MILESTONES

College of Dental Hygienists of Ontario

Protecting your health and your smile

2021 | ISSUE 03

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.

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College of **Dental Hygienists** of Ontario
L'Ordre des **hygiénistes dentaires** de l'Ontario
Protecting your health and your smile / Nous protégeons votre santé et votre sourire

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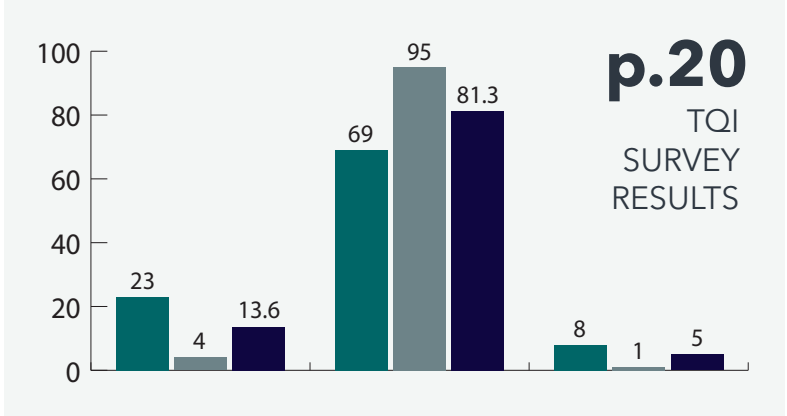

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FEATURES

 Publications Mail Agreement No. 40026784. Return undeliverable Canadian addresses to: College of Dental Hygienists of Ontario, 175 Bloor Street East, North Tower, Suite 601, Toronto, ON M4W 3R8

PRESIDENT'S MESSAGE

CAROLINE LOTZ BA, RDH, MSc

As we move beyond the pandemic, many of the solutions implemented will undoubtedly become best practice for our organization and will continue into the foreseeable future.

In keeping with our public safety mandate, the ever-evolving nature of the pandemic, coupled with emerging data and trends, required the CDHO to expend significant staff resources to the task of reviewing and assessing data, consulting with various health authorities, and comparing emerging best practice directives with current standards. The CDHO's goal continues to be ensuring that IPAC guidance is up to date for registrants and the public. While at times it seemed as though recommendations were changing rapidly, the College was and continues to be committed to communicating updates to registrants so that they can adapt their practice accordingly.

A collaborative effort between CDHO, the College of Dental Technologists of Ontario, the College of Denturists of Ontario, and the Royal College of Dental Surgeons of Ontario resulted in further providing registrants with consistent IPAC guidance.

Thank you to all registrants for ensuring that the public who entrusts their oral health to your care receive safe, high quality services.

In addition to the work undertaken relating to IPAC, at our September Council meeting, the dedicated staff at CDHO provided Council with an overview of some of the innovative ways they overcame various challenges that we as a health regulator faced during the past 18 months working within the constraints of a global pandemic. From rapidly adjusting to a remote work environment to seeking ways of adapting registration processes toward digital records intake, redefining QA timelines, and transitioning discipline hearings from in-person to virtual, CDHO has risen to the challenge!

From challenges come opportunities. As we move beyond the pandemic, many of the solutions implemented will undoubtedly become best practice for our organization and will continue into the foreseeable future. CDHO is fortunate to have such a hard-working team of individuals working tirelessly in support of registrants, the public and Council.

Our next meeting of Council will be held virtually on Friday, December 3, 2021. If you are interested in attending, the meeting link will be posted on the CDHO website.

We wish everyone a Happy Holiday Season.

Caroline Lotz

ANNOUNCING OUR NEW **REGISTRAR AND CEO**

DR. GLENN PETTIFER

The Council of the College of Dental Hygienists of Ontario (CDHO) is very pleased to announce the appointment of **Dr. Glenn Pettifer** to the position of Registrar and Chief Executive Officer. Dr. Pettifer comes to the CDHO with significant leadership experience at the Senior Management level of Ontario Health Profession Regulatory Colleges, most recently serving as Registrar & CEO for the College of Denturists of Ontario. Prior to entering the regulatory world, Dr. Pettifer was an educator and researcher in the field of veterinary anesthesia and pain management and held faculty appointments at several North American universities.

In his regulatory work, Dr. Pettifer demonstrates a strong collaborative and educative approach to public protection, engaging regulated health professionals in self-regulation and supporting the work of health profession regulatory Councils and Committees. His work includes a keen attention to legislative mandates, organizational efficiency, data informed governance and transformational engagement strategies. Complementing his significant regulatory experience, Dr. Pettifer holds a Certificate in Strategic Management of Regulatory Agencies from Harvard Kennedy School and the Osgoode Certificate in Health Law from Osgoode Hall Law School.

The College of Dental Hygienists of Ontario is excited to embark on this partnership. Dr. Pettifer's appointment will begin January 4, 2022.

The College is the regulatory organization for over 14,000 dedicated Registered Dental Hygienists who provide foundational oral health care to the people of Ontario. The CDHO Council wishes to thank **Jane Keir** who served as Interim Registrar & CEO and the College staff who provided their continuing expertise and support during this transition period. The Council also wishes to thank the **Odgers Berndtson Executive Search Firm** for their support in this recruitment process.

COUNCIL HIGHLIGHTS

September 24, 2021

At the September 24, 2021 virtual meeting, Council approved **meeting dates for 2022** as follows:

- Friday, January 21, 2022 (Election of the Executive Committee)
- Friday, March 4, 2022
- Friday, June 10, 2022
- Friday, September 16, 2022
- Friday, December 2, 2022

Council appointed **Terri Strawn** (Professional Member), **Pella Giabanis** (Public Member), and **Jane Keir** (Acting Registrar), to the **Transition Oversight Committee**.

Council approved the revised **GP-7 Council and Committee Stipend & Expenses policy**.

Council approved a new **Council and Committee Onboarding Plan** to be developed and implemented.

Council approved the revisions to the **Discipline Committee's Terms of Reference**.

Rebecca Durcan, from **Steinecke Maciura LeBlanc**, gave a presentation on the regulatory responses to the pandemic and the achievements, risks, and recommendations learned from the Professional Standards Authority for Health and Social Care in the UK.

The Lieutenant Governor in Council appointed **Angelica Palantzas** as a new public member.

Council was informed of the latest committee updates since their last report to Council:

The **Discipline Committee** heard *CDHO v. Kristin Chant* on May 21, 2021.

The **Inquiries, Complaints and Reports Committee** (ICRC) reported that since the last report to Council, it has received 8 new complaints and 1 Registrar's Report. In total, the ICRC is currently investigating 37 matters, including 14 formal complaints, and 23 Registrar's Reports.

The **Registration Committee** reported that since their last report to Council, 166 new applications for registration were received. Of these, 2 applications required detailed review by the Registrar. CDHO

UPCOMING COUNCIL MEETINGS

2021 COUNCIL MEETING DATES

Friday, December 3

VIRTUAL MEETINGS

The CDHO Council meetings are now virtual. They can be viewed on the CDHO YouTube channel.

2022 RENEWAL NOTICE

KYLE FRASER RDH, BComm, BEd, MEd
Manager, Registration

Renewals for 2022 will open on November 15, 2021. All registrants are required to either renew their certificate of registration or formally resign from the College on or before **January 1, 2022**. Log in to the Self-Service Portal using your six-digit registration ID number and password and click the 2022 Renewal link to begin the process.

CHECK YOUR LIABILITY INSURANCE

You **must** hold valid professional liability insurance for the 2022 registration year prior to completing your renewal online. You will be asked during the renewal process if you have the required insurance. If you indicate that you do not have insurance, you will be prevented from completing your renewal. If you do indicate that you have insurance when in fact, you do not, you would be providing false or misleading information to the College, which is considered professional misconduct.

DO NOT LEAVE IT UNTIL THE LAST MINUTE

If you do not renew on or before **January 1, 2022**, a $100 late penalty fee will be charged for renewals that have not been received by the deadline. There will be office closures around the holidays in December so there could be limited assistance available. If you run into any issues, the processing of your renewal may be delayed. Renewals open on November 15, 2021, so there is plenty of time to sort out your options and complete the process before the holidays.

Registrants who do not intend to renew for 2022 need to formally resign from the College by January 1, 2022, by logging into their Self-Service account and selecting the "Resign" link under the Registration heading. Not renewing is not the same as resigning and failure to inform the College of your resignation will result in the suspension of your certificate of registration.

If you fail to renew or resign, your certificate of registration will be **suspended** effective **February 11, 2022**. Suspensions are recorded permanently on the Public Register and this information will be published in *Milestones*. There is a $500 fee to reinstate a suspended certificate of registration, in addition to any outstanding registration fees. Forgotten passwords can be reset by using the "Forgotten Password" button on the Self-Service login page. Follow the prompts to restore your access. The College is not able to give out passwords over the telephone. If you did not receive an email prompting you to renew, it is likely because the email we have on file for you is incorrect. Log in to your account on CDHO's Self-Service Portal and correct your contact information using the "Address Information" link available in your menu. Remember, it is your responsibility to keep all of your information current. Registrants are required to update their contact information on file within 14 days of any changes. Do not forget, we are here to help. If you have concerns or questions about your particular situation, please feel free to contact us. CDHO

VACCINE MANDATES

The Government of Ontario has released the most comprehensive mandatory vaccination policies in Canada. As of September 22, 2021, Ontarians will need to be fully vaccinated (two doses plus 14 days) and provide their proof of vaccination certificate along with photo ID that has their name and date of birth to access certain public settings and facilities, such as indoor seating in restaurants and gyms. This approach focuses on higher-risk indoor public settings where face coverings cannot always be worn. An enhanced digital vaccine certificate with a unique QR code has been made available as of October 22, 2021. The QR code contains the same information as the original certificate. You will have to present the QR code for scanning along with a valid piece of identification. The QR code is read by a provincial application that verifies that it is from a trustworthy source and then displays your vaccination status based on Ontario guidelines.

PURPOSE OF ENHANCED VACCINATION CERTIFICATES (QR CODES)

1. **Individual control:** Ensures Ontarians can obtain and use their vaccination certificate when and how they choose
2. **Privacy enhancements:** Strengthens and protects Ontarians' privacy
3. **Stability for businesses:** New technology tool to help keep businesses open during the fourth wave
4. **Foundational capability:** Prepares for interoperability and integration with federal vaccine passport for international travel
5. **Interoperability:** Use of standard technology facilitates the vaccination status to be accessible across Canadian jurisdictions.

For questions on how to access your vaccination records, you can contact the Provincial Vaccine Information Line at 1-888-999-6488 (TTY for people who are deaf, hard of hearing or with speech disabilities, contact 1-866-797-0007). Information is available in over 300 languages from 8 a.m. to 8 p.m. every day.

The CDHO strongly encourages all dental hygienists to be vaccinated against COVID-19 at the earliest available opportunity. In keeping with guidance from Public Health Ontario and Health Canada, the College's guidelines on infection prevention and control state that all dental hygienists should be vaccinated against transmissible diseases, where possible. For more information on COVID-19 and vaccination for dental hygienists and the public, please visit the *Frequently Asked Questions* on the CDHO website: https://www.cdho.org/my-cdho/practice-advice/covid-19-faq

Lastly, regardless of vaccination status, please continue to follow all Public Health Guidelines.

REFERENCE

Government of Ontario (2021). Proof of COVID-19 Vaccination.
https://covid-19.ontario.ca/proof-covid-19-vaccination CDHO

UPDATING THE COLLEGE

EVA ROSENSTOCK
Case Manager, Complaints and Investigations

Registration at the College comes with benefits and responsibilities. One of those responsibilities is meeting your reporting requirements and ensuring, for example, that your contact information is current and updated through the Self-Service Portal.

Article 14.3 of Bylaw No. 5 reads,

The Registrant shall update their information on the College website or notify the College, in writing, of any changes to the following information within 14 days of the effective date of the change:

a) The Registrant's name;
b) The address and telephone number of the Registrant's primary residence and a current email address to which only the Registrant has access;
c) Every employment address and employment telephone number, and, if available, every business facsimile number and business email address;
d) The Registrant's professional liability insurance as required by Article 7.3 of this Bylaw;
e) Details about registration, membership or licensure with any regulatory body inside or outside of Ontario;
f) Details about misconduct, incompetence, incapacity or similar proceedings against the Registrant, whether completed or ongoing, by a regulatory body in or outside of Ontario;
g) Details about any finding by a court against the Registrant in respect of a federal, provincial or other offence;
h) Conditions, terms, orders, directions or agreements relating to the custody or release of the Registrant in respect of federal, provincial or other offence processes; and
i) Details about any current charges against a Registrant, in respect of a federal, provincial or other offence.

The College encourages all registrants to review the College Bylaws from time to time.

While the Public Register is available as a resource for the public (including employers) to learn where a registrant works, when they graduated and from where, other information provided to the College (such as your personal contact details) is necessary so that the College can contact you when required.

The College regularly contacts registrants for information – this may be information related to a complaint or investigation or it may be to advise you of important information by way of E-Brief.

Registrants are required to respond to all inquiries from the College and it can be considered an act of professional misconduct not to do so. If the College cannot contact you, you will not receive important information. Further, you may be investigated for not complying with, not responding to, or not cooperating with the College. Anything mailed to your current addresses is presumed received within five days. You cannot simply say, "I did not get it as I moved", since the College is required to have your current contact details.

If you ever have any questions about what must be reported or updated, contact the Registration Department or Practice Advice. CDHO

QUALITY ASSURANCE MATTERS

TERRI-LYNN MACARTNEY BA (HONS)
Manager, Quality Assurance Program

UPDATE ON THE 2021 QUALITY ASSURANCE ASSESSMENTS

In 2020, notice was sent to 2,583 registered dental hygienists requesting submission of their QA records for the Peer and Practice Assessment, due by January 31, 2021. Of these, 2,566 were selected because their registration number ends in either a "5" or a "7" (Regular Selection), while 17 were selected because they did not complete the mandatory annual Self-Assessment (Self-Assessment Selection). An additional 15 registrants submitted assessments in January 2021 that had been deferred from a previous selection year.

Of the 2,598 total records requested (as of October 1, 2021):

	Number of Registrants from Regular Selection	Number of Registrants from Self-Assessment Selection	Total
Met the assessment guidelines with initial submission	1,723	7	1,730
Assessed with deficiencies but met the assessment guidelines with an additional submission and/or remediation	514	5	519
In remediation	57	0	57
Still in assessment phase: On-site practice reviews	33	1	34
Resigned	220	2	222
*Other: Includes registrants who were granted extensions or deferred to another assessment period, as well as those currently suspended, revoked, referred to ICRC, or under investigation.	34	2	36
Total			**2,598**

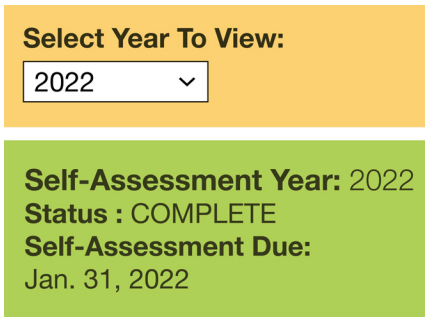
NOTE: The 15 registrants that were carried forward from previous selection years are included in the Regular Selection group in the table above.

REMINDER: MANDATORY 2022 SELF-ASSESSMENT

The 2022 Self-Assessment Tool will be available in your SMILE Portal starting mid-November and is due by **January 31, 2022**. As a reminder, the Self-Assessment is mandatory for **all** registrants, regardless of registration status or employment situation — this includes Active and Inactive registrants, whether you are working in dental hygiene or not, and those living or working outside of Ontario. If you are registered, you need to complete the annual Self-Assessment.

The 2022 Self-Assessment can be accessed in the SMILE Portal by choosing "**2022**" from the "Select Year to View" dropdown menu on the dashboard. You will need to complete Step One first by verifying your employment status and practice address(es) before you can move on to access the Self-Assessment in Step Two. In the table that appears in Step Two, click on the "#1: General" link to open the Self-Assessment. The word "General" here does not refer to the general registration category or a practice setting type, but to the general Standards of Practice relevant to all dental hygienists. Educators are required to complete an additional Self-Assessment that will appear as "#2: Educator", which is based on the *Standards of Practice for Dental Hygiene Educators*.

Year	Standard of Practice Type
2022	#1: General
2022	#2: Educator



The General Self-Assessment contains 109 questions, and the additional Self-Assessment for Educators contains 32 questions. The Self-Assessment should take approximately 15–20 minutes to complete. However, if you would like to save your work and return to complete the Self-Assessment at a later date or time, you can click "Save and Continue Working" and exit the SMILE Portal at any time. Once all the questions are answered and you are satisfied with your work, you will need to click "I'm All Done" at the bottom of the page. This will complete your Self-Assessment and submit the completion status to CDHO. You should see a green checkmark next to Step Two and your dashboard will reflect completion of your Self-Assessment.

WHAT HAPPENS WHEN A REGISTRANT DOES NOT COMPLETE THE SELF-ASSESSMENT?

The Self-Assessment is how we monitor whether registrants are participating in the Quality Assurance program annually, as required under the *Regulated Health Professions Act, 1991*. Failure to complete the annual Self-Assessment does have serious consequences. Per the Quality Assurance Committee's policy, any registrant who fails to complete the mandatory Self-Assessment by the January 31st deadline may be added to the following year's QA selection and be required to submit their QA records for audit.

Depending on individual circumstances, some registrants in the past have also been subject to a $50 fee for failing to respond to the College (per CDHO Bylaw No. 5). Failure to pay this prescribed fee can result in the suspension of a certificate of registration for non-payment of fees. The fee to reinstate a suspended certificate of registration is $500. In other cases, registrants have been referred to the Inquiries, Complaints and Reports Committee (ICRC) for professional misconduct, as it is considered professional misconduct to fail to respond to a request from the College.

ARE YOU SUBMITTING YOUR QA RECORDS IN 2022?

For registrants who were selected to submit for the upcoming audit — either because your registration number ends in a "4" or a "9", or because you otherwise received notice from the College that you would need to submit — your Quality Assurance records must be submitted via the SMILE Portal by **January 31, 2022**. The SMILE Portal will allow you to submit your records for assessment beginning on January 1, 2022. You need to have a green checkmark next to each of the steps in your dashboard, then you will be asked to read and agree to a declaration before you are able to finalize your submission. The College will not receive your records until the declaration has been agreed to and your dashboard indicates that you have submitted everything. Please note, for those of you who completed the QA Test before the end of 2021, you will still need to return to your SMILE Portal and finalize your submission in January 2022. CDHO

THE CDHO KNOWLEDGE NETWORK

7 UPDATED FACT SHEETS

- Anxiety and Anxiety Disorders
- Cardiac Implantable Electronic Devices (Also available under Pacemaker)
- Hypertension
- Hyperthyroidism
- Hypothyroidism
- Post-Myocardial Infarction
- Zika Virus Disease

2 NEW FACT SHEETS

- Hypertension in Children and Adolescents
- Obsessive Compulsive Disorder (OCD)

4 UPDATED ADVISORIES

- Anxiety Disorders
- Hypertension
- Hyperthyroidism
- Hypothyroidism

Find the clinical information you need at **www.cdho.org**

ICRC CORNER: LESSONS LEARNED #2

ROULA ANASTASOPOULOS RDH, BEd
Investigator

ROBERT FARINACCIA RDH, BSc
Case Manager

The Inquiries, Complaints and Reports Committee (ICRC) of the CDHO reviews and decides on complaints made about dental hygienists, as well as other concerns where the Registrar believes there are grounds for an investigation.

This ongoing series will examine common concerns that have come before the ICRC, inspired by actual cases, to help registrants understand and avoid similar concerns in their own practice.

THE SCENARIO

- On August 15, 2021, a 17-year-old male client attends an orthodontic practice and requests to be seen on an emergency basis. The orthodontist has left for the day and is not available by phone. An experienced dental hygienist in the practice agrees to see the client to determine if she can assist him.
- Based on her review of the clinical chart, the dental hygienist can see that the client is in the retention phase of orthodontic treatment and that his last appointment was in March 2021.
- At the current appointment, the client reports that he lost his retention appliance at the beginning of June 2021, and he is afraid that his teeth might shift. He requests a replacement appliance. The client says that he is soon returning to school out of town and needs a new appliance right away.
- The dental hygienist notes that a Hawley retainer was prescribed, fabricated, and delivered to the client in February 2021. To accommodate the client's schedule, the dental hygienist decides to re-write the same prescription for the appliance, sign it, and send it to the lab for fabrication of a replacement.
- The client returns to the practice a few days later, and the dental hygienist delivers the replacement appliance to him; however, the client tells the dental hygienist that the Hawley appliance looks different than the appliance he had lost.
- Upon further review of the client's orthodontic record, the dental hygienist notes that the original treatment plan developed by the orthodontist approximately three years ago set out that an Essix appliance, not a Hawley appliance, would be used for the retention phase.
- Not wanting to inconvenience the client, the dental hygienist decides to change the prescription for the Hawley appliance she signed to an Essix appliance and sends it back to the lab. The client returns a few days later, and the dental hygienist checks the fit and delivers the new Essix appliance.
- In early November 2021, the dental hygienist leaves the orthodontic practice for another employment opportunity. After leaving the orthodontic practice, the dental hygienist remembers that she had forgotten to document the fabrication of the Essix appliance in the client's oral health record.

- The dental hygienist calls her previous orthodontic practice and requests access to the records for the purpose of completing them. The office refuses to allow the dental hygienist access to any client records. The dental hygienist decides to not pursue or follow up on the matter.

Do any of the details in this scenario sound familiar? Have you come across a similar situation? Was there anything that concerned you regarding the dental hygienist's conduct when dealing with the situation?

Think about how you might have handled the situation before reading the concerns noted by the ICRC in similar cases below. Did you think of all these concerns? Did you think of others?

Concern → Out of scope of practice

Under the *Regulated Health Professions Act, 1991* (RHPA), the fitting or dispensing of a dental prosthesis, orthodontic or periodontal appliance, or a device used inside the mouth to protect teeth from abnormal functioning is a controlled act. Only specific regulated health professionals, such as dentists, are permitted to engage in this act when providing health care services.

Dental hygienists are not authorized to engage in this controlled act and cannot independently fit or dispense orthodontic appliances. The dental hygienist in this case was, therefore, breaching the RHPA and acting outside of her scope of practice when she delivered the orthodontic appliance to the client. It is a dentist who would be authorized to verify the fit and dispense the replacement orthodontic appliance to the client.

Concern → No client-specific order

Dental hygienists are authorized to perform orthodontic procedures while practising dental hygiene (such as placing, cementing, and removing bands, brackets, space maintaining and orthodontic appliances); however, a dental hygienist may **only** do so if the procedure is **ordered by a member of the Royal College of Dental Surgeons of Ontario (RCDSO)**. Additionally, it is up to the dentist to determine the level of supervision required, and the dental hygienist must be confident and competent to perform the procedure.

This authority can be found in sections 4 and 5 of the *Dental Hygiene Act, 1991* (DHA), which reads in part as follows:

Authorized acts

4. In the course of engaging in the practice of dental hygiene, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Scaling teeth and root planing including curetting surrounding tissue.
2. **Orthodontic and restorative procedures.**
3. Prescribing, dispensing, compounding or selling a drug designated in the regulations.

Additional requirements for authorized acts

5 (2) A member shall not perform a procedure under the authority of paragraph 2 (#2 Orthodontic and restorative procedures) of section 4 **unless the procedure is ordered by a member of the Royal College of Dental Surgeons of Ontario**.

Dental hygienists may also be involved in the design, construction, repair, and alteration of an orthodontic appliance, so long as the technical aspects of the design, construction, repair or alteration are **supervised by a member of the RCDSO or the College of Dental Technologists of Ontario (CDTO)**. This authority is found in section 32 of the RHPA, which reads as follows:

Cont'd on next page

Dental devices, etc.

32(1) No person shall design, construct, repair or alter a dental prosthetic, restorative or orthodontic device unless,

(a) the technical aspects of the design, construction, repair or alteration are supervised by a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario; or

(b) the person is a member of a College mentioned in clause (a).

In this case, the dental hygienist did not have a client-specific order and fabricating a different orthodontic appliance was not ordered or overseen by a dentist.

Although the CDHO considers the dentist's orthodontic treatment plan as evidence of a client-specific order when dealing with orthodontic procedures, consideration also needs to be given if an extended period of time passes, such as in the scenario above (approximately three years). Since the treatment plan was developed, a number of clinical changes to the client's dentition could have occurred, warranting the need for consultation with a dentist for a more current client-specific order.

Even in cases where a client-specific order is present, ultimately, it may be wise to let the dentist have the final look before the client is dismissed.

Although the dental hygienist noted that the treatment plan developed by the orthodontist included the fabrication of an Essix appliance, **the dental hygienist practised outside of her scope of practice**. The dental hygienist should have considered the following before making the decision to proceed:

1. The length of time that had passed since the orthodontist created the treatment plan (approximately three years ago).
2. Why the prescription she first altered was for a Hawley appliance when the treatment plan mentioned an Essix appliance. Was there a treatment plan modification by the orthodontist from an Essix appliance to the fabrication of the Hawley appliance?
3. The length of time since the client had been seen by the orthodontist (approximately five months ago).
4. Possible movement of the teeth since the client verbalized losing his appliance three weeks ago.

Given all the above factors, the dental hygienist should have consulted with a member of the RCDSO prior to proceeding with any treatment. Ask yourself, was this a true emergency or should you have waited until the client could have been seen by the orthodontist?

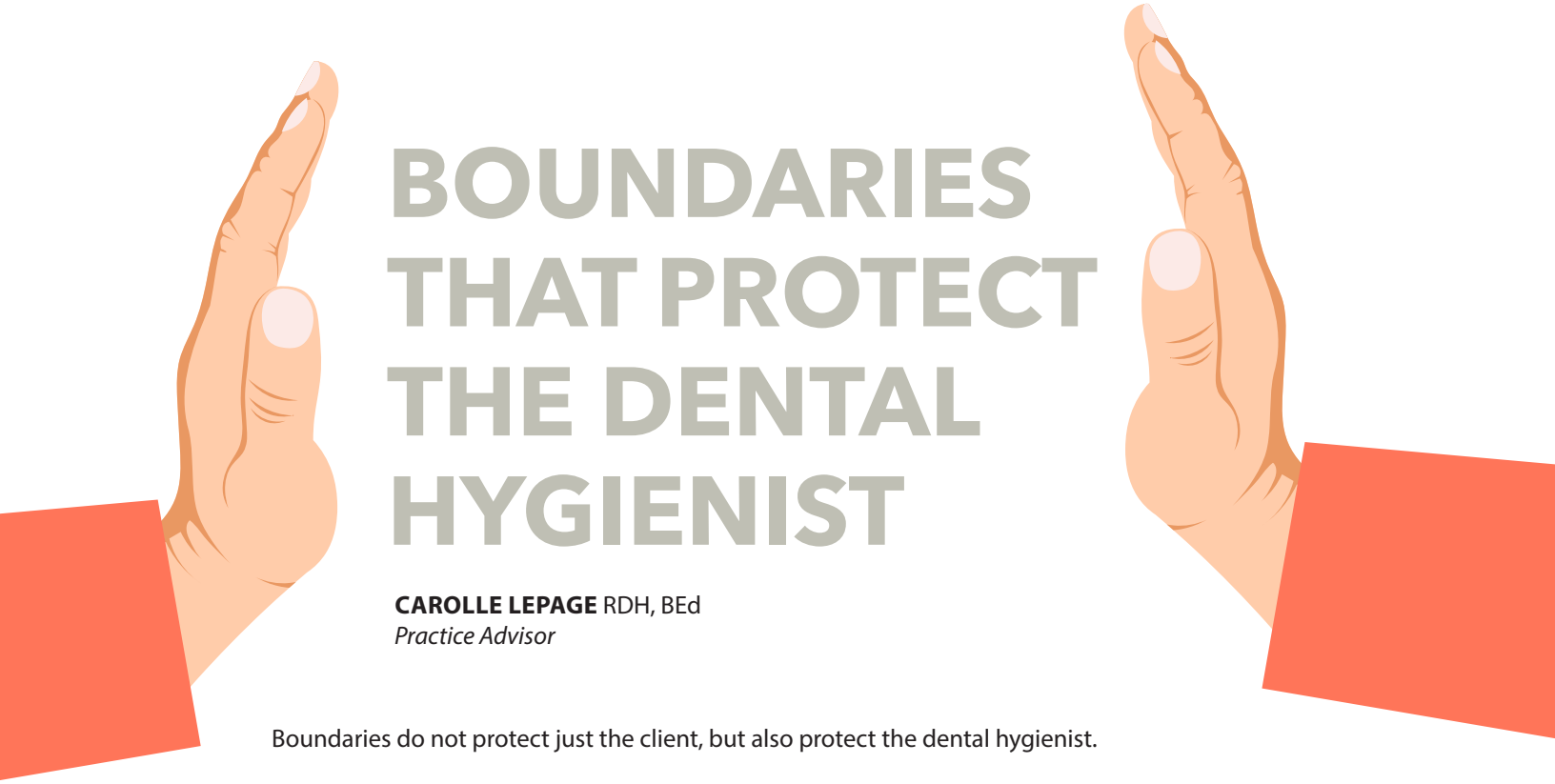
Concern → Record Keeping Deficiencies

Thorough and proper documentation in client records is not only an obligation but is also a dental hygienist's best defense should they be involved in an investigation. A proper client record allows continuity of care to occur between health care providers (both intra- and interprofessional) and provides transparency to the clients who are being treated. For this reason, it is important for dental hygienists to document all treatment activities in accordance with the Records Regulation of the DHA.

Oral health records are critical in a dental hygienist's accountability for services. Clients, employers and the CDHO will rely heavily on the dental hygienist's records in assessing whether the dental hygienist met the standards of practice and provided competent dental hygiene services following the process of care. The saying, "if it wasn't recorded, it wasn't done" is a good motto for practice, and a dental hygienist may have difficulty convincing someone examining their practice that something was done if the chart had no record of it. Therefore, it is vitally important for a dental hygienist to document all clinical care provided to a client in a timely and appropriate manner.

In the scenario above, the dental hygienist forgot to document the orthodontic care she provided to the client and subsequently left the practice. The dental hygienist's initial approach to resolving the issue was correct, in that she requested access to the client records to include the forgotten clinical notes. Any late clinical chart entries need to clearly document the actual date on which they were made.

When she was denied access, however, the dental hygienist's efforts should not have ended as her record keeping deficiency in that client's chart remained. The dental hygienist must consider an alternative to ensure the treatment they provided is accurately documented in the client's oral health records. In this case, the dental hygienist could have written the clinical record on a piece of paper, sent it to the dental office to be filed in the client's oral health record, and kept a copy for herself, as evidence that she had made an effort to correct the deficiency. In this manner, the dental hygienist would have made better efforts to fulfil her record keeping obligations. CDHO



BOUNDARIES THAT PROTECT THE DENTAL HYGIENIST

CAROLLE LEPAGE RDH, BEd
Practice Advisor

Boundaries do not protect just the client, but also protect the dental hygienist.

While rare, some clients can become **verbally, emotionally or physically abusive towards a dental hygienist**. Typically, this occurs where a client has other psychological, personality or emotional issues occurring in their lives. It is important to realize that the abuse is not a result of your behaviour, but of other conditions that have simply been triggered by something during your encounter.

Often, you may be able to review what you know about the client and how they have responded to previous interactions to understand the true reason for the client's conduct. If the abusive behaviour is in its milder and earlier stages, you can sometimes respond successfully by fixing firm boundaries.

This boundary establishment could involve:

- advising the client that such conduct is not appropriate, and
- asking the client to be more careful in the future.

Sometimes changing the context or circumstances of your interactions may still allow you to continue treatment by implementing a high level of safeguards in place:

- Use a different office near the front desk and leave the door open.
- An assistant or colleague can join your sessions.
- Transfer the care of your client.

Where the abusive behaviour is significant or repetitive, consideration must be given to terminating the relationship.

It is important to balance your own need for protection and safety, which is valid and important, with the client's need for care. If you must transfer a client, it must be made in accordance with the Professional Misconduct Regulation.

RESOURCES

CDHO Registrants' Handbook, Chapter 8
https://www.cdho.org/docs/default-source/pdfs/reference/registrantshandbook.pdf

Guideline: Prevention of Sexual Abuse and Maintenance of Professional Boundaries https://www.cdho.org/docs/default-source/pdfs/reference/guidelines/sexual-abuse-and-professional-boundaries.pdf CDHO

COMMON REPORTING REQUIREMENTS FOR DENTAL HYGIENISTS

CAROLLE LEPAGE RDH, BEd
Practice Advisor

A special duty under the *Regulated Health Professions Act, 1991* (RHPA), and indeed other statutes, is to make mandatory reports to the proper authority when certain events occur. Dental hygienists have an obligation to make a mandatory report to the proper authorities in circumstances where they become aware of concerns about the welfare of certain vulnerable individuals.

Many of these mandatory reporting criteria refer to "reasonable grounds". That phrase has two components:

1. "Reasonable grounds" refers to objective information, not personal belief. If the facts are present, a report must be made even though you might not believe the facts to be true. You do not have to make a detailed evaluation of whether the person providing the information is credible.
2. "Reasonable grounds" describe the type of information needed for a report to be made. Mere rumour or gossip are not reasonable grounds; however, you do not need hard evidence or clear proof either.

A report should either be made in writing or be confirmed in writing. For details on what should be included in a report, see p. 2–10 of the CDHO Registrants' Handbook at https://www.cdho.org/docs/default-source/pdfs/reference/registrantshandbook.pdf.

TABLE OF COMMON MANDATORY REPORTING REQUIREMENTS BY DENTAL HYGIENISTS

LEGISLATION / LEGAL AUTHORITY	WHAT MUST BE REPORTED	TRIGGER FOR REPORT	AUTHORITY REPORT IS MADE TO
Regulated Health Professions Act	Sexual relations, touching, behaviour or remarks of a sexual nature between a registered health practitioner and a client where you know the name of the alleged abuser	Reasonable grounds obtained either: 1. in the course of practising your profession or 2. if you operate a health facility	Registrar of the College to which the alleged abuser belongs
Regulated Health Professions Act	Professional misconduct, incompetence or incapacity of a registered health practitioner	1. You are terminating employment 2. You are revoking, suspending or imposing restrictions on privileges 3. You are dissolving a partnership or association or 4. You intended to terminate or revoke and the person quits first	Registrar of the College to which the health practitioner belongs
Child, Youth and Family Services Act, 2017	That a child (under 16) is in need of protection as defined in the *Child, Youth and Family Services Act, 2017* (e.g., suffering abuse or neglect)	Reasonable grounds to suspect	Children's Aid Society (report must be personal, cannot delegate)
Long-Term Care Homes Act, 2007	That a nursing home resident has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect	Reasonable grounds to suspect	Director of Nursing Homes
Case law "duty to warn"[1]	That an identifiable person or group is at substantial risk of serious harm or death from another person	Reasonable grounds	To an appropriate authority and, possibly, the intended victim

[1] This case law duty to warn has been recognized in s. 40 of the *Personal Health Information Protection Act, 2004*.

TYPES OF CONCERNS THAT A DENTAL HYGIENIST MUST REPORT

The following are some common mandatory reports that dental hygienists must make. This is not an exhaustive list, and it does not cover all possible situations and reporting responsibilities. If you are unsure of your reporting obligations in particular circumstances, you should reach out to the College's Practice Advisory Service for more information or consult a legal advisor.

Children and youth account for 57% of the abuse that is reported to the authorities.

1. *Sexual relations, touching, behaviour or remarks of a sexual nature*

between a registered health practitioner and a client (other than what the Spousal Exception Regulation defines as "Spouse") where you know the name of the health practitioner.
See *Guideline: Prevention of Sexual Abuse and Maintenance of Professional Boundaries* (see Resources on page 19 for link).

a. A major theme of the RHPA is the eradication of sexual abuse of clients by registered health practitioners. Sexual abuse is defined broadly in the RHPA as sexual intercourse or other forms of sexual relations between a practitioner and a client; touching of a sexual nature of a client by a practitioner; or behaviour or remarks of a sexual nature by the practitioner towards a client. Sexual abuse does not include touching, behaviour, or remarks of a clinical nature appropriate to the service being provided. Any sexual behaviour in the presence of a client, including making a coarse or sexually disrespectful comment, constitutes sexual abuse. Also, there is an obligation to report sexual abuse by other registered health practitioners.

b. Significant consequences can occur when a mandatory report regarding sexual abuse is not made. In some cases, you can be prosecuted and fined up to $50,000 in Provincial Offences Court. Generally, it is professional misconduct to fail to make a mandatory report. A registered health practitioner could also be sued for any harm that results from failing to make a mandatory report.

Reporting

Section 85.3(4) of the *Health Professions Procedural Code* states: "The name of a client who may have been sexually abused must not be included in a report unless the client/guardian, consents in writing to the inclusion of its name." Therefore, you do not need the client's consent to make a report, but you do need their written consent to include their name in the report.

Section 85.1(3) of the *Code* also states: "If a registration is required to file a report because of reasonable grounds obtained from a client, the registrant must notify the client of the requirement to make the report before doing so."

2. *Professional misconduct, incompetence, or incapacity of a registered health practitioner*

a. In the *Code*, the requirement to report professional misconduct (not including sexual abuse), incompetence, or incapacity only applies in certain circumstances. For example:

- See Professional misconduct legislation: https://www.cdho.org/docs/default-source/pdfs/reference/regulations/professionalmisconduct.pdf

Reporting

The reporter does not need the consent of the health professional to make the report.

3. *That a child (under 16) is in need of protection as defined in the Child, Youth and Family Services Act, 2017, including physical, emotional and sexual abuse, neglect, and/or a pattern of abuse or risk of harm*

a. **In Ontario, it is the law to report suspected child abuse or neglect to a Children's Aid Society.** Also, you only need reasonable grounds to suspect child abuse or neglect to make a report.

b. All suspicions of child abuse or neglect must be reported directly to your local Children's Aid Society. Children's Aid Societies have the exclusive mandate, under the *Child and Family Services Act*, to investigate allegations of child abuse or neglect and to deliver child protection services. To learn how to recognize the signs of child abuse and neglect, visit http://www.oacas.org/childrens-aid-child-protection/what-is-abuse/

Reporting

Section 125(1) of the *Child, Youth and Family Services Act, 2017*, requires anyone (including health care professionals) who has reasonable grounds to suspect that a child is at risk as described in that section to make a report to the

Cont'd on next page

appropriate children's aid agency. You do not need the consent of the child or their caregivers to make the report. The duty to report is broad and overrides health information confidentiality. To learn more about how you can identify children in need of protection, as well as the specific circumstances that must be reported, please see the *Child, Youth and Family Services Act, 2017 and Reporting Child Abuse*, on page 23 of this issue.

4. That a long-term care home / nursing home resident has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect

a. These include **physical abuse, sexual abuse, emotional abuse, financial/material exploitation, neglect, abandonment, and self-neglect**.

b. Elder Abuse is a contemporary issue that, given the projected demographics, is expected to intensify over the coming years. By the year 2031, one in four people will be over 65 years old, with the largest cohort of this demographic being aged between 79 and 84 years.

ELDER PHYSICAL ABUSE WARNING SIGNS

- Unexplained signs of injury, such as bruises, welts, or scars, especially if they appear symmetrically on two sides of the body.
- Broken bones, sprains, or dislocations.
- A report of drug overdose or an apparent failure to take medication regularly (a prescription has more remaining than it should).
- Broken eyeglasses or frames.
- Signs of being restrained, such as rope marks on wrists.
- Caregiver's refusal to allow you to see the elder alone.

Reporting

Section 24(1) of the *Long-Term Care Homes Act, 2007*, requires anyone (including health care professionals) who has reasonable grounds to suspect that certain forms of elder abuse have or may occur to make a report to the appropriate authority. You do not need the consent of the resident or their caregivers to make the report. The duty to report is broad and overrides health information confidentiality.

5. That an identifiable person or group is at substantial risk of serious harm or death from another person

a. The "duty to warn" is the most difficult of these mandatory reports because it is not specified in statute; it arises from case law. The duty to warn typically arises where a client has confided to you a threat to harm another person or identifiable group (e.g., "That is the last straw, I am going to blow him away"). If the threat is clear, immediate, and it appears that the client has the ability to carry it out, then there is a duty to warn those threatened. Usually reporting the matter to the police is sufficient.

b. The *Personal Health Information Protection Act, 2004* supports the duty to warn. Under section 40, a health information custodian can disclose personal health information where there is a significant risk of serious bodily harm. The provision reads as follows:

Reporting

Section 40(1) of the *Personal Health Information Protection Act* permits a health information custodian to disclose personal health information "if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons." The custodian does not need the client's consent to make the disclosure. This is also a discretionary disclosure, rather than a mandatory disclosure, although there may be an ethical and professional duty to make a report to the relevant authorities (e.g., the police).

ABUSE OF ADULTS WITH DEVELOPMENTAL DISABILITIES

People with disabilities experience higher rates of domestic violence, sexual assault, and abuse.

Abuse is a serious threat to many people with disabilities. A range of Criminal Code offences may relate to abuse, including **assault and sexual assault, fraud, theft, mischief, criminal harassment (also known as "stalking"), uttering threats, intimidation, and extortion**.

The Government of Ontario is expanding ReportON, a new service for reporting suspected or witnessed abuse of adults with developmental disabilities.

The 24/7 phone line and email service is the latest step taken by the Ministry of Community and Social Services to further improve the safety of adults with developmental disabilities.

Abuse is often hard to identify. Examples can include being denied basic necessities like food, shelter, clothing or medicine. Even if you are unsure, but suspect abuse or neglect of an adult with a developmental disability, you should contact ReportON at 1-800-575-2222 or by email at reportONdisability@ontario.ca.

If you suspect abuse is happening to a child, elder or any vulnerable individual, there are a number of options you have for immediate help. They include :

This list is not exhaustive, and it is suggested to establish a list of contacts for your area.

- **Call 9-1-1** (if available in your area), or your **local police emergency number**.
- The **Children's Aid Society** can provide help and information if child abuse is suspected or taking place.
- Call your local **Children and Family services**.
- Call a local crisis or help line, such as the **Ontario Victim Support Line** at 1-888-579-2888 or 416-314-2447, or the **Assaulted Women's Helpline** at 1-866-863-0511 or 416-863-0511.
- **Ontario Victim Services** can help provide services such as food, clothing and shelter.
- Contact the **Ontario Ministry of Women's Issues** or the **Ontario Association of Interval and Transition Houses** for a list of shelters in your area that can give temporary help and somewhere safe to stay.
- The **Kids Help Phone** can connect kids, teens and young adults, from any community in Canada, to a professional counsellor 24 hours a day, 365 days a year. Call 1-800-668-6868, or visit KidsHelpPhone.ca.
- For adults with a developmental disability, you should contact **ReportON** at 1-800-575-2222, or reportONdisability@ontario.ca.
- Find help across Canada: https://endingviolencecanada.org/getting-help-2/
- **Municipal Police Services**

RESOURCES

CDHO Registrants' Handbook
https://www.cdho.org/docs/default-source/pdfs/reference/registrantshandbook.pdf

Prevention of Sexual Abuse and Maintenance of Professional Boundaries
https://www.cdho.org/docs/default-source/pdfs/reference/guidelines/sexual-abuse-and-professional-boundaries.pdf

Ontario's Legislation for Child, Youth and Family Services
http://www.children.gov.on.ca/htdocs/English/professionals/childwelfare/modern-legislation.aspx

Ministry of Children, Community and Social Services
https://www.ontario.ca/page/ministry-children-community-and-social-services

***Child, Youth and Family Services Act, 2017*, S.O. 2017, c. 14, Sched. 1**
https://www.ontario.ca/laws/statute/17c14

Children's Aid & Child Protection
http://www.oacas.org/childrens-aid-child-protection/

Elder Abuse Prevention Ontario
http://www.eapon.ca/

Adult Protection Service Association of Ontario
http://apsao.org/

Information about elder abuse
https://www.ontario.ca/page/information-about-elder-abuse

Ending Violence in Ontario
https://endingviolencecanada.org/getting-help-2/

Health Professions Procedural Code
https://www.ontario.ca/laws/statute/91r18

Dental Hygiene Act, 1991
https://www.ontario.ca/laws/statute/91d22

Long-Term Care Homes Act, 2007
https://www.ontario.ca/laws/statute/07l08

Personal Health Information Protection Act
https://www.ontario.ca/laws/statute/04p03 CDHO

TQI SURVEY RESULTS

TERRI-LYNN MACARTNEY BA (HONS)
Manager, Quality Assurance Program

Every six to seven years, the Quality Assurance (QA) Committee administers a Total Quality Improvement (TQI) survey for registrants in order to understand dental hygiene practice in Ontario. The data collected from the first TQI survey in 1995 was used as a baseline profile of dental hygiene practice in Ontario and for surveys conducted in later years. The survey has helped the College develop and make changes to the QA Program, assess dental hygiene practice patterns, and identify areas for practice improvement.

In June 2020, the College contracted a research team from the University of Toronto to carry out the latest TQI survey. Due to the unique circumstances presented by the COVID-19 pandemic, the survey was split into two parts. The initial survey went out in October and focused on pre-pandemic practices (i.e. prior to March 2020), while the COVID-19 survey went out in December and captured changes in practice patterns as a result of the pandemic.

A little over 2,400 dental hygienists completed part one of the TQI survey over a three-week period. Survey results suggest that dental hygienists have adapted their practice in response to recent changes in the professional, oral health care, health care, public health, and social environment. The data collected also suggests that dental hygienists are becoming more autonomous in decision-making and responsibilities around client care. These insights serve as a starting point for further evaluation and to help produce resources aimed at ensuring that dental hygienists continue to provide safe and effective care to the public of Ontario.

PROFESSIONAL AUTONOMY AND DECISION-MAKING IN THE WORKPLACE

Compared to past surveys, an increased number of respondents reported that they were authorized to self-initiate the controlled acts of scaling and root planing. Now, more than ever, registrants are actively participating in decisions around developing the dental hygiene care plan and oral hygiene education activities. These findings suggest that dental hygienists are becoming more autonomous and responsible for the activities undertaken in the clinical practice environment.

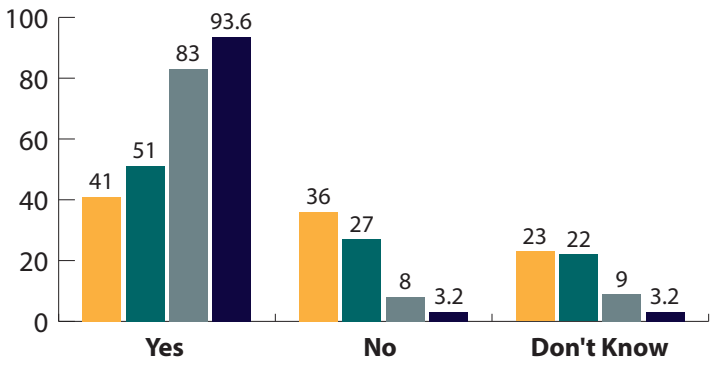
As of March 2020, there has been an increase in the number of respondents who worked with IPAC policies that were developed solely by dental hygienists. Over 95% of respondents also reported consistency of the IPAC policies across all dental team members.

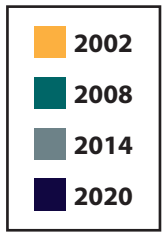
The majority (70%) of respondents also stated that they had or could have influence on the re-design of client chart forms. There continues to be an increase in the number of respondents stating 'yes' to this question across survey years.

There has been an **increase in the number of respondents who have IPAC policies specified in writing.** Also, over 90% report that compliance with their policy is regularly monitored.

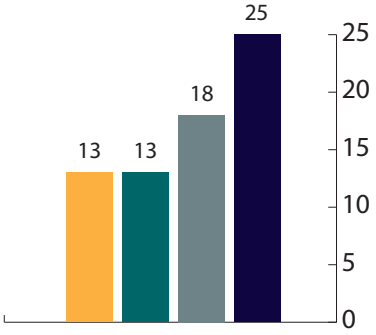
Compared to previous years, a higher number of respondents stated that their **workplace was supportive and receptive to change without limitations**.

PROCEDURES SPECIFIED IN WRITING



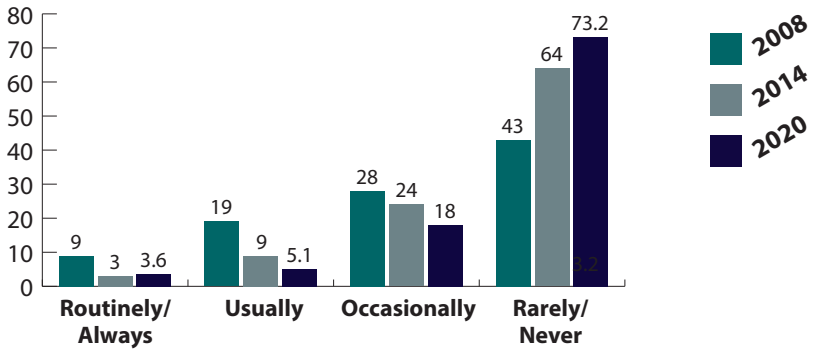


SUPPORTIVE AND RECEPTIVE TO CHANGE WITHOUT LIMITATIONS



CHANGES IN THE PRACTICE SETTING

The great majority of respondents report that they **do not have a dental assistant available when performing intraoral procedures**. This number has steadily increased since 2008.



As of March 2020, most respondents see **five to seven clients within a seven-hour working day**. Compared to previous years, fewer respondents were seeing eight to twelve clients per day.

The majority of respondents have appointment times that are 45 minutes or longer for adult clients, 31–45 minutes for child clients, and 45 minutes or longer for clients with periodontal needs. Most respondents preferred these appointment times for their clients.

SOCIAL MEDIA USE

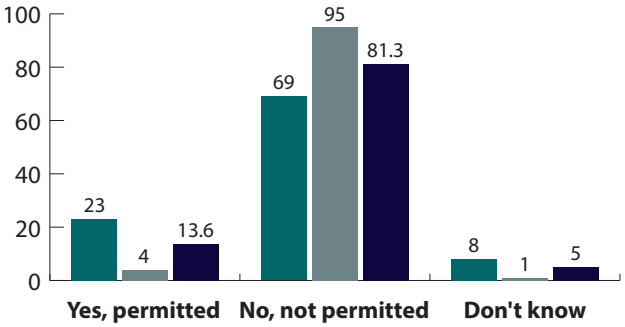
For the first time, respondents were asked about social media use. Most respondents knew that social media activities related to client care were not appropriate conduct for dental hygienists. This includes seeking out client information, connecting with clients, and posting information related to an actual client or client scenario. Most respondents also understood that engaging in or posting content that may be viewed by others as unprofessional would be unacceptable conduct for a dental hygienist.

TREATING SEXUAL PARTNERS AND SEXUAL ABUSE

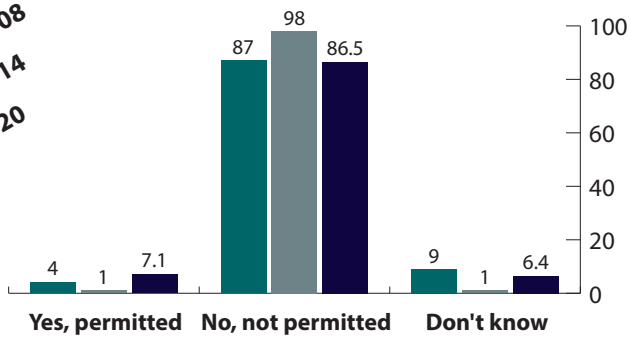
There has been an increase in the number of respondents who stated that dental hygienists are permitted to treat their partner (boyfriend/girlfriend) or other clients who have consented to a sexual relationship. There may have been some confusion at the time the survey was conducted since it was right around when the Spousal Exception was passed.

To the best of your knowledge, are dental hygienists permitted to provide oral health care to clients in each of the following situations?

CLIENT IS DENTAL HYGIENIST'S BOYFRIEND/GIRLFRIEND



CLIENT HAS CONSENTED TO A SEXUAL RELATIONSHIP



To confirm, **dental hygienists may only treat a spouse** and the definition of spouse in this context is very narrow. **Treating a sexual partner who does not meet the definition of a spouse under the RHPA continues to be considered sexual abuse.** Registrants can refer to the announcement in *Milestones 2020, Issue 3* (page 13) or contact a Practice Advisor for further clarity on this issue.

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USE OF PERSONAL PROTECTIVE EQUIPMENT

The survey revealed that the majority of dental hygienists do not routinely wear eye protection (goggles or face shield) or protective gowns in practice, which is consistent with 2019 IPAC survey results. CDHO *Infection Prevention and Control (IPAC) Guidelines* recommend the use of this personal protective equipment when performing dental hygiene procedures that may promote spatter or spray. The College anticipates that we will see a change in responses to this question in future, since more dental hygienists are now aware of the need to wear eye protection and gowns.

PRACTICE ENHANCEMENT THROUGH QUALITY ASSURANCE ACTIVITIES

Over half of respondents reported pursuing cannabis use as a learning goal topic in the past two years, and two out of ten registrants reported having counseled clients on cannabis use in their clinical practice. Similarly, nearly half of respondents have studied electronic cigarettes and vaping in this time frame, and the majority have provided some counseling for e-cigarette or vaping use. One in three respondents also reported having taken a course on silver diamine fluoride (SDF) in the same period. These findings show that dental hygienists are learning and adapting their practice to meet the needs of their clients, and that the QA Program is fulfilling its mandate to promote continuing competence and quality improvement that addresses changing practice environments.

REGISTRANT FEEDBACK

At the end of the survey, dental hygienists were given an opportunity to comment about their practice or other issues related to dental hygiene. About one in five survey respondents used this open text response option and many of those took the opportunity to provide feedback about the QA Program itself. The College reviewed all comments with interest and these comments will be used to inform the QA Program evaluation that is currently underway. Because the TQI survey is not meant to be a feedback survey, registrants will be surveyed again in coming months to provide more in-depth feedback about the QA Program.

Thank you to everyone who took the time to respond to one or both parts of the TQI survey in 2020. The College understands that it was a very busy time and there were a number of other industry surveys being conducted last year. The data collected through the TQI survey is critical to many CDHO functions and your input is greatly appreciated.

COVID-19 SURVEY FINDINGS

A second part of the survey was conducted to capture responses relating to the impact of the COVID-19 pandemic on dental hygiene practice in Ontario and the potential implications for quality assurance and other activities aimed at protecting the public. A total of 2,118 dental hygienists responded.

The survey results suggest that dental hygienists are practising according to COVID-19 related guidance produced by the CDHO. Nearly all respondents follow enhanced IPAC precautions, including the use of face shields and protective gowns for all clients, and limiting the use of AGPs or wearing enhanced PPE and imposing fallow periods when AGPs are performed. CDHO

THE CHILD, YOUTH AND FAMILY SERVICES ACT, 2017
& REPORTING CHILD ABUSE

The purpose of the *Child, Youth and Family Services Act, 2017* (CYFSA) is to promote the best interest, protection and well-being of children by governing the planning, decisions, and delivery of certain programs and services for children, youth and families. The CYFSA defines children in need of protection as a child who is under the age of 16 and who is, or appears to be, suffering from abuse and/or neglect. A report may be made regarding 16- and 17-year-olds if you are concerned that they are, or may be, in need of protection. If a child is felt to be in immediate need of protection, the local police department should be contacted.[1]

The CYFSA mandates that every individual, including a dental hygienist, who has reasonable grounds to suspect child abuse must make a written report of their suspicions to their local Children's Aid Society. The duty of making a mandatory report lies with each practitioner who has the reasonable grounds (or, in the case of child abuse, reasonable suspicion). Thus, a dental hygienist cannot simply advise her or his employer and expect the employer to make the report. Nor can the dental hygienist let an employer dissuade the dental hygienist from making a report where grounds exist (even if the employer disagrees). To make a report under the CYFSA, you only need reasonable grounds to "suspect", not to "believe". This means that the degree of information suggesting that a child is in need of protection can be quite low. Dental hygienists will be protected against civil action for making a report as long as their report is not motivated by malice and is within reasonable grounds. Failure to make a report may lead to a fine upon conviction.

WHEN SHOULD YOU MAKE A REPORT?

Section 125 (1) of the CYFSA defines a child in need of protection and specifies how you can identify these children. The section also describes the specific circumstances that must be reported.

1. The child has suffered physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,
   - i. failure to adequately care for, provide for, supervise or protect the child, or
   - ii. pattern of neglect in caring for, providing for, supervising or protecting the child.
2. There is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,
   - i. failure to adequately care for, provide for, supervise or protect the child, or
   - ii. pattern of neglect in caring for, providing for, supervising or protecting the child.
3. The child has been sexually abused or sexually exploited by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual abuse or sexual exploitation and fails to protect the child.
4. There is a risk that the child is likely to be sexually abused or sexually exploited as described in paragraph 3.
   - 4.1 The child has been sexually exploited as a result of being subjected to child sex trafficking.
   - 4.2 There is a risk that the child is likely to be sexually exploited as a result of being subjected to child sex trafficking.
5. The child requires treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide the treatment or access to the treatment, or, where the child is incapable of consenting to the treatment under the *Health Care Consent Act, 1996*, refuses or is unavailable or unable to consent to, the treatment on the child's behalf.
6. The child has suffered emotional harm, demonstrated by serious,
   - i. anxiety,
   - ii. depression,
   - iii. withdrawal,
   - iv. self-destructive or aggressive behaviour, or
   - v. delayed development,

   and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.

Making a mandatory report for a child in need of protection was probably one of the more frequent mandatory reports that dental hygienists would have had to consider making during their career. However, during the COVID-19 pandemic, the likelihood of having to make a mandatory report for a child in need of protection may have increased. Emerging research findings revealed that the "pandemic has worsened conditions and intensified risks for vulnerable children in the youth justice and child welfare systems, children living in unstable environments, and homeless youth. There is evidence that, in many situations, children became more vulnerable to violence, abuse, and exploitation as a result of the pandemic."[2] Therefore, dental hygienists have an important role in recognizing and identifying the possible signs and symptoms of child abuse during the dental hygiene appointment, documenting it and making the report to the local Children's Aid Society.

PHYSICAL ABUSE Physical abuse involves nonaccidental injuries caused by physical forces and can include biting, kicking, hitting, burning (not an exhaustive list). There may be bruising or lesions that appear inconsistent with usual childhood activities. Physical injuries can leave marks on the child's skin.

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For example, there may be unexplained bruises on the orofacial area in different stages of healing or a mark left by a belt buckle or a cigarette burn. Conditions of physical abuse in the oral cavity include, but are not limited to, infection, haemorrhage, trauma (lip, frenum and gingival lacerations and corners of the mouth), avulsed teeth, fractured teeth, haemorrhage associated with trauma, pathology, and open carious lesions into the dentin. As most physical abuse and neglect are visible and involve the child's face, head, and neck areas that are commonly assessed during a dental hygiene intra-extra-oral examination, a dental hygienist can be the first line of defense in helping a child in need of protection by identifying the most common visible clinical indicators of abuse.

NEGLECT Neglect is the failure of a parent, caregiver, or guardian to provide adequate physical, emotional and educational needs of a child. It may include lack of adequate food, water, health care, psychological support, and parental supervision. Dental hygienists can also recognize signs of neglect and pick up on cues that raise concerns from the manner of interaction between the child and their parent/guardian, particularly if it adds to comments made by the child. For example, if a child discloses to you that they are in pain, this can be an urgent need that you need to address. Signs of neglect in the oral cavity may include unmet oral health needs, such as poor oral hygiene and rampant caries.

SEXUAL ABUSE As signs of sexual abuse are often present in the child's mouth, a dental hygienist may be able to detect signs of oral sexual activity during a child's dental hygiene assessment. Signs and symptoms of sexual abuse can include trouble walking and sitting and itching in the genital area. In the oral cavity, signs and symptoms may include petechiae on the soft palate, which may be a sign of forced oral sex, venereal warts on lips, tongue, or palate. Dental hygienists need to examine the oral cavity for oral manifestations of syphilis, gonorrhea, herpes, and the human papilloma virus.

EMOTIONAL ABUSE Emotional abuse refers to a pattern of behaviour by the parent or guardian that is destructive to the child's development and self-esteem. It can include verbal abuse, destroying the child's favourite items, and withholding love and affection. It can include constant criticizing or belittling the child. Although there was not an overt example of oral manifestations of emotional abuse in the literature, dental hygienists can pick up on signs of emotional abuse from non-verbal and verbal communication during the dental hygiene appointment between the parent or guardian and the child. For example, a parent or guardian may humiliate their young child for having poor oral hygiene even though the child is too young to brush effectively on their own. Another example would be ridiculing their child's parafunctional habit, such as thumb sucking, in hopes of getting them to stop.

Although bullying is not specifically mentioned in the CYFSA, almost all forms of abuse can be manifested through bullying. Bullying can be verbal, social, physical and cyber. Verbal bullying aligns with verbal and sexual abuse as it can manifest as name calling and unwanted sexual comments. Manifestations of social bullying include the emotional abuse forms of humiliating an individual and excluding them from joining a group, leading to isolation. Physical bullying manifests similarly to physical abuse but it can also include elements of sexual abuse, which is perpetrated through unwanted sexual touching. Cyberbullying uses the Internet and social media to promote most forms of abuse. In Canada, at least one in three adolescent students have reported being bullied.[3] From a dental hygiene perspective, it is noteworthy that children with orofacial or dental abnormalities, including malocclusion, are more likely to be bullied, which may lead to psychological consequences, including depression and suicidal thoughts.[4]

The Government of Canada has responded to the increased risk of child abuse during the COVID-19 pandemic and have increased funding to support programs for child and youth victims of abuse and violence in Ontario.[5] As dental hygienists, we can also respond by ensuring that we are knowledgeable about the types of abuse, their manifestations and bullying practices to ensure we can recognize children who may be at risk of being abused and in need of protection both in our professional and personal lives. As primary oral care providers, dental hygienists are well poised to recognize and identify signs and symptoms of suspected child abuse and should document the salient details in the client health record (text including direct quotes from the client, pictures), as well as the report to the local Children's Aid Society, which can help reduce/end the deleterious effects of abuse and neglect for children.

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4. Fisher-Owens, S. A., Lukefahr, L., & Rao Tate, A. (2017). Oral and dental aspects of child abuse and neglect. *Pediatrics*, 140(2), 1–8. http://pediatrics.aappublications.org/content/140/2/e20171487
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NEW REGISTRANTS

JUNE 1, 2021 – OCT. 15, 2021

Adams, Becky	021447
Adu, Sandra	021399
Ahmadzai, Saima	021518
Alegre, Alexandra	021371
Al-Hussein, Mahdi	021416
Ali, Raghad	021386
Allan, Heather	021368
Al-Obaidi, Mina	021480
Alward, Tristan	021397
Al-Zuhairi, Rafal	021375
Amiri, Shaian	021474
Aneel, Indra	021534
Arsenault, Jade	021524
Bagnulo, Tianna	021515
Bahl, Vinshu	021531
Barbosa, Charlotte	021545
Barry, Cassandra	021400
Beaune, Kylie	021367
Bennett, Naomi	021529
Bernard, Chelsea	021505
Bian, Chunming	021388
Borrelli, Julia	021376
Brown-Russell, Trevana	021477
Caraion, Natalia	021461
Chohan, Reema	021527
Coleiro, Nicole	021508
Collier, Sarah	021540
Connors, Caitlin	021436
Couper, Kereny	021544
Crittenden, Danielle	021533
Davies, Morgan	021481
Deol, Rupinder Pal	021542
Derkach, Jessica	021468
Deslate, Katherine	021427
Di Carlo, Laura	021510
Dicaire, Erin	021452
Ding, David	021471
Ding, Suzan	021489
Doering, Jenna	021374
Dubé, Camille	021398
Duplantie, Roxanne	021407
Durivage, Janel	021445
Edwardson, Riley	021377
Enriquez, Andrea	021493
Escubil, Guillian	021494
Fatmy, Hadia	021372
Fenn, Khaley	021396
Fernandez, Joceline	021504
Fielding, Alyssa	021357
Foley, Alexa	021428
Fortuno, Thea	021498
Fry, Sydney	021439
Garg, Isha	021454
Gauley, Shyanne	021538
Gibson, Chelsea	021419
Gignac, Emilie	021453
Gonsalves, Krystal	021513
Grimmer, Olivia	021369
Guevarra, Ma Julie	021467
Gupta, Yatharth	021409
Gutierrez Oliva, Gloria	021521
Hanafy, Mariam	021503
Hashim, Natasha	021488
Heilman, Brittney	021405
Heo, Rina	021526
Hooker, Jennie	021417
Hrichi, Nada	021385
Ilkhani, Dorsa	021402
Inkulu, Sashikanth	021472
Jamali, Munira	021441
Joha, Basma	021500
Johnson, Leanne	021517

UPDATES TO THE PUBLIC REGISTER

Jose, Sinu	021536
Joy, Julia	021530
Kaufman, Holly	021430
Kaviani, Mahshid	021382
Kelemen, Valentina	021506
Khan, Adeel	021442
Khatri, Divyesh	021473
Labrada Pena, Liliana	021440
Lee, Sojung	021418
Lin, April	021401
Lin, Shirley	021491
Loomba, Seep	021519
Luu, Betty	021404
MacDonald, Bethany	021422
Malo, Kirsten	021403
Manlapid, Jumer	021546
Marshall, Carley	021502
McGogy, Kai	021384
Meadows, Jillian	021378
Meeboer, Natasha	021492
Mendiola, John Thomas	021511
Middegaal, Regan	021434
Mohabat, Soheila	021432
Mohammed, Hanna	021361
Molloy, Hallsey	021482
Moradi, Galavizh	021479
Murphy, Makayla	021475
Nash, Naomi	021370
Ncala Nabe, Simona	021535
Ngotzamanis, Helen	021516
Nguyen, Jennifer	021366
Nguyen, Jessica	021446
Nikuze, Carine	021393
Nothdurft, Lauren	021512
Novis, Ashley	021463
O'Brien, Shannon	021450
Omazic, Julie	021411
Page, Hannah	021381
Papadopoulos, Kate	021380
Pavlovets, Anna	021433
Pazmino Roman, Melany	021383
Pickford, Rachel	021509
Pospelova, Anna	021528
Power, Samantha	021410
Poyer, Brittney	021431
Qureshi, Nouma	021525
Radcliff, Caitlin	021390
Raina, Gurvinder Singh	021522
Rambhia, Megha	021387
Ramcharan, Nicollette	021462
Rao, Jing	021470
Rapi, Rudina	021514
Rauf, Khaulah	021543
Rayka, Swasti	021451
Redman, Samantha	021389
Reeves, Mornisha	021460
Renahan, Elizabeth	021412
Rich, Abby	021457
Rimando, Ellen Joy Javier	021455
Romero Guevara, Ana	021537
Rumph, Megan	021394
Ryan, Kate	021456
Sabourin, Jeannie	021539
Sam, Rose'Anne	021466
Saran, Mankiran	021365
Sarault, Melissa	021495
Sarmento, Alexa	021413
Segreto, Iqra	021486
Sehdev, Rajleen	021520
Semeniuk, Anton	021487
Seraj, Kimia	021363
Shah, Stuti	021421
Sherpa, Pasang	021469
Singh, Reetu	021420
Singh, Himit	021532
Sivadas, Nimal	021459
Slack, Holland	021484
Smith, Maddie	021425
Song, Eunjee	021449
Soos, Amber	021448
Starr, Natalie	021465

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Steckley, Brooke	021414
Stephens, Hannah	021478
Sultan, Fatima	021424
Sumintra, Poonam	021464
Tang, Jenny	021359
Taylor, Christine	021426
Thakur, Poonam	021437
Tocheri, Lauren	021408
Tran, Benjamen	021362
Tuliao, Kristine	021444
Tusek-Fagnan, Kelsey	021406
Tustin, Brylie	021395
Twomey, Jillian	021485
Unitt, Dominique	021415
Vaughan, Nicole	021373
Verma, Kartikey	021476
Versteegh, Abi	021438
Villanueva, Jasmine	021391
Vinette, Valerie	021458
Voroniuk, Olena	021379
Wagman, Tammy	021358
Wallis, Courtney	021392
Watson, Jenn	021507
Wattanawongpitak, Nipaporn	021499
Weng, Joanne	021435
Whitworth, Emily	021541
Wiarda, Rachel	021496
Wilson, Jessica	021360
Wongus, Bailee	021501
Wu, Rachal	021423
Yang, Mingyu	021443
Yesmin, Sultana Farzana	021490
Yip, Terri	021364
Zahran, Ghewa	021429
Zhang, Shirley	021497
Zhao, Juliet	021483
Zhong, Ping	021523

AUTHORIZED PRESCRIBERS

JUNE 1, 2021 – OCT. 15, 2021

Brestovac, Alejandra	014284
Chahal, Amreen	016659
Donevan, Danielle	017694
Eldesouki, Fatma	019894
Feres-Patry, Kathleen	001472
Holmes, Natasha	012107
Johnson, Mahalia	019853
Keir, Jane Ellen	003191
Lyster, Michelle J	007164
McIntyre, Brianna	019724
Menard, Renee	009375
Ranitsky, Julia	013099
Zachary, Bessie	007969

AUTHORIZED FOR SELF-INITIATION

JUNE 1, 2021 – OCT. 15, 2021

Ahmad, Iqra	019006
Aitken, Emily	012189
Albonese, Renata Jean	010465
Allen, Jamie	018205
Amezquita Baquero, Shana	015360
Babiuk, Jennifer	014086
Barbour, Jackie	008249
Bayford, Jo-Ann	000915
Bennett, Victoria	018964
Borhan Mojabi, Katayoun	019089
Boschi, Natalia	018229
Bramwell, Lily	020187
Brar, Bhav	016693
Brearley, Kellie Lynne	009355
Buragina, Merisa	019519
Byle, Halley	020848
Carrière, Hannah	018901
Catalano, Nancy	007157
Chen, Liling	014211
Chmiel, Izabella	010215
Ciampaglia, Amanda	018061
Cilia, Romina	011493
Cowton, Meagan	019884
Crichton, Olivia	014857
Crisol, Meg	017754
Del Rosario, Maria Diva	018765
Desjardins, Jayden	018500
Dhanji, Safia	017880
Fairbairn, Courtney	019324
Foster, Whitney	020099
French, Lee	006290
Gentile, Julia	018125
Gill, Ravleen	019551
Golec, Emily	015411
Greb, Helaina	018203
Hadish, Melony	020593
Hall, Deborahlin	016333
Harley, Samantha	018479
Hashimi, Sultana	016664
Havinga, Crystal Dawn	014103
Hill, Brittney Marleah	013245
John, Sharon	018667
Joly, Renee	018589
Kaur, Pavanpreet	018586
Kelemen, Ainsley Kathleen	017322
Ker, Jessica	010038
Kerkhof, Anita	003567
Khan, Nerissa Ferina	010831
Khan, Maryam	019809
King-Robbins, Donna	006294
Kormano, Amy	016201
Kramp, Melissa	020344
La, Michelle	018030
Lazo Sierra, Keyla	019780
Leon, Rachel Carolyn	017097
Leonte, Alejandra	018576
Lepage, Arya	019948
Lin, Susanne	019502
Liu, Chen	019866
Lopez, Luzviminda	018583
Luu, Kien	019531
Lyster, Michelle J	007164
Mahn, Lisa	013988
Mandoobhashemi, Leila	014111
Marshall, Lisa	020065
Martins, Mary	007647
Matko, Helene	007277
McLean, Katherine	017645
McLeish, Kendra	014289
McPherson, Stacy	013966
Mehan, Natasha	016588
Newfield, Terra	010834
Nsekanabo, Hope	019597
Ong, Christopher	019450
Pal, Laurie	010696
Palmer, Kelsey	019512
Patel, Manisha	017122
Pettipiece, Marissa	016267
Pilgrim, Chelsea	012120
Plebon, Brooke	020758
Popalzai, Zahra	019459
Quinn, Crystalle	018217
Raghavan, Pranamya	020445
Rahman, Shadia	015897
Rocheleau, Lise	004539
Rosso, Courtney	018794
Rotariu, Diana	019123
Santos, Dannielle	018341
Sarang, Naznin	020212
Schlosser, Gabrielle	019932
Sharifi, Bareen	018487
Skrobek, Serena	020678
Smetana, Jadelyn	020672
Snyder, Rebecca Robinson	019785
Sprawson, Heather	002227
Sran, Kanwer Paul	018131
Stevens, Jordan	019041
Sutherland, Jaclyn	018031
Tannis, Carol June	017719
Tan-Raymond, Jessica	007869
Tatebe-McKee, Patricia	013729
Toth, Julia	019025
Vachon, Valerie Brenda	009506
Vallecorsa, Deliana	014099
Vieira, Carla	012655
Wander, Aniljot	019535
Watson, Lisa	020446
Wilson, Amelia	016965

RESIGNATIONS

JUNE 1, 2021 – OCT. 15, 2021

Andrews, Sara	020902
Balac, Sonja	014461
Ballouk, Rana	010384
Bass, Jayde	018630
Baynton, Mary Anne	002077
Bellamy, Sherri	019066
Blanchette, Celine	009988
Bolduc, Josee Rita	004102
Brouillette, Ginette Yvette	005423
Burns, Brenda	001119
Camara, Sandra	013059
Carson, Coco	015052
Chebotarov, Fania	015703
Daluz, Shealyn	020536
Danielson, Lauren	020437
Detlor, Margaret	003509
Dittrich, Michelle	016677
Elliott, Kathy	002071
Fisher, Kelsey	016125
Frenza, Diana	006646
Gendron, Joanne	007958
Grech, Joelle	018789
Guillemette, Julie Joanne	006398
Haeck, Terri Lynn	012119
Hitchcock, Bobbi-Jo	006869
Hogan, Sylvie	003854
Johnston, Shannon Marie	008461
Kenwell, Leslie	003514
Klein, Karen	015663
Kokoris, Victoria	020016
Le, Lilianne	018149
Leblanc, Lynn	004278
Long, Mary	006538
Matthew, Linda	002235
McGill, Louise	001676
McIndoe, Lila	001722
McKellar, Cheryl	001190
McQueen, Cindy	003951
Patrick, Heather	008181
Patterson, Julie	017797
Phillips-Frost, Claire	001994
Prabhakaran, Sujatha	016569
Renaud, Carmelle	002509
Rennehan, Shala	020408
Robert-Mallette, Madeleine Anne	002362
Shafa, Mirella Dorina	002487
Southern, Barbara	002514
Stewart, Elizabeth	017614
Tala, Samiha	018491
Todd, Allison	007815
Wilkes, Betsy	004468
Wilkinson, Amy	008988
Wu, Qian	019881

SUSPENDED/ REVOKED

In accordance with Section 24 of the *Health Professions Procedural Code* (Schedule 2 of the *Regulated Health Professions Act, 1991*), the following registrants have been suspended or revoked for non-payment of the annual renewal fee. These registrants were forwarded notice of the intention to suspend and provided with two months in which to pay the fee. If a registrant who has been suspended for non-payment does not reinstate her or his certificate of registration, that certificate is deemed to be revoked two years after the failure to pay the annual fee.

SUSPENDED

EFFECTIVE AUGUST 3, 2021

Benarroch, Esther	009157

EFFECTIVE JUNE 11, 2021

Stewart, Tara	011670

EFFECTIVE JUNE 1, 2021

Weeks, Taylor	019673

REINSTATED

JUNE 1, 2021 – OCT. 15, 2021

Amjad, Nida	019824
Brunt, Megan	017280
Fox, Jessica	016776
Jeans, Sarah	017069
Kasprzyk, Cynthia	008713
McGuire, Amy-Lou	013273
McLean, Katherine	017645
Moham, Keena	020450
Nightingale, Stephanie	012570
Older, Sandra	011196
Rodrigues, Cristina	010910
Weeks, Taylor	019673

DECEASED

JUNE 1, 2021 – OCT. 15, 2021

Chen, Jing	016203
Helmuth, Stephanie	013352
McFadden, Janice	007167

RDH EXPERTISE FOR RDHs

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RDH, BEd
Ext. 226
clepage@cdho.org

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.

You can reach a CDHO practice advisor by phone at **416-961-6234** or **1-800-268 -2346,** or by email at advice@cdho.org.