Informed Consent
Who qualifies as a substitute-decision maker?
What’s Inside  OUR JUNE 2010 ISSUE

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.

Council
Carol Barr Overholt – District 3 (RDH)
Heather Blondin – District 7 (RDH)
Denise Burdon – Non-Council (RDH)
Kathleen Feres Patry – District 6 (RDH)
Diane Greenwood – District 1 (RDH)
Linda Jamieson – Academic (RDH)
Audrey Kenny – Non-Council (RDH)
Nancy Kitchen – District 5 (RDH)
Caroline Lotz – Academic (RDH)
Inga McNamara – District 2 (RDH)
Heather Murray – Non-Council (RDH)
Lucy Pavao – District 4 (RDH)
Shirley Silverman – District 4 (RDH)
Ilga St. Onge – District 8 (RDH)
Julia Johnson – Onllia (PM)
Shori Katyal – Toronto (PM)
Samuel Laldin – Kingston (PM)
Derrick McLennon – Scarborough (PM)
Tote Quizan – Scarborough (PM)
Salam Rifai – Mississauga (PM)
Ben Shayan – Richmond Hill (PM)
Anne Venton – Toronto (PM)

RDH - Registered Dental Hygienist
PM - Public Member

President’s Message
Registrar’s Message
Council Highlights
Practice Advice
CDHO News
News From the Field
Practice Advice
Jurisprudence Education Module

Quality Assurance Column
Your Questions Answered
Aspects of Client Privacy
Mandatory Reporting Obligations
for Operators of Facilities and
Employers of Regulated Health
Professionals
Discipline Decision
Registrant Changes

College Staff
Registrar/Chief Administrative Officer
Fran Richardson, frichardson@cdho.org
416-961-6234 x 229

Deputy Registrar
Evelyn Waters, ewaters@cdho.org, x 228

Associate Registrar
Lisa Taylor, ltaylor@cdho.org, x 239

Registration Manager/Practice Advisor
Varinder Singh, vsingh@cdho.org, x 231

Practice Advisor/Quality Assurance Administrator
Jane Keir, jkeir@cdho.org, x 235

Practice Advisor/Patient Relations
Elaine Powell, epowell@cdho.org, x 237

Director of Finance
Mary Catalfo, mcatalfo@cdho.org, x 227

Information Technology Manager
Tom Amsden, tamsden@cdho.org, x 232

Executive Assistant
Jane Cain, jcain@cdho.org, x 226

Administrative Assistant, Investigations
Spring Shen, sshen@cdho.org, x 238

Administrative Assistant, Quality Assurance
Denise Lalande, dlalande@cdho.org, x 230

Administrative Assistant, Quality Assurance
Regina Sy, rsy@cdho.org, x 241

Administrative Assistant, Registration
Heather Boucher, hboucher@cdho.org, x 240

Receiver
Vivian Ford, vford@cdho.org, x 0 or x 221

Features
4  President’s Message
6  Registrar’s Message
8  Council Highlights
6  Practice Advice
10  CDHO News
11  News From the Field
12  Practice Advice
15  Jurisprudence Education Module
Now Online

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Find the clinical information you need!

Recent additions to the advisories include:

- Anemia
- Gastroesophageal Reflux Disease
- HIV AIDS
- Leukemia
- Lymphoma
- Menopause
- Nutritional Disorders
- Oral Cancer
- Oral Disorder and Autoimmune Disease
- Polycythemia
- Pregnancy
- Sjogren Syndrome
- Sleep Apnea
- Viral Hepatitis

Not finding the medical advisory you need?
Let Lisa Taylor know at ltaylor@cdho.org and help us grow the Knowledge Network!

Find the clinical information you need at:
www.cdho.org/QAKnowledgeNetwork.htm

COMING SOON!

CDHO’s website is being redesigned from the ground up to help you better navigate our site and access the information you need.

The site will have improved functionality, and a streamlined navigation and layout, including:

- A front-page news feature so you can quickly stay up to date
- Improved navigation menus that enable fast and efficient browsing
- A search engine to help find what you are looking for
- Hot buttons for the most accessed areas like the Knowledge Network
- An integrated public information section

Look for the re-launch of www.cdho.org later this summer!
President’s Message

Linda Jamieson, RDH, BA, MHS
President

National standards advance the profession

I

n my previous President’s message I wrote about the need to update the CDHO Standards of Practice. I also introduced you to the Entry-To-Practice Competencies and Standards for Canadian Dental Hygienists (January 2010). I am pleased to report that the regulatory authorities of all 10 provinces have now accepted these national standards. This is a significant accomplishment and a huge step toward a consistent approach for dental hygiene education and practice across Canada.

There are two parts to the Entry-To-Practice Competencies and Standards. Part A identifies competencies, or learning outcomes, that all students need to achieve during their academic program. This section is organized in a fashion that will be familiar to educators. Part B takes these competencies and associates them with various aspects of dental hygiene practice. Examples are provided to assist dental hygienists in recognizing how these competencies apply to practice. The CDHO was a key participant in the development of the national competencies and standards and will use these to develop new CDHO Standards of Practice. I encourage you to review the competencies and standards. They can be found at: www.cdho.org/Home_WhatsNew_Main.htm.

Developing the new standards will occur over the remainder of this year, and will involve a number of steps before final approval. Registrants and other stakeholders will have an opportunity to comment on the new standards prior to final approval.

I encourage you to become well informed and participate in the consultation process.

Changes to standards of practice are part of the normal growth of a profession. Dental hygiene practice has already evolved beyond our current published standards. The new standards will be more reflective of how dental hygienists are practicing now, but will also establish the importance of inter-professional collaboration and evidence-based practice in all practice settings. Dental hygienists in Ontario, through the Quality Assurance Program, have demonstrated their ability respond to change. I am confident that with support and guidance all registrants will be able to meet the new standards.

See next page for an excerpt from the Entry-To-Practice Competencies and Standards for Canadian Dental Hygienists...
An excerpt from the *Entry-To-Practice Competencies and Standards for Canadian Dental Hygienists*:

**DENTAL HYGIENIST-CLIENT RELATIONSHIP**
Each dental hygienist ensures client-centred care by establishing and maintaining positive, professional relationships with clients, families and significant others which are focused on client needs and based on respect, empathy, and trust.

Competencies related to maintaining Dental Hygienist-Client Relationships include the ability to:

- Assess, diagnose, plan, implement and evaluate services for clients.
- Use effective verbal, non-verbal, visual, and written communication when working with clients, family members, substitute decision makers and stakeholders.
- Demonstrate active listening and empathy to support client services.
- Respect diversity in others; to support culturally sensitive and safe services.
- Respect the autonomy of clients as full partners in decision-making.
- Select communication approaches based on clients’ characteristics, needs, and linguistic and health literacy level.
- Accept the views of clients about their values, health and decision-making.
- Convert oral health information in a manner relevant to clients using the principles of health literacy.
- Support clients in using community resources when needed.
- Communicate with clients in an open, honest, clear and timely way.

**EXAMPLES OF PERFORMANCE INDICATORS**
(Example indicators are provided as suggestions and are not considered an exhaustive list)

A dental hygienist demonstrates competence by:

- Promoting a philosophy of client-centred care and collaborative relationships;
- Maintaining boundaries between professional relationships and non-professional personal relationships;
- Demonstrating respect, empathy and interest for the client;
- Respecting the rights of clients to select the care they receive;
- Adjusting communication strategies to ensure clients understand information provided;
- Recognizing when clients need to be directed to community agencies for services and or information;
- Using culturally relevant visual images when displaying oral health education material;
- Using easy to understand terms when explaining periodontal conditions to clients;
- Accessing language specific information to support clients for who English is an additional language;
- Providing clients with enough information about alternative treatments to support their ability to make informed decisions;
- Providing clients with a private environment to discuss health issues;
- Providing clients with a list of government health care services;
- Working with families to address the oral health needs of children and dependent adults;
- Working with the community to promote oral health.
Canada is a big country, but dental hygiene is a small world!

Geographically, Canada is the second largest country in the world next to Russia. However, our population is small compared to the landmass that we call home. This can make the provision of health care services difficult, as people often have to travel long distances to receive even basic preventive care. Modern legislation and the reduction in monopolies (e.g., the ability of dental hygienists to self-initiate) have now made it easier for health care practitioners to travel to the client rather than always expecting clients to travel to the cities where most professionals practice. In addition, in most parts of Canada, people can choose the type of health care practitioner that most closely meets their needs.

Having recently been involved with dental hygiene issues in Vancouver, Calgary and Charlottetown, it is easy to understand why there are such variances in the ways in which members of the Canadian public can access preventive oral health services. Health legislation is under the authority of the provincial governments; consequently, local issues and lobby efforts by special interest groups are able to maintain the status quo if it is not in their particular interest to move forward in health care reform. This is especially acute when the particular type of health care reform being requested is not within the provincial funding system, and/or when the detractors are the major employers of those requesting the reforms.

Dental hygiene regulatory authorities across the country have recently agreed to endorse the Entry-to-Practice Competencies and Standards for Canadian Dental Hygienists (January 2010), and both the national Dental Hygiene Certification Board (NDHCB) and the Commission on Dental Accreditation of Canada (CDAC) will be using these competencies as their benchmarks for future development of the NDHCB examination and accreditation standards respectively.

So why is the scope of practice so different from one Canadian jurisdiction to another? There is no easy answer, but there are many factors at play. Basic competencies for dental hygiene practice are similar across the country with the Dental Hygiene Process of Care (DHPC) being the requisite standard of practice. However, in certain jurisdictions, dental hygienists are permitted to administer local anesthesia and/or nitrous-oxide oxygen, while in other jurisdictions, the public is denied these tried and true methods of pain control unless administered by another health care provider (who is often the employer of the dental hygienist).

Direct access by the client to a dental hygienist is permitted in most of Canada, yet in other areas of the country there is still tussling over the level of supervision a dental hygienist requires! This happens when the dental hygienist is required to work with an ‘order’ for a procedure, when the employer must be on-site to ensure that no harm comes to the client, the dental hygienist must be employed by an agency that also hires a specific health care practitioner even if that person performs no clinical duties, and when there is a requirement for an individual to be seen by another health care practitioner within a specified period of time. These so-called “safeguards” negate the professional role and autonomy of the dental hygienist, their regulatory body and the legislation that is there to protect the public.
So why does the public in one part of Canada deserve better access to preventive oral health care than do their compatriots in the opposite end of the country?

Economics plays a large part in the changes that are made within the health care system. Research has shown that an unhealthy mouth can lead to unhealthy conditions in the rest of the body. Yet, preventive oral health care services largely remain outside of the funding system that we call “universal health care”. Logic would dictate that if there were more healthy mouths, then there would be more healthy bodies! More healthy bodies would lead to a reduction in health care costs that would free up the resources required to deal with life-threatening conditions. But logic rarely plays a part in economics, policy or politics.

Another reason is outdated or outmoded legislation. Legislation is very difficult to change. It takes time, and is costly. There is only one reason for dental hygienists to be regulated/licensed – because there is a risk of harm to the public by unregistered practitioners. To practice in any jurisdiction in Canada, a dental hygienist must be duly registered/licensed with the appropriate regulatory authority. Therefore, one can surmise that the regulatory authority has deemed the applicant competent to practice. The regulatory authority holds the registrant accountable to the public via the respective Acts, Regulations and Bylaws. Therefore, it is illogical for there to be oversight by a different health care practitioner – it is just one more layer that consumes valuable resources that could be better utilized in other ways. However, there is hope! Legislation is changing in Newfoundland and Labrador. British Columbia is seeing the unnecessary restrictions on the public imposed by the 365-day rule amended and PEI dental hygienists have taken the first step toward self-regulation. This will mean their primary employer – a known conflict of interest, will no longer regulate dental hygienists in all 10 provinces.

However, the most prominent reason for the diversity of access is fear of change. Fear of change is what reduces access to care; change is seen as too difficult, it means taking responsibility for one’s own actions and putting the public good above the need for prestige, economics, power and control.

When every Canadian across this vast land of Canada has an opportunity to choose preventive oral health care when, where, how and from whom they choose, then dental hygienists will have fulfilled their ethical responsibilities to the public and to the profession. Advocating for direct access to preventive oral health care is not external to the mandate of the various dental hygiene regulatory authorities but central to the understanding of what regulation truly means—protecting the public.

How can regulatory authorities protect the public and regulate a profession in the public interest if only a small proportion of the public is even able to access those services? Perhaps that is the question that should be posed the next time a detracting organization states that dental hygiene regulatory authorities should not be in the business of advocating on behalf of the public. The public is why we are here.

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**Setting the Record Straight**

As with many areas of life, rumours abound. Here are a few related to the activities of the CDHO, followed by the correct information.

**Rumour:** The CDHO is demeaning and untrusting of CDHO registrants by the presence of the contraindications regulation related to self-initiation.

**Fact:** The CDHO had no choice in approving the regulation following the 2006/07 meetings held between the Ontario Dental Hygiene Association and the Ontario Dental Association, where both parties agreed upon the contents of the regulation. The CDHO and the Royal College of Dental Surgeons of Ontario (RCDSO) were informed of the agreement by the Ontario Ministry of Health and Long-Term Care.

**Rumour:** The CDHO wants all Ontario dental hygienists to go into independent practice.

**Fact:** The CDHO wants all Ontarians to have access to preventive oral health care services and for dental hygienists to have the option of choosing how, when and where they practice.

**Rumour:** Dental hygienists are expected to keep more detailed records with whom they practice than dentists.

**Fact:** The CDHO Record Keeping Regulation is closely aligned with the RCDSO Record Keeping Regulation.
Executive Committee
The Executive Committee presented several issues for decision. The auditor presented the audited financial statements for 2009, which were subsequently approved by Council. In addition, the firm of Soberman, LLP was reappointed as auditors for 2010. The Conflict of Interest Regulation was approved for circulation to registrants and stakeholders for the requisite 60 days, and there were several minor amendments to the bylaws – most notably in Section 7.3 that states the registrant must be personally named in the policy for professional liability insurance. Council also approved Schedule V – Rules of Order of the Council.

Registration Committee
Registration Statistics as of May 11, 2010: General –10,092; Inactive – 776, Specialty – 512; Authorized to Self-Initiate – 2,949; The total number of registrants is 11,380.

The Registration Committee reported that one long-standing case before the Health Professions Appeal and Review Board (HPARB) was cancelled before the hearing as the applicant withdrew her appeal. HPARB upheld the Committee’s decision not to grant registration to an applicant who had failed the clinical competency evaluation four times. Another candidate who has had four unsuccessful attempts at the clinical evaluations has also appealed to HPARB. That hearing is pending.

There are currently 16 non-accredited dental hygiene programs in Ontario. Three programs have participated in an accreditation site visit during 2010 and will be informed of their status in December. All non-accredited programs must apply for accreditation by August 1, 2010 or the Ontario Ministry of Training, Colleges and Universities will rescind their permit to operate.

It was also noted that the Jurisprudence Education Module is now on-line (see page 15 of this issue for more information). The module replaces the jurisprudence presentations that applicants were required to attend prior to registration with the College. Registrants are encouraged, but not required, to complete the module as part of their professional portfolios.

Quality Assurance Program
The Quality Assurance Committee noted that of the 198 professional portfolios requested in 2010, 76 have met the assessment guidelines, 105 are still in process and 35 are participating in directed learning/remediation activities. Of the 101 on-site practice assessments requested, seven have met the guidelines, 79 are still in process and 15 are participating in directed learning/mentorship activities.

Inquiries, Complaints and Reports Committee
The Inquires, Complaints and Reports Committee (ICRC) reported that they are currently investigating 21 cases – 10 formal complaints, five referrals from the Quality Assurance Committee, six Registrar-initiated matters and two mandatory reports. An ICRC Panel concluded its investigation into two matters. There are currently eight matters pending before HPARB.

Discipline Committee
The Discipline Committee reported that a hearing was held on April 30, 2010 for Ms. Jacqueline Speight.
Ms. Speight was found guilty of professional misconduct. A summary of the reasons is available on the CDHO website and on page 24 of this issue.

**Administrative Report**

Fran Richardson, Registrar noted that both Evelyn Waters, Deputy Registrar and Lisa Taylor, Associate Registrar had been assigned additional responsibilities. The Registrar then introduced new members of the College administration team:

- Mary Catalfo, CAE, Director of Administration
- Jane Keir, RDH, Practice Advisor/Quality Assurance Coordinator
- Varinder Singh, RDH, Registration Manager/Practice Advisor

**Patient Relations Committee**

The Patient Relations Committee reported that it was currently in the evaluative stage on two projects: 1) Sensitive Practice based on the *Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse*, and 2) the Public Awareness program.

The guest speaker was Ms. Lori Coleman, Chief Operating Officer/Registrar, Health Boards Secretariat, Ministry of Health and Long-Term Care. Ms Coleman spoke about the role of the Secretariat, the various Boards that it facilitates and the procedures on how public members on Boards, Councils and Agencies are reimbursed by the government.

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**An Invitation to Evaluate the Sensitive Practice Handbook for Healthcare Practitioners**

CDHO’s Patient Relations Committee is interested in your thoughts and opinions about the *Sensitive Practice Handbook Healthcare Practitioners*. Please complete a short (just five minutes to complete) online questionnaire about the handbook found at Survey Monkey. Note: It is important that you fill out this questionnaire before you read the Handbook. [www.surveymonkey.com/s/7P8LYGF](http://www.surveymonkey.com/s/7P8LYGF)

Next, you are asked to read the handbook itself. This will take you several hours to read, but we are truly interested in your thoughts and opinions. You should be aware that due of the nature of the subject matter, some people may find it difficult to read parts of the material. After you have read through the handbook, you are asked to complete your participation in our evaluation. [www.surveymonkey.com/s/75867K2](http://www.surveymonkey.com/s/75867K2)

Please be assured that both questionnaires are completely anonymous. Thank you!

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**Next Council Meeting:** October 22, 2010

To attend, please call Jane Cain at 416-961-6234 ext 226 or 1-800-268-2346, or email jcain@cdho.org. Seating is limited.
The College Welcomes New Staff
Mary A. Catalfo, CAE, joined the College as the Director of Administration in May. She is a Certified Association Executive with more than 15 years experience in the not-for-profit sector as well as managing a professional services firm. Prior to joining CDHO Mary had her own consulting business for five years, helping organizations improve operational efficiencies including administration, human resources, finance as well as governance and program development.

Jane Keir, RDH, BSc, BEd, joined the College in May 2010 as Practice Advisor/Quality Assurance Administrator. Jane has been a Quality Assurance Assessor since 2006. Prior to joining CDHO, Jane worked in general and orthodontic practices in Northern Ontario. For the last three years she has been involved in the field of dental hygiene education as an instructor and as a Program Director of an accredited dental hygiene program.

Varinder Singh, RDH, BSc, joined the College in June, 2010 as Registration Manager/Practice Advisor. Varinder is no stranger to the CDHO as she has served as a Quality Assurance Assessor and as a Non-Council Member on various College Committees. Prior to joining CDHO, Varinder taught for the last seven years at the Canadian Academy of Dental Hygiene. As a bonus, she is fluent in Punjabi and comprehends both Hindi and Urdu.

Use of the New CDHO Logo
The College is pleased that many people, both members of the public and CDHO registrants have commented favorably on the new CDHO logo and public awareness campaign. In fact, several individuals have requested permission to use the CDHO logo in their own advertisements. Please note, this is not possible as the CDHO logo and tag line are both property of the CDHO and trademarked.

CDHO on the Street
As part of CDHO’s Public Education Plan, the above billboard went up in a well-trafficked location in downtown Toronto on June 21, and will be showcased for four weeks.
Adverse Reaction Monitoring Program and Database

Dental hygienists should report adverse drug reactions for both prescription and non-prescription drugs. This includes natural health products. Reports may be made on-line.

Phone: 1-866-234-2345
Fax: 1-866-678-6789
www.healthcanada.gc.ca/medeffect

Health Canada Advisories

Health Canada provides timely information on issues that concern the health of Canadians. There are four types of risk communications products:

- Public Advisories
- Public Warnings
- Information Updates
- Foreign Product Alerts

www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/index-eng.php

New Federal Requirements for Dental Amalgam Waste

There are new federal requirements for keeping the mercury found in dental amalgam waste out of the environment. It will require dental clinics who have not implemented best management practices for dental amalgam waste before the publication of the notice to prepare and implement a pollution prevention plan.


Network for Seniors’ Health Launched

The SHRTN Collaborative is a network of networks—a partnership that includes the Seniors Health Research Transfer Network (SHRTN), the Alzheimer Knowledge Exchange (AKE) and the Ontario Research Coalition (ORC). These three partners work together to improve the health and health care of seniors in Ontario.

In SHRTN, a CoP Community of Practice is a group of people who come together to exchange information on a topic related to seniors’ health, health system, or disease. This can take the form of interactive education programs, awareness initiatives, and networks.

The purpose of the Oral Health Community of Practice is to disseminate evidence-based and clinically relevant oral health information to care providers of older adults. This is done through four methods:

- Awareness-raising strategies.
- Education and learning opportunities.
- Collaboration and networking (health care and oral/dental health sectors).
- Core Working Group/ Membership/ Partners

SHRTN Community of Practice Oral Health consists of a working group of committed professionals engaged in the oral care of older adults.

A variety of electronic resources have been created and made available for health care and oral health professionals, practitioners and educators to use.

A new website is currently being constructed. https://www.ehealthontario.ca/portal/server.pt?open=512&objID=705&mode=2
Milestones  JUNE 2010

Can you explain when to use nitrous oxide and oxygen for conscious sedation?*

The number of calls coming into the CDHO requiring clarification on the use of nitrous oxide and oxygen for conscious sedation has been on the increase of late. Dental hygienists report that dentists are expecting them to work on clients who are receiving nitrous oxide and oxygen without the appropriately trained health professional in the room to monitor the client.

In accordance with the Regulated Health Professions Act 1991, dental hygienists are not authorised to administer nitrous oxide and oxygen by inhalation or monitor clients receiving nitrous oxide and oxygen for conscious sedation. Dental hygienists may perform dental hygiene interventions on clients receiving nitrous oxide and oxygen if the following conditions are present:

- Nitrous oxide and oxygen has been administered and is being monitored by an appropriately trained dentist, or a trained registered nurse or respiratory therapist under the order of an appropriately trained dentist.
- If a registered nurse or respiratory therapist is administering or monitoring the nitrous oxide and oxygen delivery, the appropriately trained dentist must be present in the office suite and immediately available for emergency.
- Clients must be monitored by the appropriate professional mentioned above by direct and continuous clinical observation for level of conscious sedation and assessment of vital signs.
- The dental hygienist is never left alone with the client while the client receives nitrous oxide and oxygen.

The Royal College of Dental Surgeons of Ontario has guidelines for use of sedation and anaesthesia in a dental practice that all dentists should be aware of and should adhere to. The guidelines do not allow for dental hygienists, whether appropriately trained or not, to administer and/or monitor nitrous oxide and oxygen for the purpose of conscious sedation. Dental hygienists must refuse to provide dental hygiene services to clients who are receiving conscious sedation without the appropriate care and supervision by an authorised health care professional. – L.T.

* Reprinted from Milestones, 2007

I am planning on leaving my practice to set up independent practice. What advice can you give me to let my clients know that I am leaving?


Where do I find dental hygienists working in independent practice?

The CDHO website provides names of dental hygienists in Independent practice under the “Find a Dental Hygienist” tab. http://www.cdho.org/cdho_search_Independent.aspx

The website www.dhpo.ca provides information about independent practitioners and their contact information.

My website designer wants to place an advertisement in an online social networking forum. Is this allowed?

The CDHO has an advertising regulation available at www.cdho.org/LegislationAndByLaws/Advertising.pdf.

All advertisements must adhere to the regulation and be professional. The information in the advertisement must be clear to the public. RDHs are advised to provide
An Example of Best Practice

[Editor’s note: The following was forwarded to the Registrar by the faculty at a Community College Dental Hygiene Program in Ontario. It is reprinted with permission. The names have been removed for privacy reasons.]

Congratulation to [name of school] of year two hygiene. Our long-time client, Ms. XYZ, called from Florida because she ended up collapsing and was hospitalized. During her appointment in our clinic in October, our student assessed her as presenting with low blood pressure and talked to her about it. The student encouraged her to seek medical advice from her physician. Ms. XYZ did. Her physician told her that there was nothing wrong with her and that it was age-related.

Ms. XYZ sought a second opinion and was told the same thing. So, off she went off to Florida with the notion that she was fine. Ms. XYZ collapsed and ended up in the hospital in Florida and now has a $14,000.00USD medical bill.

She called to tell us, that because [student] was diligent in her assessment, Ms. XYZ had been pre-warned of this condition. She feels that the best part of the treatment are the assessments, and that they are indispensable. She recommended that it never be discontinued.

Pre-entering Billing Codes

The CDHO is very concerned that some offices are pre-entering insurance codes (which do not accurately reflect dental hygiene care) into computers prior to the client’s appointment and not adjusting them to what the client actually received. No one can accurately predict the care a client will require at the next appointment, as each client is an individual. Filling out insurance claim forms or charts in advance is also inappropriate.

The CDHO Records Regulation stipulates that registrants must record a full description of all dental hygiene interventions including, where appropriate, the billable time used. While the CDHO does not require the recording of billing codes and fees, the College does understand that in many cases it is an employment expectation. However, if the dental hygienist chooses to enter the codes for services rendered, then they must accurately reflect the services that the dental hygienist has provided.

In addition, some consultants have indicated what treatment is to be provided and that is entered in the computer. The dental hygienist must make the determination on the required treatment based on the dental hygienist’s assessment and the client’s needs, not what the consultant prescribes.

Direct Billing for Services

If you are direct billing for services, third party claim forms (insurance plans, government benefit plans, etc.) must be submitted and signed by the dental hygienist who provided the service. Dental hygienists may not submit claims for services that were provided by another dental hygienist.

Billing Insurance Companies

Representatives of various insurance companies that administer dental benefits have contacted the CDHO due to concerns related to billings for self-treatment or for treatment on immediate family members.
...continued from page 13

Should the CDHO receive a complaint from an insurance company and choose to investigate, the dental hygienist in question must be able to show that the client (i.e., the family member) was indeed charged the usual and customary fee, and that the co-pay was collected. In addition, treating oneself is not usually a prudent practice – but to charge the insurance company for that treatment is definitely unwise, could be considered fraudulent, and may raise a concern about unethical practice! [See the enclosed summary of a discipline case relevant to this issue on page 24.]

Antibiotic Prophylaxis

The CDHO continues to receive enquiries regarding antibiotic prophylaxis for clients who have had a joint replacement. Registrants would be wise to view the information on the web site of the American Academy of Orthopaedic Surgeons (AAOS) for additional information: www.aaos.org/about/papers/advismt/1033.asp.

For those who present with a history of joint replacement, dental hygienists are advised to consult with the individual’s orthopaedic surgeon to confirm if prophylactic antibiotic coverage is required prior to invasive dental hygiene interventions.

For further information about this medical condition, please check the CDHO Knowledge Network at www.cdho.org.

Documenting DHPC and Non-employer Compliance

Dental hygienists are required to practice according to the Dental Hygiene Process of Care (DHPC) – [assessment, planning, implementation and evaluation]. Unfortunately, the CDHO often receives inquiries from registrants who indicate that their employer has directed them not to utilize the amount of “charting space” required to document the relative components of the DHPC. While the employer may require certain behaviour from employees, dental hygienists, as regulated health care practitioners, are responsible to the CDHO first and to their employer second. This means that if the employer is, for whatever reason, restrictive on the information that the dental hygienist is required by the CDHO to write in the charts, then the dental hygienist may need to maintain separate files with the client information required by the CDHO. (Hint: to reduce space, use abbreviations and keep the list of abbreviations accessible.)

Be Sure That You are Practicing Under Your Name as Listed on the CDHO Website

Recently, the Registrar received a copy of an article, published in a local area newspaper, which identified an individual as a dental hygienist. Unfortunately, the name of the dental hygienist was not available on the CDHO web site under “Find a Dental Hygienist” and the person who submitted the material to CDHO was concerned that this may be a case of illegal practice. Fortunately, the CDHO database was able to identify the person and confirm that the individual was indeed a registered dental hygienist practicing under a different name (she had recently married). The moral of this story is: notify the CDHO as soon as possible if you change your name!
Jurisprudence Education Module
now Online

Test your knowledge of dental hygiene standards and government legislation!

On April 15, 2010 the College launched the new online Jurisprudence Education Module (JEM). Inspired by a need identified by the Registration and Quality Assurance Committees, the online module was created with two purposes in mind.

The first is to facilitate the registration requirements of applicants to the College by offering a standardized online educational tool that can be accessed by both dental hygiene students and graduate dental hygienists who are moving to Ontario from outside the province. In keeping with the proposed amendments to the regulations, all those applying for registration in Ontario will be asked to successfully complete the module prior to submitting their application for registration. By completing the module, all new registrants will have the confidence that they understand the legal, ethical and moral obligations they have to the public as health care practitioners.

The second reason the module was created is to provide a continuing education opportunity for dental hygienists who are already practicing and want to make sure that they are complying with the College’s expectations on their knowledge of dental hygiene standards and have current knowledge of the legislative changes to dental hygiene practice.

JEM is a free resource to registrants that lends itself to distance learning and offers the flexibility of being available 24/7. While it is not mandatory at this time for dental hygienists to complete the module as part of the Quality Assurance Program, the Quality Assurance Committee recommends the completion of this module as a learning goal for all dental hygienists within the next three years.

How does JEM work?
The module has two distinct features. The learning portion of JEM was designed by the College and uses the Registrants’ Handbook as a reference to each section.

The second feature, the final quiz, allows participants to apply the knowledge acquired from the module and provides feedback, if required, on any sections that should be reviewed. The CDHO acknowledges that the final quiz is based upon materials developed by the College of Physiotherapists of Ontario and distributed with its permission.

The learning portion of the module contains 10 sections. Designed to be used with the CDHO Registrants’ Handbook and the College’s web resources, each section has a specific knowledge domain:

1. Introduction to Jurisprudence
2. Dental Hygienists as Regulated Health Professionals
3. Confidentiality and Privacy
4. Consent to Treatment
5. Record Keeping
6. Conflict of Interest
7. Professional Boundaries
8. Mandatory Reports
9. Working for Yourself and Others
10. Responsibilities of Council

Completing the module is done by a timed final quiz. The quiz questions are case-based and test critical thinking skills. Upon completion of the quiz, the system will report back to the participant on the number of correct and incorrect answers scored and will guide them to the appropriate module sections for review. Participants are permitted to retake the examination as many times as necessary to attain the 100% pass rate required. Current CDHO registrants can access JEM at no cost.

To access JEM, visit the CDHO website at www.cdho.org and follow the link on the front page to the module.
Step 1: Portfolio Selection
Each year, approximately 10% of dental hygienists are selected to submit their Professional Portfolios for review. Selection is based on a stratified random sample using predetermined demographic criteria. The number selected from each district and graduating year is proportional to the total number in each group. Those registrants selected for the current review have already received notification by mail.

Step 2: Portfolio Assessment
Upon receipt of the 1,042 portfolios selected for January 2011, each will be assigned to one of the Quality Assurance (QA) assessors for review. The QA peer assessors are practicing dental hygienists who have applied for the position and have met the College’s criteria for selection. During a portfolio review the assessors rigidly adhere to the assessment guidelines based on the CDHO’s Standards of Practice, regulations, guidelines, bylaws and Code of Ethics. A replica of the form used by the portfolio assessors can be found at www.cdho.org/QualityAssurance/QAPackage_En/SectionA.pdf in the QA Package (Section A, Appendix 2). At this point, for many registrants (approximately 80%) the assessment process is complete as their portfolio has met or exceeded the expectations of the guidelines.

Step 3: Telephone Interview
In cases where a registrant has not clearly demonstrated that she/he is practicing dental hygiene safely and effectively or that she/he has based their decisions and interventions on current evidence-based research and theory, the assessors have been instructed to perform a telephone interview. The telephone interview allows registrants the opportunity to clarify any areas of confusion or to add information that may have been inadvertently omitted. Once again, for many registrants the assessment process ends at this stage (approximately 95 to 98% in the last five years). Following the telephone interview, assessors complete a practice review of those registrants who have not successfully demonstrated that their practice meets the guidelines. This information is then sent to the QA Committee.

Step 4: Practice Review
Statistics from the last five years show that 0.01 to 0.05% of registrants each year have undergone an on-site practice review. During the practice review, assessors act as fact-finders and collect evidence for review by the QA Committee. Prior to the review, assessors will contact the registrant to make a mutually agreeable arrangement for a date and time for the review. This can be done outside of regular office hours and assessors will make every attempt to meet any reasonable request regarding booking a review time.

At this time, assessors will also provide registrants with necessary information regarding their review including, but not limited, to the requirement for a reliable photocopier for the chart audit. If your office has any specific visitor requirements, this would be the appropriate time to inform your assessor. The template used by the assessors at this review can be found in the QA Package (Section A, Appendix 3) [www.cdho.org/QualityAssurance/QAPackage_En/SectionA.pdf]. Following the practice review, a written report of the assessment will first be forwarded to the dental hygienist with 30 days notice of the right to make written submissions to the QA Committee.

While not all practice reviews result in deficiencies being identified, for those who have deficiencies the opportunity to submit a response to the report allows registrants to address any inconsistencies in the report, corrections that have been made to practice since the assessor’s visit or plans to address the deficiencies. After considering the report, the dental hygienist’s written submission and
any other available information, the QA Committee may require the dental hygienist to correct any deficiency within a specified period of time, grant an exemption, or direct the dental hygienist to complete specified continuing education programs within a specified period of time and/or direct a second review of the dental hygienist’s practice following completion of remedial activities.

The most common deficiencies found at an onsite practice review are: failure to have complete periodontal assessments; failure to complete treatment plan; incomplete medical histories; lack of documentation for consent; failure to record time spent on dental hygiene interventions and/or inappropriate billing practices; failure to reassess outcomes of dental hygiene interventions and recommended home care; no evidence that a prescription for radiographs has been received; and poor infection control practices.

Registrants are encouraged to use the Clinical Self-Assessment tool available in the QA Package section D or the Practice Check-up tool found under the Quality Assurance tab.

Maintaining Your Professional Portfolio

As part of the Quality Assurance Program, all dental hygienists are expected establish and maintain a Professional Portfolio as a condition of annual renewal of their certificate of registration.

Need help with your Professional Portfolio?
Visit www.cdho.org/Quality_English_QAPackage.htm to find a Professional Portfolio forms tutorial, sample forms and a list of frequently asked questions to help create your own Professional Portfolio.

CDHO ON THE ROAD

Scheduled Presentations by Members of CDHO Administration

All CDHO presentations are open to all registrants and dental hygiene students.

If hosted by a dental hygiene society, non-member fees may apply to cover facility costs. Please note that most hosts require advance notice of attendance.

Dryden
September 11, 2010
CDHO Update – Elaine Powell, RDH, Practice Advisor/Patient Relations
Contact: Silvana Edenburn, RDH
807-223-7444

London
September 15, 2010
Hosted by the London Dental Hygienists Society
Quality Assurance Program – Lisa Taylor, RDH, Associate Registrar and Jane Keir, RDH, Practice Advisor/Quality Assurance Administrator
$10.00 fee for non-members
Contact: Erica Hayward, RDH
eforsberg@sympatico.ca

Mississauga
October 19, 2010
Halton-Peel Dental Hygiene Society
CDHO Update – Fran Richardson, RDH, Registrar
Contact: Beata Jedrzejczak, RDH
jedrzejczakfamily@rogers.com

Toronto
December 6, 2010
Toronto North Dental Hygiene Society
CDHO Update – Fran Richardson, RDH, Registrar
Contact: Debbie Richmond, RDH
debbierichmond@sympatico.ca
We recently received the following inquiry from one of our members:

...I am seeking some firm clarification with regards to child guardianship during dental hygiene treatment. Could a legal guardian of a child appoint someone else to be the attending guardian of that same child during a dental hygiene session? For example, if I wanted my child to be treated at school but I was unable to attend the appointment, could I appoint my friend or neighbour or family member to substitute as a guardian on my behalf? This substitution would also include formal documentation of the nature of all proposed treatment consented by the actual legal guardian.

**Short Answer**

Friends and neighbours cannot be substitute decision makers. However, the friend or neighbour could communicate the parent’s (or other substitute) consent (e.g., by delivering a signed consent form and, perhaps even, by verbally confirming the parent’s consent).

A family member who is at least 16 years old can often act as a substitute decision maker unless a closer relative would object.

**Analysis**

As dental hygienists provide “treatment” to their clients, they are subject to the Health Care Consent Act (the “Act”) and to the professional misconduct regulations relating to consent. These provisions require that before treatment is administered by the dental hygienist, consent must be obtained.

The Act does not set out a minimum age of consent. The individual must merely have sufficient “capacity” to consent to the treatment. For the purposes of this article, we will assume that the child in question does not have sufficient capacity to consent to the treatment.

In such a situation, a substitute-decision maker (“SDM”)

needs to provide the requisite consent before the treatment is administered.

The Act provides a hierarchy of individuals who are able to provide consent on behalf of the child:

1. The child’s guardian of the person (appointed under the Substitute Decisions Act, 1992)
2. The child’s attorney for personal care
3. The child’s representative appointed by the Consent and Capacity Board
4. Spouse or partner (not applicable)
5. The child’s parent (but not a parent who only has a right of access)
6. The child’s parent who only has a right of access
7. The child’s brother or sister (but they must be at least 16 years old)
8. Any other relative (related by blood, marriage or adoption) of the child

These individuals must:

- Be capable to provide consent
- Be at least 16 years old (unless she or he is the child’s parent)
- Not be prohibited by court order or separation agreement from having access to the person or providing consent on their behalf
- Be available (i.e., within a time that is reasonable in the circumstances to communicate with the person and obtain a consent or refusal); and
- Be willing to assume the responsibility of giving or refusing consent.

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1 There are rare exceptions that would not normally apply here.

2 Please note the General Regulation to the Dental Hygiene Act, 1991 uses the term “authorized representative.”
In most situations, the child will not have a guardian of the person so the first person on the hierarchy that is qualified to provide consent would be the parent. If, as previously indicated, the parent is not available to provide consent (thereby not fulfilling one of the requirements), and if the brother or sister is under the age of 16 (thereby not fulfilling one of the requirements), then “any other relative of the child” would be able to provide consent—as long as the relative was available and willing to assume the responsibility.

The Act does not contemplate a friend or neighbour providing consent for treatment unless they were appointed as the child’s guardian or some other rare exception applies. This will be extremely rare.

The Act does not contemplate one SDM delegating the authority to consent to treatment to another SDM (i.e., a parent to an “other relative”).

In the above situation, the neighbour or friend could certainly attend with the child at the appointment or drive the child to the appointment—but they are not, themselves, able to provide the requisite consent. They may, however, be able to communicate the consent (e.g., by bringing a signed consent form from the parent). Theoretically, the communication could be verbal (e.g., “I spoke with Jade’s mom who told me she consents to you checking Jade and understands what all is involved”). Where the verbal communication of the parent’s consent appears genuine in the circumstances, the dental hygienist could rely upon it.

The Act does permit treatment to be administered in emergency situations but the scenario described above would clearly not fall within the definition of “emergency.”

Please note that the parent need not be physically present to provide the necessary consent. As noted above, “available” means that the parent is able to communicate. Therefore, even if the parent cannot accompany their child to a dental hygienist appointment, the parent can still communicate the necessary consent via the phone or in written format. Of course, in order to be able to provide consent, the parent (or whoever is the proper SDM) will need to be informed, i.e., be advised of the nature of the treatment, expected benefits, material risks, material side effects, alternative courses of action and likely consequences of not having the treatment. In some contexts, it would take very little for the consent to be informed. We would recommend that you briefly document the consent.

Please note that this article is not intended to be interpreted as legal advice and is only expressing the College’s expectations in obtaining consent before treatment is administered. (It is an act of professional misconduct to treat a client except with consent of the client or the client’s authorized representative). It is important to note that certain sub-sections of the Health Care Consent Act were not quoted in this article and such sub-sections could apply in different situations. The College does not administer the Health Care Consent Act. The College recommends that if members are concerned about civil liability, or other legal matters, they should retain their own legal counsel.

The College welcomes all inquiries from members regarding issues relating to the dental hygiene profession.
Aspects of Client Privacy

Protecting Client Health Information when using Mobile Technology

These days more and more dental hygienists are practicing in multiple locations. Sometimes travel between offices or to a mobile practice includes transporting client information. When you travel with a client’s personal health information, whether it be in paper or electronic format, you are accountable for the safety and security of the document.

This is most obvious when you think about the paper chart, but consider that personally identifiable health information on your electronic devices poses additional challenges that you may not be aware of. When you walk out the door with client information on your laptop, universal serial bus (USB), personal digital assistant (PDA) or cell phone, the information contained on these devices can disappear as easily as the device on which it is stored.

According to the Office of the Information and Privacy Commissioner of Ontario (IPC), identity thieves are looking for opportunities to grab personal identity information and business data, and thousands of mobile devices go missing every year in North America alone. Identity thieves do this in a number of ways: stealing the hardware; hacking into software; and by shoulder surfing.

Remember when you travel with personally identifiable health information or collect new information off-site, you are responsible for ensuring that privacy is protected.

The IPC offers the following advice to protect the information you keep on your mobile technology:

- If you keep personally identifiable information on your mobile device, encrypt the data and password protect the device.
- Protect your passwords and encryption keys.
- All electronic devices should, at minimum, have personal firewall, anti-virus and anti-spyware programs that are up to date.
- Use a lockable briefcase or laptop case that does not bear any visible logos of your practice or business.
- Only conduct confidential work on mobile devices over which you have control. Do not use public computers or networks, or work on confidential material in public places.
- Beware of public wireless networks such as “Wi-Fi” or “Hot Spots” in airports, hotels and coffee shops:
  - Data transmitted across open airwaves can easily be picked up and read by another device.
  - Watch out for shoulder surfing.
  - Never connect two separate networks simultaneously (e.g., Wi-Fi and Bluetooth) as doing so turns your computer into a bridge or access point.

For more information, visit the IPC website at: www.ipc.on.ca.

What to do when Client Privacy is Breached

A privacy breach occurs whenever a person has contravened, or is about to contravene, a provision of the Personal Health Information Act, 2004 or its regulations including Section 12(1). Section 12(1) of the Act requires health information custodians to take steps that are reasonable in the circumstances to ensure personal health information in their custody or control is protected against theft, loss and unauthorized use or disclosure, and to ensure that records containing personal health information are protected against unauthorized copying, modification or disposal.

During the course of practice, a dental hygienist may become aware of a privacy breach in a number of ways. For example, she or he may witness a breach or it may be brought to her or his attention by a co-worker or a client. She or he may also become aware of a breach when a formal complaint has been received from a client by the
Office of the Information and Privacy Commissioner of Ontario (IPC). If the latter is the case, the College expects that dental hygienists will co-operate fully with the Privacy Commissioner.

Most instances of breach are unintentional, but registrants should also be aware that intentional breaches can occur. For example, unauthorized access of patient/client files by office staff and outside contractors. The College recommends dental hygienists have a “privacy breach protocol” in place so they will be prepared to do the right thing if a breach occurs. The IPC offers the following guidelines when client personal health information has been compromised:

1. Respond immediately by ensuring that the privacy information protection officer for your practice is notified of the breach.
2. Retrieve the hard copies of any personal information that has been disclosed, or in the case of electronic security breaches, change passwords, identification numbers and/or temporarily shut down the system.
3. Notify those individuals whose privacy was breached of what and how their information was breached. Advise them of steps you have taken to address the breach.
4. Investigate how the breach occurred and review the adequacies of existing policies and procedures. Make the necessary corrections to ensure that the breach is not repeated.

For more on the benefits of having a privacy breach protocol and how to avoid a privacy breach, please review “What to do When Faced with a Privacy Breach: Guidelines for the Health Sector” at www.ipc.on.ca.

RDH Expertise for RDHs

CDHO practice consultants 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.

Our practice consultants can help:

- Assist you in understanding how legislation, regulations, standards and guidelines apply to your practice
- Act as an informed sounding board to help identify problems or questions related to dental hygiene practice
- Propose a range of viable options that will help you make good decisions related to your dental hygiene practice
- Guide you in developing problem solving/conflict resolution strategies in your workplace
- Provide constructive and supportive feedback focused on improvements related to client safety, work environments, etc.
- Suggest accessing relevant practice resources

To reach a CDHO practice consultant, call or email, 416-961-6234 or 1-800-268-2346 to reach:

Jane Keir, RDH, x 235, jkeir@cdho.org
Elaine Powell, RDH, x 237, epowell@cdho.org
Varinder Singh, RDH, x 231, vsingh@cdho.org
Recent amendments to the Reporting Requirements (Section 85.2) of Schedule II (the Health Professions Procedural Code) to the Regulated Health Professions Act, 1991 (RHPA) have added two new reporting obligations for facilities where regulated health professionals (the “member”) practice. In addition to the requirement to report suspected sexual abuse of clients/patients, reports must also be made if there are reasonable grounds (i.e., more than just a rumour) to believe that a member who practices at the facility is incompetent or incapacitated. Reports about a member are to be made to the member’s college.

In addition to the requirements set out in s. 85.2, s. 85.5 of the Code mandates employers to report the termination of a member for reasons of professional misconduct (i.e., not just for suspected sexual abuse), incompetence or incapacity.

Either of these reports must be filed within 30 days after the obligation to report arises (i.e., when reasonable grounds arise, or when the termination or suspension occurs). However, if there are reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients, or that incompetence or incapacity of the member is likely to expose a client/patient to harm or injury, and there is an urgent need for intervention, the employer/operator of the facility must file the report immediately.

The legislation does not define “facility” but it likely includes any location (e.g., office, long term care home) where dental hygiene services are provided.

With respect to the employer’s duty to report, the employer must be aware that should the member decide to resign before she or he is terminated or suspended out of concerns with suspected professional misconduct, incompetence or incapacity, the duty on the employer to report still remains. The employer must file the report within 30 days after the resignation.

Should the corporate employer/operator of a facility not make the mandatory report, fines have been increased to not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence. If the employer or operator of a facility is an individual, the fines are $25,000 for a first offence and not more than $50,000 for a second or subsequent offence. Be aware that all reports filed must be made in good faith.

**Incompetence**

The definition of incompetence includes three key components:

- it must relate to the member’s professional care of a client/patient;
- the member must display a lack of knowledge, skill or judgment; and
- the deficiencies must be of a nature or to an extent that demonstrates that the member is unfit to continue to practise, or that her or his practice should be restricted.

It should be noted that not every mistake or breach of standards equates to incompetence. Often, incompetence is revealed by gaps in comprehension, application of basic care principles, or a lack of understanding of the ramifications of potential outcomes for clients/patients who receive substandard care.

**Incapacity**

The two components to the definition of incapacity are:
Milestone

23

- the member is suffering from a physical or mental condition or disorder; and
- the condition or disorder must warrant restrictions (or a prohibition) on the member’s practice.

If a member understands that a health condition is affecting their practice and takes time off from her or his practice to deal with it, a report may not need to be filed as the condition or disorder is not affecting the member’s practice. Incapacity usually arises with regard to mental health or addictive disorders, which may impair the member’s ability to recognize the illness’s impact upon their practice.

If there is any uncertainty on the part of the facility operator/employer with regard to professional misconduct, incompetence or incapacity, inquiries should be made to your legal counsel or the applicable college.

Report Outcomes

Upon receipt of the report, the regulatory college’s Registrar will refer the report to the Inquiries Complaints and Reports Committee (ICRC) for their consideration, along with any other previous decisions involving the member (unless the decision was to take “no further action”). The Registrar will give the member notice of receipt of the report and an opportunity to provide written submissions to the ICRC. After reviewing all of the above, the ICRC can take several actions including (1) refer any allegations of professional misconduct or incompetence to the Discipline Committee (2), refer to a panel of the ICRC for incapacity proceedings (3) require the member to appear before the ICRC for a caution or (4) take action it considers appropriate, including dismissing the matter.

It should be noted that not every mandatory report of professional misconduct, incompetence or incapacity will require a formal investigation. Instead, ongoing monitoring and restrictions to practice may provide satisfactory public protection. If a formal investigation is initiated, the ICRC will review the outcome. If there is sufficient concern of risk to the public, the committee will refer the member to the Discipline Committee or the Fitness to Practice Committee for a hearing. Members who are found to be incapacitated may be required to comply with appropriate medical treatment before returning to practice. Those found incompetent may be required to complete additional education or training. It is likely in both scenarios that restriction and monitoring will be placed upon the individual’s practice when they return to work.

To Make a Report

- To file a report on a dentist, contact Complaints info@rcdso.org, or phone 416-961-6555 or 1-800-565-4591
- To file a report on a dental hygienist, contact the Deputy Registrar ewaters@chdo.org, or phone 416-961-6234 or 1-800-268-2346, ext 228
- To file a report on a dental technologist, contact the Registrar info@cdto.ca, or phone 416-438-5003 or 1-877-391-CDTO
- To file a report on a denturist, contact the Registrar at info@denturists-cdo.com. The College of Denturists of Ontario does not accept complaints by telephone.

The College appreciates the assistance of Richard Steinecke, legal counsel, in the preparation of this article.
Discipline Decision
SUMMARY & REASONS

Jacqueline Speight # 00860

Allegations
In a hearing held on April 30, 2010, a Panel of the Discipline Committee found Ms. Jacqueline Speight guilty of professional misconduct in that she submitted a false or misleading account or charge for services and acted disgracefully, dishonourably or unprofessionally.

Agreed Statements of Facts
An Agreed Statement of Facts and Joint Submission on Finding was filed with the Panel which included the facts that in or about March, April and May 2009, Ms. Speight submitted insurance claim forms for dental services for herself, her husband and her two sons, when those services were either not provided or were provided without charge by her employer. In the process of completing the claim forms, Ms. Speight used the personal office verification stamp of her employer without his permission. Prior to submitting the insurance claims, Ms. Speight had told her colleagues that her family no longer had insurance coverage, when that was not true. Ms. Speight had since reimbursed Blue Cross the monies it had paid her.

Submissions on Penalty
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 Statement of Agreed Facts, the Joint Submission on Penalty and Costs, the case law cited, and 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. Ms. Speight was required to appear before a Panel of the Discipline Committee to be reprimanded, the fact of which shall be recorded on the register of the College of Dental Hygienists of Ontario;

2. The Registrar was directed to suspend the certificate of registration of Ms. Speight for a period of sixteen (16) weeks, to be served on dates to be set by the Registrar;

3. Six (6) weeks of the suspension would themselves be suspended if Ms. Speight complied with the remainder of the order within the deadlines set out therein;

4. The Registrar was directed to impose on the certificate of registration of Ms. Speight a specified term, condition or limitation requiring her to provide proof of successful completion, in the opinion of the Registrar, an Ethics and Jurisprudence course acceptable to the Registrar, at Ms. Speight’s own expense, within six (6) months from the date the Discipline Panel’s Order became final. Ms. Speight would be required to provide proof satisfactory to the Registrar, within three (3) months from the date the Discipline Panel’s Order became final, that she had made arrangements to take the Ethics and Jurisprudence Course.

5. Ms. Speight was required to pay to the College costs in the amount of $2,500, to be paid in 35 monthly installments of $69.44, and one last installment of $69.60, to be paid in full within 36 months of the fifteenth day of June, 2010. Ms. Speight provided post-dated cheques for the costs at the time of the hearing. No interest would accrue on the outstanding amounts so long as they were paid on time. At all times, Ms. Speight shall be at liberty to increase the amount of her monthly payment, solely at her discretion.

Penalty
The Panel considered that the Order addressed the principles of public protection, general deterrence and specific deterrence that must be considered in determining the penalty on a finding of professional misconduct.
Firstly, Ms. Speight engaged in dishonest conduct that was serious and unacceptable. This compromised public trust and the dignity of the profession of dental hygiene. The profession must maintain the respect and trust of both the public who seek dental hygiene services and insurance companies who reimburse dental costs.

Secondly, this penalty served as a general deterrent to the dental hygiene profession to underline the fact that this conduct was inappropriate. The four-month suspension indicated the gravity of the offence.

Thirdly, the penalty also served as a specific deterrent as it was sufficient to prevent a recurrence of the conduct and to assist Ms. Speight in making more professional decisions in the future. It also served to rehabilitate Ms. Speight as she was required to take a course in Ethics and Jurisprudence at her own expense.

The Panel accepted the penalty order as fair in light of the mitigating factors in this case. This was the first time Ms. Speight had appeared before the discipline committee and she had been cooperative with the College from the onset of the discipline process. Ms. Speight pled guilty which saved the College time and expense and expressed remorse and made no excuses for her actions. The Committee also noted that Ms. Speight lost her job as a result of her actions.

At the conclusion of the hearing, Ms. Speight waived her right of appeal and the reprimand was administered by the Panel.

When filling out the online change of business address, be sure to include the type of your practice setting, as well as the name of the business.

Here’s a guide to determine your business practice setting:

- Solo Practice Office – One Dentist Owner
- Group Practice Office – Multiple Owners
- Independent Practice – Dental Hygiene Practice
- Hospital – Including Long Term Care
- Post Secondary Institution – Educator
- Public Health Unit – Government Facility
- Administration – Office Managers, Program Managers
- Other

**Note:** An Independent Practice is not automatically enrolled in the website’s Independent Practice lookup. If you would like your Independent Practice to appear in the lookup or be removed from the lookup, please call the College and we will change the web status for you.

Remember, if you change your home or business address, you are required to notify the College within 14 days.

Notification can be done by either:

1. **Using the online change of address**
2. E-mailing the CDHO your name, Registration ID and address change to addresschange@cdho.org.
3. Phoning 416-961-6234 or 1-800-268-2346

To update your address information:

Please login to the “Registrant Address Change” page on the Registration tab at www.cdho.org.

**Your login ID** is your CDHO Registration ID (6 digits).

**Your password** is your birth date in the format of YYYYMMDD (8 digits).

Use the buttons on the left of the screen to navigate to your existing address/addresses.

You may add up to four secondary business addresses in addition to your primary business address.

Please note, your mailing address must be either your residence or primary business address.
### New Registrants

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<th>Name</th>
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<tr>
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### Registrant Changes

#### February 19, 2010 - June 11, 2010

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#### Milestones

- February 19, 2010 - June 11, 2010
- Registrant Changes

### Reinstated

(as of June 11, 2010)

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Tanner, Shandie Lynn 013554
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Tuomala, Amy Lynn 013365
Turcotte, Cherie-Lee Ann 005897
Wells, Marcia Geraldine 004292
White, Ashley Lynn 013122
Williamson, Elizabeth 006118
Zaid, Ghazala 010823

**Authorized for Self-Initiation**
(February 19-June 11, 2010)

Abbott, Jillian Shelley 010051
Amerka, Kate 011479
Anderson, Isabel Fernanda 009124
Anuda, Darla 008621
Atkinson, Catherine Anne 002380
Aubie, Andrea D 008312
Avena, Merja Sultana 005154
Ballance, Debra Jeanne 001822
Barth, Natalie Jean 009939
Benett, Jennifer M 007713
Bodendistel, Janet 005560
Boulanger, Marnie Jane 010609
Bouman, Jennifer Robyn 007467
Breton, Melissa 010554
Britton, Helen 003105
Bucilli, Sonia-Maria 007098
Buckingham, Pamela Jane 006579
Burrell, Sharon 008664
Caballero, Cynthia 011098
Callaghan, Mary Beth 011175
Campbell, Sharon Elizabeth 004392
Carroll, Andrea Marie 009615
Caverley, Crystal 010715
Chanthavong, Chulaphone 010740
Chatterton, Andrea Christine 006138
Chevalier, Linda Louise 005385
Corrier, Cecilie Marie 006564
Correa, Suzy 010898
Coulobme, Yvonne Michelle 007933
Creighton, Lisa Christine 007550
Cugliari, Nadi 009609
Dailly-Armstrong, Patricia Lynn 004884
Dambvoie, Laura Lynn 006312
Davis, Janice Pearl 004064
Davis, Laurie Lynne 011024
D'Emilio, Tanya 009611
Desjardins, Juliane 011140
Dhir, Devi 011130
Dixon, Rhiannon Julie 010076
Donaldson, Laura-Lee 010983
Downs, Kim 010501
Dundas, Shannon Louise 010045
Dunn, Ann 008434
Estacio, Diana 010623
Facca, Sylvia Santana 011279
Ferreira, Sharon June 001602
Fiorucci, Sabrina 006440
Fitzpatric, Robert Diane 005352
Fraser, Kyle Willard 011742
Frenza, Diana 006646
Frey, Julie Mae 007450
Gainer, Teresa Anne 003192
Galazka, Ana 007045
Gazalka, Ursula 007514
 Gibson, Sandra Lynn 001598
Gilchrist, Susan Deb 006838
Gingras, Nicole Elizabeth 010097
Giovannetti, Sheila Marie 002263
Godin, Rozanne Crystal 005863
Grzela-Dupuis, Diane J 004982
Guayasamin-Santos, Carmen Michelle 009187
Gunn, Patricia L 007775
Hall, Kelly 001780
Harris, Holly Mia 005311
Haskins, Brenda Ann 008139
Hatheway, Tracy 009208
Hazelwood, Susan Elizabeth 002635
He, Ying 011710
Hochman, Staci Milana 007043
Hong, Zheng 009981
Huddleston, Amanda Catherine 011612
Hunter, Alice Mathilde Frieda 006536
Hurley, Sheila Patricia 003721
Hurst, Sarah Louise 007870
Hussey, Lori-Jane 008413
Jarvis-Matney, Jill Linda 001882
Jiang, Siqing 009308
Judd, Cindy Ann 008157
Kasprzyk, Cynthia 008713
Katies, Linda Merle 000233
Kaur, Amrit Pal 009585
King, Erica Beth 004356
Kolter, Jo-Anne 010482
Kordish, Shauna 011155
L'Ecuyer Racine, Marie-Josse 006175
Lee, Kimberly Mae 007817
Lee, Shannon Rae 008394
Leonard, Danielle Rene 009797
Lepere, Margaret Mary 004990
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Lorentz, Heidi Nicole 009036
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Miller, Jackie 007215
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Ricciardi, Enza 009147
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Scully, Wendy Marie 004063
Silva, Manuela 004994
Smith, Estelle 005339
Smith, Nicole Dianne 007549
Sonier, Josee 008175
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Stephenson, Corny-Lin 009228
Stobor, Sonja Annedore 004729
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Sweeney, Nadine 010126
Szklak, Susan Grace 001023
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Taylor, Laura 013509
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Veeneman, Kimberly Anne 007338
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Wilson, Kristie M 008243
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Xia, Lei 011620
Ye, Jacqueline 011981
Young, Michelle Lee 007400
Zister, Erika Daunne 006715

**Resignations**
(February 12, 2009-June 11, 2010)

Darlington, Laura Jane 005617
Dean, Melanie 011495
Frassetto, Sonia Maria 002375
Gupta, Bhumijsa 012540
Patek, Awanben 012828
Roy, Nasim 011680

**Deceased**
(November 12, 2009-June 11, 2010)

Gregoire, Julie 010685
Ouellet, Janice Marie 003666
Romanidis, Theodora 004010
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• Oral health comprises more than just teeth and gum care, and is key to your overall health.
• Your dental hygienist is the expert for preventive oral health care.
• The CDHO regulates the professional practice of dental hygienists to ensure all Ontarians receive high quality care.

We encourage you to visit and direct your clients to the new public information section of www.cdho.org.