to be an acupuncturist must register with the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario. Anyone practising acupuncture while not being a member of CTCMPAO could face a fine of up to $25,000 for a first offence and up to $50,000 for subsequent offences. Acupuncture is not within the scope of practice for dental hygienists in Ontario.
What does this all mean?

With an increase in the aging population, it becomes evident that the delivery of care model for seniors may continue to shift from clients receiving care in traditional dental/dental hygiene settings to dental hygienists bringing their services to the client. Dental hygienists should look to get involved with other health care providers that deal directly with seniors to help ensure that senior’s oral care needs are being addressed. This is a perfect opportunity to play an active role in a senior’s circle of care.

Demographics of Ontario’s Senior Population and RDH in Ontario

<table>
<thead>
<tr>
<th>District</th>
<th>RDH*</th>
<th>Population of Seniors (65+) (2013)**</th>
<th>Ratio of Seniors per RDH*</th>
<th>Dental Hygiene Schools*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Bruce, Grey, Elgin, Essex, Huron, Kent, Lambton, Middlesex, Oxford, Perth</td>
<td>1377</td>
<td>274,050</td>
<td>199:1</td>
<td>2</td>
</tr>
<tr>
<td>2 Wellington, Simcoe, Dufferin and the regional municipalities of Halton and Peel</td>
<td>2511</td>
<td>366,070</td>
<td>146:1</td>
<td>1</td>
</tr>
<tr>
<td>3 Brant and the regional municipalities of Haldimand-Norfolk, Hamilton-Wentworth, Niagara and Waterloo</td>
<td>1659</td>
<td>287,280</td>
<td>173:1</td>
<td>2</td>
</tr>
<tr>
<td>4 York and Metropolitan Toronto</td>
<td>3606</td>
<td>541,380</td>
<td>150:1</td>
<td>6</td>
</tr>
<tr>
<td>5 Frontenac, Peterborough, Hastings, Lanark, Lennox and Addington, Prince Edward, Victoria, Haliburton, Northumberland and the regional municipality of Durham</td>
<td>1201</td>
<td>218,720</td>
<td>182:1</td>
<td>1</td>
</tr>
<tr>
<td>7 Algoma, Cochrane, Manitoulin, Muskoka, Nipissing, North Bay, Parry Sound, Sudbury and Timiskaming</td>
<td>635</td>
<td>121,010</td>
<td>191:1</td>
<td>3</td>
</tr>
<tr>
<td>8 Rainy River, Thunder Bay and Kenora</td>
<td>237</td>
<td>39,200</td>
<td>165:1</td>
<td>1</td>
</tr>
</tbody>
</table>

* All CDHO statistics current as of May 29, 2013
** Population Statistics and Estimates current as of Spring 2012 and Courtesy of the Ontario Ministry of Finance

References
1 Canadian Dental Association Report on Seniors’ Oral Health Care
   http://www.adha.org/resources-docs/7112_Access_to_Care_Position_Paper.pdf

Did you know that peer mentors are not responsible for client care delivered by their mentees?

Peer mentors are a resource to dental hygienists who have been authorized to self-initiate with the condition that they work with a peer mentor. While discussions about client care are part of the mentoring, the mentee’s treatment planning and clinical skills are already proven to be sound. As registered dental hygienists, mentees are fully responsible for all client care decisions and interventions.
In a hearing held on March 18, 2013, a Panel of the Discipline Committee found Ms. Fabrizia Couteiro guilty of professional misconduct in that she contravened or failed to maintain a standard of practice; failed to keep records in accordance with generally accepted standards of practice or the regulations; failed to take steps to ensure information provided to the College was accurate; failed to cooperate with a College investigator or to provide access to and copies of all records to a College investigator; and engaged in conduct that was unbecoming a dental hygienist.

An Agreed Statement of Facts was filed with the Panel which included the facts that Ms. Couteiro submitted an insurance claim form for dental hygiene services that were provided to her husband when the services were actually provided by another dental hygienist, Ms. D.B. Ms. Couteiro billed for three units of root planing without confirming that the services provided were actually three units of scaling and she assigned Mr. Couteiro’s insurance benefits to herself on the claim form. Ms. Couteiro billed $120.00 for the dental hygiene services, even though Ms. D.B. did not receive any payment from either Mr. or Ms. Couteiro. She did so under the belief that the services could nonetheless be billed by her clinic, and after learning that the claim was denied, Ms. Couteiro charged her husband $120.00 for dental hygiene services that were provided to him without charge by Ms. D.B.

It was also agreed that Ms. Couteiro created a client ledger and a duplicate client chart for her husband, which implied that he had obtained dental hygiene services through her business, Fabulous Smiles Inc. Mr. Couteiro received treatment from Ms. D.B. on September 22, 2011, but the client chart created by Ms. Couteiro and the insurance claim she submitted identified the treatment date as September 23, 2011.

Furthermore, it was agreed that when requested by a College of Dental Hygienists of Ontario investigator for Mr. Couteiro’s client record, Ms. Couteiro told the investigator that she was not in possession of her husband’s client chart. However, when the investigator was taken to the client charts, she was able to retrieve a client chart for her husband, which included client information, appointment list, insurance claim submitted, client route slip, client ledger and appointment schedule. Ms. Couteiro also agreed that she made an incorrect statement to the College investigator when she stated that she paid Ms. D.B. $35.00 in cash to treat Mr. Couteiro. She agreed that she did not make reasonable efforts to ensure that her answer to the College investigator was correct. Ms. Couteiro also agreed that she instructed Ms. D.B. to provide her husband with three units of scaling prior to Ms. D.B. doing her assessment of Mr. Couteiro’s needs.

The parties filed a joint submission with respect to an appropriate penalty and costs order to be made in this case. The Panel carefully considered the Agreed Statement of Facts, the Joint Submission on Penalty and Costs, the case law cited, the oral submissions made and concluded that the proposed Order met the needs of this case and the principles appropriate to setting the penalty. Accordingly, the Panel accepted the joint submission and made the following Order:

1. That Ms. Couteiro shall receive a reprimand, the fact of which shall be recorded on the public register of the College.
2. That the Registrar suspend Ms. Couteiro’s certificate of registration for a period of eight (8) weeks, to be served on dates to be set by the Registrar.
3. That Ms. Couteiro pay a fine to the Minister of Finance in the amount of $250.00 to be paid within thirty (30) days from the date of the Order.
4. That the Registrar impose a specified term, condition and limitation on Ms. Couteiro’s certificate of registration requiring her to successfully complete, in the opinion of
the Registrar, an approved ethics course, at her own cost, within eight (8) months from the date of the Order.

5. That Ms. Couteiro pay costs to the College in the amount of $2400.00 at the rate of $100.00 per month by way of post-dated cheques for twenty-four (24) months, starting on the 15th day of the first month after her suspension has been fully served. No interest will accrue on the outstanding amounts so long as they are paid on time. At all times, Ms. Couteiro shall be at liberty to increase the amount of her monthly payment, solely at her discretion.

The Panel was of the opinion that the penalty imposed appropriately addressed the principles of penalty which include public protection, general deterrence and specific deterrence.

Ms. Couteiro committed acts of professional misconduct by creating a client chart and ledger that implied that she had provided dental hygiene services, when she had not, failed to maintain a standard of practice, and engaged in unethical and dishonest conduct. The Panel was extremely concerned by these facts, and so directed the Registrar to impose a specified term, condition and limitation on Ms. Couteiro’s certificate of registration requiring her to successfully complete an approved ethics course, at her own cost, within eight (8) months from the date of the Order. The Panel expects that this course will assist to rehabilitate Ms. Couteiro and impress upon her the obligation to conduct her practice in an ethical and honest manner.

Ms. Couteiro’s certificate of registration was also suspended for a period of eight (8) weeks. The suspension reflects the serious acts of professional misconduct committed by her. She will have no income from a dental hygiene practice during the period of suspension. She is also required to pay a fine and costs. Specifically, Ms. Couteiro was ordered to pay $2400.00 toward the College’s costs of the investigation and hearing process, as well as a fine of $250.00 to the Ministry of Finance within thirty (30) days of the Order. Moreover, other Registrants will also have the opportunity to read this Order and reasons (in print and on the CDHO website). This will make clear that the College will not tolerate acts of professional misconduct. It is the Panel’s belief that the penalty in its totality will act as both a general and specific deterrent.

The Panel considered the following mitigating factors in this case:

- Ms. Couteiro had no prior record of professional misconduct
- There was an admission of professional misconduct by Ms. Couteiro
- Ms. Couteiro was eventually cooperative with the College
- Her guilty plea spared the necessity of calling witnesses

The Panel reviewed penalties given in two (2) cases with aspects similar to those of Ms. Couteiro’s case and was satisfied that the penalty was within the range of what is reasonable and appropriate.

At the conclusion of the Hearing, Ms. Couteiro waived her right of appeal and the reprimand, as part of the penalty, was administered by the Panel.

WENDEL WASHINGTON McFARLANE – 008694

City: Hamilton

In a hearing held on March 18, 2013, a Panel of the Discipline Committee found Mr. Wendel McFarlane guilty of professional misconduct in that he contravened the Regulated Health Professions Act, 1991, the Dental Hygiene Act, 1991, or the regulations thereunder and engaged in conduct that was unbecoming a dental hygienist, was disgraceful, dishonourable or unprofessional in that he failed to reply appropriately to the College, and failed to comply with a direction of a panel of the College.

The Notice of Hearing contained the following allegations:

1. Mr. McFarlane was a duly registered dental hygienist authorized to practise in Ontario until his certificate of registration was suspended for non-payment of fees on or about February 24, 2012.

2. It was alleged that on or about April 20, 2011, the Quality Assurance Committee of the College directed Mr. McFarlane to submit a personal learning plan or sign an Undertaking not to practise as a dental hygiene educator until a deficiency related to student assessment and evaluation was addressed.

3. It was alleged that Mr. McFarlane failed to comply with the direction of the Quality Assurance Committee and did not respond to further correspondence from the College.

4. It was alleged that on or about August 3, 2011, the Quality Assurance Committee referred Mr. McFarlane to the Inquiries, Complaints and Reports Committee for failing to comply with the Quality Assurance Committee’s direction.
5. After investigating the matter, it was alleged that on or about January 26, 2012, the Inquiries, Complaints and Reports Committee ordered Mr. McFarlane to appear before it to be cautioned with respect to his failure to initially comply with the Quality Assurance requirements and his failure to respond to numerous inquiries from the College.

6. It was alleged that on or about March 22, 2012, the Deputy Registrar of the College wrote to Mr. McFarlane advising him of the requirement to appear before the Inquiries, Complaints and Reports Committee for an oral caution, and requested that he confirm that he would attend the caution by April 5, 2012.

7. It was alleged that Mr. McFarlane failed to confirm by April 5, 2012, or at any time thereafter, that he would attend the caution, as requested by the Deputy Registrar.

8. It was alleged that a further letter was sent to Mr. McFarlane on April 25, 2012 reminding him of the upcoming caution on May 3, 2012. Mr. McFarlane failed to respond to that letter.

9. It was alleged that Mr. McFarlane failed to appear before the Inquiries, Complaints and Reports Committee on May 3, 2012 to be cautioned.

10. It was alleged that the conduct described above constituted professional misconduct under Section 15 of Ontario Regulation 218/94, as amended to Ontario Regulation 36/12, under the Dental Hygiene Act, 1991, being: paragraph 43 (failed to reply appropriately to the College), and/or paragraph 45 (failure to comply with an order of a panel of the College), and/or paragraph 47 (contravened by act or omission the Dental Hygiene Act, 1991 or a regulation thereunder), and/or paragraph 52 (disgraceful, dishonourable or unprofessional conduct), and/or paragraph 53 (conduct unbecoming a dental hygienist).

An affidavit of service was filed showing that Mr. McFarlane was duly informed of the date, time and place of the hearing, pursuant to Part IV of the Dental Hygiene Act, 1991. After an appropriate interval, the hearing commenced without his presence and/or that of his legal counsel. A plea of “not guilty” was entered, given Mr. McFarlane’s failure to attend upon the hearing. When a registrant refuses or fails to appear at a discipline hearing, when duly served, the Discipline Committee has the jurisdiction to proceed with the hearing in the absence of the registrant. A registrant cannot avoid the discipline process by a failure to respond to the Notice of Hearing.

The College filed a Book of Documents and called witnesses to support the allegations in the Notice of Hearing. The Panel considered the documentary evidence and oral testimony and found that the allegations of fact set out in the Notice of Hearing were supported by the information contained in the Book of Documents and further supported by the testimony of the witnesses. The Committee found specifically that Mr. McFarlane failed to co-operate with the College as required under the Regulations. He did not respond to any of the written or telephone communications from the College and did not comply with the requests of the Inquiries, Complaints and Reports Committee.

The Panel made the following order on penalty and costs:

1. Mr. McFarlane’s certificate of registration shall be revoked.

2. Mr. McFarlane shall pay to the College the amount of $10,000.00 in costs within 30 days of the Discipline Panel’s Order becoming final.

The revocation Order was appropriate given the seriousness of the misconduct. It was justified as necessary in the circumstances of this case to uphold the College’s mandate to protect the public against ungovernable registrants.

By way of general deterrence, the seriousness of the penalty communicates to the profession that such misconduct will not be tolerated. By way of specific deterrence, it tells the registrant that the College will punish acts that disregard the College’s public protection mandate.

The Panel wanted to send a strong message that compliance with the regulatory requirements for dental hygienists was fundamental to the practice of dental hygiene. Cooperation with the College in its public duties and compliance with orders made by the College was expected. Mr. McFarlane’s failure to respond to the College, and his failure to comply with a direction of the Quality Assurance Committee and an order of the Inquiries, Complaints and Reports Committee, demonstrated a blatant disregard for the laws that govern dental hygienists in Ontario.

The Panel also considered the following aggravating factors in this case:

- Previous Inquiries, Complaints and Reports Committee decisions regarding Mr. McFarlane’s failure to provide updated contact information to the College
- Failure to respond to numerous communications from the College over an extended period
- Disrespect for the legislative mandate of the College
- Conduct that clearly indicated that the registrant was ungovernable
- Failure to respond to the Notice of Hearing.
REGISTRANTS UPDATE

New Registrants
February 15, 2013 to May 31, 2013

Abbott, Kenndra Deborah 016532
Akhtar, Nahrain 016471
Aldridge, Carla Elizabeth 016503
Antonyuk, Iryna 016454
Arifova, Elzara 016506
Aujla, Dimple 016484
Badhwar, Manvi 016502
Beacock, Natalie Grace Marie 016445
Berenblut, Nava 016500
Billings, Lisa Marie Frances 016500
Bisson, Natalie 016464
Boyd, Jessica 016475
Brown, Shawna Louise 016430
Cavan, Riza 016462
Cheng, Jiexin 016459
Ciacomini, Adriane 016488
Cotter, Sheria 016461
De Mel, Prashangi 016469
Demers, Robyn Jeanne 016426
Dosanjh, Pawandeep 016422
Dubreuil, Ainsley Marie 016525
Dufour, Emilie 016481
Ellsworth, Shannon 016531
El-Sabbagh, Gabrielle 016440
Fotheringham, Deborah Ann 016501
Franks, Lisa 016533
Ghandour, Ryma 016444
Giacomini, Adriana 016417
Giannetto, Lisa Marie 016488
Gill, Jaspreet 016499
Gonzalez Sapene, Alejandra 016427
Gunderson, Coreen 016477
Habas, Natasha Saverna 016427
Hadjazadeh-Raeissi, Yasamin 016457
Hawass, Eman 016449
Henningson, Kyra Merle 016489
Henry, Drew 016497
Hill, Jessica Lyndsi 016424
Howes, Shannon Marie 016433
Hurst, Katelyn Elizabeth 016529
Iveges, Amanda Alexandra 016435
Jain, Rekh 016507
Jatoi, Uzma 016452
Jonkman, Brooke 016438
Joya, Zohal 016497
Kabourian, Christina 016523
Kaczynski, Kelly Ann 016463
Kaur, Kamalpreet 016528
Kaur-Bhatti, Sukhvir 016447
Kelly, Lindsay Ann 016509

Khimani, Majida 016467
Khuram, Saleha 016414
Kidane, Salem 016465
King, Kristyn 016418
Knechtel, Kelly 016527
Kohl, Kashish 016495
Kosanyi, Laurie Teresa 016473
Kotanko, Michelle Lisa 016494
Lachapelle, Celine 016530
Lad, Amisha Pravin 016432
Lake, Ashley 016421
Latorre, Liliana 016455
Lavinde, Elena 016508
Law, Lacey 016504
Lee-McGrath, Anita 016419
Lin, Yong 016474
Linklater, Lisanne 016511
Malbarosa, Rowena 016537
Manga, Denisia 016483
Mansahia, Jasmine 016518
Marcelo, Maria Carlyn Castro 016492
Mares, Daviana 016470
Marquess, Nataly 016468
May, Candace Lynn 016539
McPhee, Meghan Celina 016513
Michaud, Jessica Lynn 016423
Minc, Alexandra 016522
Mo, Zhi Ying 016466
Molloy, Britney Nicole 016487
Moreno Rodriguez, Hiliana 016510
Naraine, Carolyn Alexandra 016517
Nourzadeh, Maci 016519
Nowshin, Tahmina 016482
Omar, Aziza 016443
Osborne, Sheena 016479
Padilla, Suzette Gano 016472
Patterson, Michaela Patricia 016514
Pauley, Teresa Lynn 016538
Qian, Congyan 016442
Raghubar, Amanda 016416
Rahman, Fahima 016526
Ramsami-Ramal, Sarasvati (Sara) 016439
Reid, Mackenzie 016448
Rezaee, Tarza Toma 016493
Rogalinski, Charlene Valerie 016485
Sanders, Erin 016450
Santos, Ariane 016434
Sawyer, Sharlene Marie 016425
Sem, Sarin 016486
Shah, Vijayta 016437
Shahid, Khema 016515
Sharafudin, Julie 016535
Shaw-Mart, Claudia Ann 016536
Sherwood, Kendra Elizabeth 016420
Singh, Prabhjot Pamela 016428
Singhal, Nidhi 016460
Soares, Megan Ashley 016512

Somerville, Sara 016446
Stamatovic, Marina 016415
Suhopoljac, Dzana 016431
Tahir, Saduf 016458
Traill, Sarah 016521
Truong, Sandy 016453
Vidal, Andrea 016498
Wool, Tamara 016429
Wirda, Amber Lee 016490
Williams, Madelyn Rose 016478
Wu, Jason 016534
Yakususke, Jordana Samantha 016480
Ye, Yizhen 016451
Yousufi, Halia 016496

Authorized for Self-Initiation
February 15, 2013 to May 31, 2013

Adams, Carrie Anne 006340
Algh, Aalam 012933
Allison, Suzanne E 003884
Altobello, Sonia 011398
Anand, Joraj Kaur 014513
Andrisevich, Deborah Laura Marta 011139
Arruda, Elizabeth 006280
Ash, Krystina Marie 008954
Ashmore, Nicole 006072
Aube-Walser, Danielle Ann 005043
Aujla, Pavan 012525
Bacopoulos, Thespina 014791
Baker, Kathleen Ann 004719
Balatsos, Anastasia 009070
Baldasar, Jennifer Margaret 006832
Baldwin, Tania 010196
Balega, Esther Merle 006686
Barde, Marilou 010151
Barich, Teresa Lynn 004652
Baumhauer, Rebecca 013502
Bedford, Devon Catherine 011167
Bell, Emily Louise 010489
Beltran, Claudia Andrea 013645
Berberi, Majlinida 012521
Bertrand, Jennifer R 000859
Besharah, Anya 006904
Biro, Kimberley 010799
Bloom, Leslie Ann 012911
Bow, Patricia 006322
Boyer, Lisa Elaine 006719
Brassard, Tania 006190
Breen, Jane Anne 013754
Bremer, Melissa Lynn 010723
Bright, Crystal 014379
Burkholder, Katelyn 014142
Bye, Darlene Myra 001270
Cacilhas, Anna 005557
Cacilhas, Susy 006569
Cambly, Lynn Marie 006151
Milestones
July 2013

Shouldice-Fleming, Teresa 007395
Shuttleworth, Katherine 013261
Sinari, Idlir 013941
Singleton, Katie-Anne 012279
Smith, Jeanette 006738
Smith, Sabrina Nicole 011198
Soor, Jagpreet Kaur 011960
Specialeire, Mary 006856
Staszuk, Marta 011659
St-Charles, Jessica 016305
Stewart, Randi May 014063
Stokes, Tonya Diana 007401
Suchodolska, Agata 008978
Sugianto, Dewayanti 013843
Suitor, Ning 005901
Suitor, Shelley 014006
Sun, Chen Chen 011940
Tafteh, Hamideh 011026
Tailleur, France 015836
Tanaka, Kaori 011536
Tessmer, Paula Nancy A 005739
T-Georgis, Helen 011355
Thomas, Lyndsay Margaret 014074
Thomas, Melissa 013753
Thompson, Amanda Marie 007321
Thompson, Brandy 014765
Timmerman, Dena 014830
To, Andrea 011146
Tobin, Cindy Marie 003516
Trachsel,Tara Nicole 013116
Tremblay, Mathilda Suzanna 001574
Tystruha, Olha 010451
Tsiganidis, Panagiota Patti 010956
Turner, Kimberly Anne 009987
Tyndall, jill Christine 005220
Vandenberg, Leanne Denise 014182
Velychko, Alena 010290
Vracaric, Danijela 013369
Waghorn, Joanne E 004066
Wakeford, Catherine Ann 003264
Walls, Hilarie 014721
Watson, Margaret Kim 004534
Watson-Robinson, Lauris Elaine 003388
Welters, Dana 010417
Whiteman, Natasha 013949
Wilkinson, Erin Heather 011888
Wilson Adams, Angela 006851
Wilson, Allissa 012486
Wilson, Jenna 010362
Wisdom, Sandra 006872
Wooldridge, Megan 013150
Wright, Carly 008486
Yacynowycz, Larissa N 007054
Yavari, Akram 014795
Ye, Lilin 008094
Ye, Xiaodi 016207
Yorke-Liberman, Rhonda Barbara 001375
Yousof, Eman 012950
Zachary, Bessie 007969
Zeng, Minxia 014345
Zechus, Kristina 013042

Reinstated
February 15, 2013 to May 31, 2013

Ahmed, Faizan 016150
Angle, Michelle 004642
Asselin, Michel 006369
Atanasov, Andrea 011709
Aulja, Kiran 014725
Bendicion, Merriam 011494
Benincasa, Marisa 004897
Bompa-MacRae, Romana 005426
Breton, Nancy 010944
Brodar, Sandy 007131
Brown, Katalin 013800
Cloutier, Stephanie 015325
Danyl, Neveen 012726
Fongie, Natasha 015998
Gauthier; Amanda 010037
Green, Christina 009099
Grewal, Simar 016195
Hussaini, Syed Basalath 014645
Jung Rappaport, Yvonne Audrey 007090
Kainula, Amanda Joy 015971
King, Jill Renee 010693
Klenke, Kaitlyn 015752
Krishko, Joely 011190
Lam, Sandy 014635
Ly,Yu 016139
Masse, Louise 004683
McGee, Rachel Alexandra 015043
Merza, Nada 010469
Paat, Taylor 015138
Pazdruk, Sophie 015913
Pickles, Kyla 015490
Pitcher, Janice 005971
Perdi, Marianne 000931
White, Linda Anne 001691
Winemaker, Kari Sarette 001418
Woolison, Kayla Nicole 015217
Wyschosanskiy, Natalie Olena 017073
Zarkari, Gelareh 016086

Resigned
February 15, 2013 to May 31, 2013

Adamopoulos, Pety Panagiota 009329
Bartolini, Adrianna Stephanie 010694
Baxter, Patti A. 008774
Bechard, Tanya 009831
Benjamin, Christine 004489
Buxey, Carole 011071
Cote, Tracey Lee 003609
Cuddy, Allison Marie 009367
DaCosta, Karen Rose-Anne 006948
Davis, Alexis 013678
Dinsmore, Emily 013884
Elsley, Ellen Marie 002744
Fregillana, Julita 012478
Fung, Lisa 014779
Gillespie, Michele 009315
Giorgis, Anita Adam 014152
Ha, Vicky 014756
Hall, Tammy Lynn 006955
Healy, Erin Melissa 010335
Hedgepeth, Paula Nicole 009659
Infuso, Kimberley Anne 006670
Jacob, Suby 012894
Legault, Lise Claudette 003905
Marek, Dorothy Elaine 002016
McEachran, Candace 010268
McEvenue, Kelly Maureen 000476
McFadden, Kelly Ann Marie 009362
McGonigle, Shelley Ann 010714
Melo, Margo Ellen 012830
Mohamed, Shabana 002992
Nantais, Krisandra Marie 008261
Nemes, Renata 012801
Newman, Mandy Carolyn 003320
Nishimura, Kelly Michele 005058
Pluviati, Daniela 009407
Prokopchuk, Joan 004499
Pyra, Wioletta 006594
Sampson, Mary Elizabeth 001088
Syridis, Elaine 010156
Shortt, Donna Lynne 003698
St. Amand Currie, Donna Mary 009089
Tesoro, Ronellyn 015645
Thayalasingham, Kishanthy 015601
Yousuf, Amal 014781

Revoked as a Result of Disciplinary Proceedings
Effective March 18, 2013

Wendel Washington McFarlane 008694

Suspended as a Result of Disciplinary Proceedings
Effective March 19 to April 15, 2013

Fabrica Nicole Couteiro 007286

Deceased
Baker, Lynda Noreen 000523
Dosaj, Jayna 011238
Did You Know?

your mouth tells your health’s story

arthritis diabetes pneumonia dry mouth oral cancer stroke gum disease reflux disease

The Link Between Your Oral and Overall Health

We all know that prevention is one of the keys to maintaining overall health. Did you know that certain medical conditions can have oral signs and symptoms that, if left untreated, may worsen already existing health conditions?

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College of Dental Hygienists of Ontario
L’Ordre des hygiénistes dentaires de l’Ontario
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For more information, please contact the College,
69 Bloor Street East, Suite 300, Toronto ON M4W 1A9
t: 416-961-6234 or 1-800-268-2346 www.cdho.org
the College’s promise
to dental hygiene clients

You can expect to receive
quality preventive oral hygiene care
from health professionals who are
registered with the College of
Dental Hygienists of Ontario (CDHO).

how we keep this promise

✓ All dental hygienists must be registered with the CDHO to practise in Ontario.
✓ Only persons currently registered with the CDHO may use the title “dental hygienist” or any variety of translation of “dental hygienist” including the initials RDH (Registered Dental Hygienist).
✓ Every dental hygienist in the province must meet the CDHO’s entry-to-practice requirements.
✓ A list of currently registered dental hygienists is available to the public.
✓ The College provides Standards of Care and Practice Guidelines to guide dental hygienists and inform the public.
✓ The continuing competency of your dental hygienist is monitored and supported by the College throughout her/his professional career.
✓ Information about oral health and access to dental hygiene care is promoted to the public.
✓ A fair and transparent complaints process is available to help clients who feel they may not have received the care they had the right to expect.
✓ The College collaborates with the Ontario Government, other health Colleges and consumer groups to promote access to safe and effective oral health care.