College of
Dental Hygienists
of Ontario

Protecting your health and your smile

Quality Assurance Program
Policies and Procedures Manual

Contents

Part A – Information and Procedures for Registrants

1. Introduction

The Quality Assurance Program focuses on excellence rather than on minimum standards. The design of the Quality Assurance Program is based on the belief that dental hygienists are competent professionals whose goals include maintaining and improving their level of competence. The philosophy of the program is to facilitate and encourage rather than to discipline. For this reason, provisions are in place to safeguard the confidentiality of information gained within the Quality Assurance Program, from other parts of the College. The Quality Assurance Program must comply with the *Regulated Health Professions Act* and ministerial guidelines; consequently, there may be some intrusive and mandatory aspects within the Quality Assurance Program.

2. Confidentiality

Like all other parts of the College, the Quality Assurance Committee must keep all information that it learns through the quality assurance process confidential and, further, the Quality Assurance Committee and staff must keep most of the quality assurance information confidential from other parts of the College. This confidentiality provides dental hygienists with the assurance that their cooperation with the Quality Assurance Program will not normally result in disciplinary action. This provision is intended to foster cooperation with the Quality Assurance Program and to emphasize its non-punitive nature. **The contents of the Quality Assurance files are confidential and only authorized personnel will have access to the dental hygienist's information.**

3. Self-Assessment, Continuing Education and Professional Development

The CDHO Quality Assurance Program supports self-directed learning. Under this program, dental hygienists are valued participants in their own learning and are entrusted to identify their own learning gaps and solve their own learning needs. The QA online System for Managing Individual Learning (SMILE Portal) provides structure while empowering dental hygienists to assume responsibility for providing a record of their learning activities during their professional career. The CDHO Self-Assessment Tool, Standards of Practice and Code of Ethics, assist the dental hygienist in self-reflective practice, to identify areas of practice that require enhancement/improvement, and to customize continuing learning activities that match personal situations and resources. The QA SMILE Portal provides an opportunity for dental hygienists to demonstrate the direct connection between learning activities and the application of new knowledge to their dental hygiene practice.

Annual Self-Assessment and Participation in the Quality Assurance Program

Every Registered Dental Hygienist is expected to practise the profession in a manner consistent with the College's Standards of Practice and Code of Ethics.

Section 19(1) of the Quality Assurance Regulation sets out that members **shall participate** in self-assessment, continuing education, and professional development activities each year in order to maintain the knowledge, skills and judgment required to practise the profession in accordance with the standards of practice and ethics set by the College. Section 19(2) of the Regulation further requires that dental hygienists keep records of their participation in self-assessment, continuing education, and professional development activities, in the form and manner approved by the Committee, and for the period of time specified by the Committee. Every dental hygienist must provide the College with sufficient evidence of participation in the Quality Assurance Program by completing the annual Self-Assessment online by January 31st of the year for which the self-assessment applies. For example, the 2022 self-assessment must be completed by January 31, 2022. Those who fail to complete the self-assessment by the deadline each year will be required to submit their Quality Assurance records for assessment the following year. In the case above, a dental hygienist who failed to complete the 2022 Self-Assessment would be asked to submit their quality assurance records for assessment in January 2023.

4. Peer and Practice Assessment

4.1 Selection for the Annual Quality Assurance Records Review (QA Audit)

The Quality Assurance Committee will review selected dental hygienists' Quality Assurance records on an annual basis. A member may be selected to participate:

- at random, including by stratified random sampling using pre-determined demographic criteria; or
- if a request is made of the registrant to provide the Committee with information on their participation in the Quality Assurance program activities, and the registrant does not provide the requested information, or does not provide accurate information, or their records do not demonstrate that they have engaged in adequate self-assessment, continuing education or professional development activities; or
- on the basis of criteria specified by the Committee and published on the College's website at least three months before the registrant is selected on the basis of that criteria.

A Quality Assurance records review, also called a Peer and Practice Assessment or "QA Audit" may include, but is not limited to:

- Monitoring and/or assessing a registrant's participation in continuing quality improvement (learning) activities (Learning Portfolio); and/or
- Reviewing the results of the written assessment (QA Test); and/or
- Reviewing the registrant's Practice Profile(s); and/or
- Discussing with the registrant about their practice (telephone interview); and/or
- Inspecting the premises where the registrant practises (onsite practice review); and/or
- Inspecting their client records (chart audit).

The effectiveness and relationship of these activities to the quality of their dental hygiene practice, and the knowledge, skills, attitudes and judgment of the dental hygienist will also be assessed.

When a review of a registrant's Quality Assurance records is requested, the submission should include only the years requested. However, **registrants must keep all Quality Assurance records for seven years**, including supporting documentation (receipts, certificates, etc.).

Supporting documentation need not be submitted, except where otherwise specified. If the Quality Assurance Committee requires supporting documentation, they will request it separately. The exception to this is that the College will require certificates of completion for anyone wishing to use the following activities as part of their Learning Portfolio:

- CDHO Online Jurisprudence module and exam; and/or
- CDHO Drugs in Dental Hygiene Practice refresher course and exam.

All registrants are expected to cooperate with the Quality Assurance assessment process, including requests from an assessor and/or the Quality Assurance Committee. **Failure to cooperate with a review, including failing to produce Quality Assurance records or other information, constitutes professional misconduct.**

4.2 Quality Assurance Records Review Process

Initially, the assessment process will commence with a review of the registrant's Quality Assurance records, as submitted via the SMILE Portal. Where this review provides satisfactory evidence of the dental hygienist's knowledge, skills and judgment, further steps may not be required in the assessment. Where additional information is required, the assessment could continue with requests for further information and/or telephone inquiries. An onsite practice review and chart audit may also be required.

If the assessor's report indicates that deficiencies have been identified, the dental hygienist will be given a copy of the report and they will have 30 days to make any written submissions they wish to make to the Quality Assurance Committee. After considering any submissions, the Quality Assurance Committee may do one or more of the following:

Extension: The Quality Assurance Committee may grant the dental hygienist an extension for a specified period of time to complete QA requirements.

Exemption: The Quality Assurance Committee may grant the dental hygienist an exemption for some or all of the requirements for the period in question. This does not apply to a registrant who has not already submitted their QA records and otherwise been assessed.

Require Participation in a Specified Continuing Education or Remediation Program: When the review indicates that the registrant's knowledge, skills, or judgment are found to be unsatisfactory, the Quality Assurance Committee may require the registrant to complete a specified continuing education or remediation program (SCERP).

The dental hygienist must complete the SCERP as indicated by the Committee and provide documentation and evidence of successful completion in the form specified by the Quality Assurance Committee. Upon review of the submission, the Quality Assurance Committee will provide feedback to the dental hygienist.

Require Participation in a Follow-up Assessment / Reassessment: When the review indicates that the registrant's knowledge, skills, or judgment are found to be unsatisfactory, the Quality Assurance Committee may also require the registrant to participate in a follow-up assessment in order to ensure that remediation or additional learning has been applied in practice and that any deficiencies identified in the assessor's report have been corrected in practice.

4.3 Compliance

The Quality Assurance Program is designed to be remedial in nature. As such, the Quality Assurance Committee will work with the registrant to ensure that QA records are completed, received, and assessed in accordance with the program, and that any identified deficiencies during the assessment process are addressed through remediation and/or further assessment. While the registrant complies with the requirements of the QA Program and any directions given to them by the QA Committee, the matter remains confidential, and the registrant may not be subjected to any punitive action.

Failure to comply with the requirements of the QA Program, however, is a serious matter. It is considered professional misconduct to fail to respond to the College, as is failure to comply with a direction of a Committee of the College. The Quality Assurance Committee may refer matters of non-compliance to the Inquiries, Complaints and Reports Committee (ICRC) for further investigation. The ICRC may bring the matter for appropriate action, which could include a referral to the Discipline Committee. The Discipline Committee has the power to suspend or revoke a registrant's certificate of registration.

In certain circumstances, the Quality Assurance Committee may also have cause to direct the Registrar to impose terms, conditions and limitations on a registrant's certificate of registration.

4.4 Terms, Conditions and Limitations

If the dental hygienist's knowledge, skill and judgment have been assessed and have found to be unsatisfactory, or if the registrant fails to cooperate with a reassessment ordered by the Committee, or the registrant does not successfully complete a remediation program as directed, the Quality Assurance Committee may direct the Registrar to impose and to record on the Public Register specific terms, conditions, or limitations on the dental hygienist's certificate of registration. The Committee will generally only resort to this action where there is a potential risk to the public as a result of deficiencies identified in the assessment process. In this case, the Committee must give the registrant written notice of its intention to impose terms, conditions or limitations on their certificate of registration. This notice includes the reason for the decision as well as copies of all written records and documentation related to the decision. The dental hygienist is then given at least 14 days to make a written submission to the Committee.

Any terms, conditions or limitations imposed on the certificate of registration may be in place for a specified period to be determined by the Committee, or until the dental hygienist provides the Quality Assurance Committee with satisfactory evidence of having fulfilled the Quality Assurance requirements. The Quality Assurance Committee may also appoint an assessor for a follow-up assessment.

5. Ongoing Support

The CDHO has made available tools and guides to assist dental hygienists in fulfilling their QA requirements. Among others, these include the online System for Managing Individual Learning (SMILE Portal), the Overview of the Quality Assurance Program, the Guide to the Online System for Managing Individual Learning (SMILE Portal), and the Requirements of the Quality Assurance Program and Guidelines for Continuing Competency.

Articles regularly appear in *Milestones* with suggested areas for learning. QA department staff, as well as two full-time practice advisors, are also available by phone or by email to assist registrants. The Quality Assurance Committee also recommends remediation programs and oversees the review and approval of facilitated remediation courses and mentoring programs.

The Quality Assurance Program strives to be as transparent as possible. The appendices included at the end of this manual support these efforts. You will find copies of the assessment worksheets, tools, and criteria used by assessors in completing a Quality Assurance records review, an onsite practice review, and a chart audit. These appendices may be helpful in the completion of your Quality Assurance records.

Part B – Policies

1. Quality Assurance Committee – Internal Policies

1.1 Policy for the Removal of Terms, Conditions and Limitations

Purpose

To address, in a timely manner, the removal of Terms, Conditions and Limitations (TCLs) which are directed by the Quality Assurance Committee (QAC) to be placed on a registrant's certificate of registration, when a registrant has fulfilled the requirements of such.

Background

Pursuant to s. 80.2 (1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

> 80. 2 (1) The Quality Assurance Committee may do only one or more of the following:
>
> 2. Direct the Registrar to impose terms, conditions or limitations for a specified period to be determined by the Committee on the certificate of registration of a member,
>
> i. whose knowledge, skill and judgment have been assessed or reassessed under section 82 and have been found to be unsatisfactory, or
>
> ii. who has been directed to participate in specified continuing education or remediation programs as required by the Committee under paragraph 1 and has not completed those programs successfully.
>
> 3. Direct the Registrar to remove terms, conditions or limitations before the end of the specified period, if the Committee is satisfied that the member's knowledge, skill and judgment are now satisfactory.

Policy

This Policy recognizes that registrants fulfill the requirements of the TCLs placed on their certificates of registration by the Registrar, under the direction of the QAC, and that the timely removal of such TCLs will facilitate the registrants' return to practice. In circumstances where the Quality Assurance (QA) Program of the College has confirmed that a registrant has fully satisfied the requirements of the TCLs placed on his/her certificate of registration by the Registrar, under the direction of the QAC, the QAC authorizes the Manager of the QA Program to direct the Registrar on behalf of the QAC, without a formal direction of the Committee, to remove such TCLs. The Manager of the QA Program is obliged to bring to the QAC for review and deliberation, any matter relating to circumstances in which the registrant does not fully satisfy the TCLs placed on his/her certificate of registration.

Outcome

Since the QA Program is designed to be non-punitive, this Policy will facilitate the timely removal of the TCLs imposed, by direction of the QAC, on registrants' certificates of registration.

Adopted by the Quality Assurance Committee on October 14, 2016
Last reviewed on January 18, 2022

1.2 Corrections of Practice Deficiencies that May Be Approved by an Assessor

Purpose

To address, in a timely manner, the completion of assessments for which practice-related deficiencies have been identified in the assessor's report and/or where the Quality Assurance Committee has requested that specific documentation be provided by the registrant as evidence that a deficiency has been corrected.

Background

The Quality Assurance Committee has a long history of decisions to draw from and has been able to set out what documentation is accepted as evidence that a deficiency has been corrected in a registrant's practice. Where the evidence is clear and demonstrative, an assessor can verify with certainty that the deficiency has been addressed. Rather than have the registrant wait until the Committee can meet to review this evidence, the Committee can direct the assessor to accept the evidence on the Committee's behalf in order to facilitate the expedient conclusion of the registrant's assessment. This policy would not apply in a circumstance where a registrant has outstanding remediation and/or a follow-up assessment and/or other requirements pending that must be brought before the Committee.

Process

The following chart represents the evidence that may be accepted by an assessor on behalf of the Committee for each of the listed deficiencies. Any submissions made by registrants that do not match the Acceptable Evidence column must go to the Committee for approval.

Deficiency	Acceptable Evidence	Requires Committee Review
No CPR	Proof of current CPR that meets the CPR Requirements as set out in the *Guidelines for Continuing Competency*	– No CPR, *or* – Expired CPR, *or* – CPR course that does not meet the CPR Requirements
No access to oxygen in practice	Proof of purchase for new oxygen tank that shows current practice address	Any submissions that do not include a proof of purchase for the registrant's current practice

Deficiency	Acceptable Evidence	Requires Committee Review
Registrant reports not knowing how to use oxygen	– Certificate of completion for oxygen training, *or* – Written submission outlining all steps for the appropriate administration of oxygen in case of emergency	– Written submission that does not outline correct steps, *or* – Registrant indicates that they are not permitted or are not able to administer oxygen
Inadequate or missing recall protocol	Copy of recall protocol that meets *CDHO Infection Prevention and Control (IPAC) Guidelines*	Inadequate recall protocol that misses any of the necessary steps
No sterilization log	Copy of completed log, showing minimum 1 week of entries	– Template log (not filled), *or* – Log entries missing any of the required parameters
Inadequate sterilizer monitoring	– Written submission outlining appropriate steps for sterilizer monitoring per *CDHO Infection Prevention and Control (IPAC) Guidelines*, *or* – Where appropriate, photos for evidence (e.g., showing correct use of PCD)	Anything that does not clearly meet *CDHO Infection Prevention and Control (IPAC) Guidelines*
Failure to disassemble handpieces prior to sterilization	– Photos showing disassembled handpieces post sterilization demonstrating that it is being done correctly, *or* – If registrant indicates that they should not or cannot disassemble, copy of MIFU confirming the same	– Photos demonstrate incorrect process, *or* – Unable to provide copy of MIFU showing that handpieces should not or cannot be disassembled
Failure to sterilize motors a) at all b) between clients c) not having enough motors to do so	a) written description of steps, including acknowledgement that it needs to be done, and photo(s) post sterilization demonstrating that it is being done correctly b) written confirmation that it is now being done between clients, including acknowledgement there are enough motors for use as needed	Any other submissions

Deficiency	Acceptable Evidence	Requires Committee Review
	c) proof of purchase that shows current practice address along with written confirmation that it is now being done as required	
Suction line / waterline maintenance a) not purging long enough b) not purging between clients	Written submission confirming process meets *CDHO Infection Prevention and Control (IPAC) Guidelines*	Inaccurate or incomplete process

Outcome

This Policy will facilitate the timely conclusion of assessments where identified deficiencies have been corrected and sufficient evidence of the correction has been provided.

Adopted by the Quality Assurance Committee on May 4, 2021
Last reviewed on January 18, 2022

1.3 Corrections of Learning Portfolio Deficiencies that May Be Approved by an Assessor

Purpose

To address, in a timely manner, the completion of assessments for which Learning Portfolio deficiencies have been identified in the assessor's report and/or where the Quality Assurance Committee has requested that specific documentation be provided by the registrant as evidence that a deficiency has been corrected.

Background

The *Guidelines for Continuing Competency* clearly set out the expectations for the Learning Portfolio. Where a deficiency has been identified in the assessor's report, an assessor has the knowledge and training to determine whether a registrant's submission is sufficient to meet the Guidelines. Rather than have the registrant wait until the Committee can meet to review the submissions, the Committee can direct the assessor to accept the submission on the Committee's behalf in order to facilitate the expedient conclusion of the registrant's assessment. This policy would not apply in a circumstance where a registrant has outstanding remediation and/or a follow-up assessment and/or other requirements pending that must be brought before the Committee.

Process

The following chart represents the type of submissions a registrant may make in response to Learning Portfolio deficiencies, which an assessor can accept on behalf of the Committee. Any submissions made by registrants that do not otherwise meet the Guidelines for Continuing Competency must go to the Committee for approval.

Deficiency	Acceptable Submissions	Requires Committee Review
Insufficient information in the Report on Learning (what was learned and/or changes that were made in practice and/or benefits to clients)	– Additional information for the Report on Learning that is of sufficient length and/or detail so as to meet the *Guidelines for Continuing Competency*, or – Additional learning completed within the assessment period that meets the *Guidelines for Continuing Competency* that the registrant has requested be used to replace the goals/activities identified as deficiencies	– A Report on Learning that does not meet the *Guidelines for Continuing Competency* – Additional learning completed outside of the assessment period – A learning plan put forward by the registrant to complete additional learning by a future date
Insufficient bibliography information	Suitable bibliography details such that a learning source can be located and verified	Insufficient bibliography details such that a learning source cannot be located or verified
Unsuitable goals or activities	Additional learning completed within the assessment period that meets the *Guidelines for Continuing Competency*	– Learning goals or activities that do not meet the *Guidelines for Continuing Competency* – Additional learning completed outside of the assessment period – A learning plan put forward by the registrant to complete additional learning by a future date – Requests for unsuitable goals or activities to be accepted by the Committee
Insufficient hours spent on learning activities	Additional learning completed within the assessment period that meets the *Guidelines for Continuing Competency*	– Learning goals or activities that do not meet the *Guidelines for Continuing Competency*

Deficiency	Acceptable Submissions	Requires Committee Review
		– Additional learning completed outside of the assessment period – A learning plan put forward by the registrant to complete additional learning by a future date

Outcome

This Policy will facilitate the timely conclusion of assessments where suitable submissions have been made by the registrant in order to correct deficiencies identified in the Learning Portfolio.

Adopted by the Quality Assurance Committee on January 18, 2022

2. Policies for Registrants

2.1 Extension / Deferral Requests

Purpose

To clarify circumstances and documentation requirements for requesting an extension or deferral of a registrant's Quality Assurance requirements.

Background

All registrants are expected to participate in the Quality Assurance Program by maintaining their Quality Assurance records in accordance with the program requirements and the *Guidelines for Continuing Competency*. The Quality Assurance Committee recognizes, however, that registrants may, from time to time, have extenuating circumstances that have hindered or delayed their ability to submit requirements by the intended deadline. To this end, the Committee will consider requests for extension or deferral of all or part of the Quality Assurance requirements where:

- the registrant has demonstrated that extenuating circumstances or personal hardship have adversely impacted their ability to participate in the Quality Assurance Program, and
- the Committee does not have cause to believe that doing so may put the public of Ontario at risk.

Definitions

An *extension request* is asking the Committee to delay the due date for some or all of a registrant's current Quality Assurance requirements. For example, requesting to submit one's 2019, 2020, and 2021 QA records by March 31, 2022, instead of the initial deadline of January 31, 2022.

A *deferral request* is asking the Committee to change assessment years by pushing the entire process forward a year. For example, instead of submitting one's 2019, 2020, and 2021 QA records by January 31, 2022, the registrant would submit records for 2020, 2021, and 2022 by January 31, 2023. Deferrals are generally only granted in exceptional circumstances.

Process

Written requests for extensions or deferrals are considered by the Quality Assurance Committee in extenuating circumstances such as: current or recent hospitalization, critical illness of the registrant, bereavement of an immediate family member, or onerous personal hardship.

Such requests must be received prior to the submission deadline and include the completed request form. If the request is based on personal medical circumstances, the registrant must also submit the *Professional Verification of Medical Condition* form, which is to be completed by a treating healthcare professional. Both forms can be accessed online at the links provided in the *Required Forms* section below.

All requests for extensions/deferrals are reviewed by the Quality Assurance Committee and granted based on individual extenuating circumstances.

Where an extended deadline requested by the registrant falls before the next scheduled meeting of the Quality Assurance Committee, the Quality Assurance Manager may consider and grant the requested extension on the Committee's behalf. The QA Manager may not act on behalf of the Committee to deny an extension request or in consideration of request for deferral.

Required Forms

The *Request for Extension or Deferral of Quality Assurance Requirement(s)* form can be accessed online here.

The *Professional Verification of Medical Condition* form can be accessed online here.

The above forms are available in PDF format. The *Request for Extension or Deferral* form can either be printed and completed entirely by hand, or filled out directly on a computer including use of a digital signature for the registrant. The *Professional Verification of Medical Condition* form, however, must be printed, then signed by the verifying professional in pen. Signed copies of both documents can be scanned/submitted as a PDF document by email to qualityassurance@cdho.org.

Exclusions from this Policy

Requests for full/permanent exemptions from being assessed under the QA Program are not considered, as participation in the Quality Assurance Program is mandated for all registrants, per S. 17(3) of O. Reg. 167/11, made under the *Dental Hygiene Act, 1991*.

The Quality Assurance Committee does not generally consider extension or deferral requests for the completion of the annual Self-Assessment. All registrants are required to complete the Self-Assessment online each year as it is an integral part of the Quality Assurance process. Verifying completion of the Self-Assessment is also the mechanism by which the College is able to monitor registrants' participation in the Quality Assurance Program, as required per the S. 80.1(c) of the Health Professions Procedural Code (being Schedule 2 to the *Regulated Health Professions Act, 1991*).

Outcome

This Policy will provide guidance and instructions to registrants seeking consideration for an extension or deferral of their Quality Assurance Program requirements.

Adopted by the Quality Assurance Committee on January 18, 2022

2.2 Accommodation Requests

Purpose

To clarify circumstances and documentation requirements for requesting accommodation(s) for the Quality Assurance written assessment (QA Test).

Background

The QA Test is an online examination, which registrants may choose to complete as part of their Quality Assurance assessment under Path Option 2 or Path Option 3. The Quality Assurance Committee may also direct a registrant to complete the QA Test as an alternative assessment or follow-up assessments.

The QA Test format is a timed, 100 question, multiple-choice exam. The total time is 2.5 hours, allowing an average of 1.5 minutes per question.

Recognizing that registrants may perform differently under these conditions for various reasons, accommodation requests may be made where:

- the registrant has verifiable need for such an accommodation, and
- a registered healthcare or other registered professional is able to provide verification of the need for the accommodation.

Process

Registrants who require accommodation for any reason may submit a request by completing the *Special Accommodation Application Form*, which can be accessed online at the link provided in the *Required Form* section below.

The first part of the form is completed by the registrant. The second part of the form is to be completed by a registered healthcare or other registered professional as verification that an accommodation is required. Details of the specific reasons for the accommodation are not needed as part of the submitted request. However, details of the type and degree of accommodation must be provided by the verifying professional (for example, extended time allotment by 1 hour).

The College will seek to provide accommodations in the manner requested by the registrant and in a way that most respects the dignity of the registrant, where doing so does not cause undue hardship on the College. The financial impact of any granted accommodations will be borne by the College.

Required Form

The *Special Accommodation Application Form* for the QA Test can be accessed online here. The form is available in PDF format and can either be printed and completed entirely by hand or filled out directly on a computer including use of a digital signature for the registrant. However, please note that the verifying professional must sign the completed form in pen. The signed copy can then be scanned and submitted as a PDF document by email to qualityassurance@cdho.org.

Outcome

This Policy will provide guidance and instructions to registrants seeking accommodation for the QA Test and facilitate staff in making arrangements for requested accommodations.

Adopted by the Quality Assurance Committee on January 18, 2022

2.3 Policy for Including the CDHO Jurisprudence Module in the Learning Portfolio

Purpose

To provide clarity and guidance to registrants who intend to include the CDHO Jurisprudence Module in their Learning Portfolio. This policy will formalize the requirement to pass the exam, as well as provide further details including the number of hours that may be claimed for the module and expectations for the Report on Learning.

Background

Registrants who intend to include the CDHO Jurisprudence Module in their Learning Portfolio must successfully pass the exam and upload the completion certificate when submitting their QA records for assessment. While this requirement was not previously set out in a formal written policy, the expectation was announced in *Milestones* 2018, Issue 3 (page 17) and came into effect on January 1, 2019.

Process

Passing the Exam

In order to include the CDHO Jurisprudence Module in the Learning Portfolio, the registrant must successfully pass the jurisprudence exam. The completion certificate must be uploaded in the SMILE Portal so that the assessor can verify that the exam was passed and credit the hours. If the certificate is not included, the assessor will mark the goal/activity as incomplete, and a note will appear on the assessor's report indicating that the hours were not credited because the certificate was not provided.

Note: Registrants should be advised that the Quality Assurance Committee does not oversee the Jurisprudence Module or accompanying exam. Questions or concerns regarding the module content, exam blueprint, or passing grade for the exam should be directed to the Registration department.

Claiming Time Spent / Learning Hours

An assessor, in their role as fact-finder and acting on behalf of the Quality Assurance Committee, may accept up to 15 hours of learning claimed for the jurisprudence module, which includes:

- Review/completion of the online education module, and
- Review/completion of the accompanying self-study guide, and
- One attempt at the exam.

Any resources referenced outside of the module or study guide, such as the *Registrants' Handbook*, may be included in the Learning Portfolio as separate activities (either secondary activities toward the same goal, or as additional non-goal related activities). Accordingly, these additional learning sources may be credited for the time spent on each of them.

Multiple attempts at the exam will not be credited toward learning hours. However, if a registrant is unsuccessful at the exam after the first attempt, additional time spent *studying* for an additional attempt or attempts may be claimed over and above the 15 hours. In this case, the registrant will see a note on the assessor's report indicating that the registrant has claimed more than the usual 15 hours and the matter will be directed to the Committee for consideration. The registrant will be expected to submit an explanation for the additional time spent studying, which they may do in writing following receipt of the assessor's report.

Writing the Report on Learning

For registrants who have successfully passed the CDHO Jurisprudence exam and included the certificate of completion in their Learning Portfolio, the assessor will consider as "met the requirement" to report on what was learned, changes made to practice, and benefits to clients.

Outcome

This Policy will provide guidance and instructions to registrants as they plan suitable goals and activities for their Learning Portfolio.

Adopted by the Quality Assurance Committee on January 18, 2022

2.4 Policy for Including the CDHO Drugs in Dental Hygiene Practice Refresher Course in the Learning Portfolio

Purpose

To provide clarity and guidance to registrants who intend to include the CDHO Drugs in Dental Hygiene Practice refresher course in their Learning Portfolio. This policy will formalize the requirement to pass the exam, as well as provide further details, including the number of hours that may be claimed for the module and expectations for the Report on Learning.

Background

Registrants who intend to include the CDHO Drugs in Dental Hygiene Practice refresher course in their Learning Portfolio must successfully pass the exam and upload the completion certificate when submitting their QA records for assessment. While this requirement was not previously set out in a formal written policy, the expectation was announced in Milestones 2018, Issue 3 (page 17) and came into effect on January 1, 2019.

Process

Passing the Exam

In order to include the CDHO Drugs in Dental Hygiene Practice refresher course in the Learning Portfolio, the registrant must successfully pass the accompanying exam. The completion certificate must be uploaded in the SMILE Portal so that the assessor can verify that the exam was passed and credit the hours. If the certificate is not included, the assessor will mark the goal/activity as incomplete, and a note will appear on the assessor's report indicating that the hours were not credited because the certificate was not provided.

Note: Registrants should be advised that the Quality Assurance Committee does not oversee the Drugs in Dental Hygiene Practice refresher course or accompanying exam. Questions or concerns regarding the course content, exam blueprint, exam fee, or passing grade for the exam should be directed to the Programs and Exams department.

Claiming Time Spent / Learning Hours

An assessor, in their role as fact-finder and acting on behalf of the Quality Assurance Committee, may accept up to 25 hours of learning claimed for the refresher course, which includes:

- Review/completion of the self-build study guide, and
- Review of the required resources, and
- One attempt at the exam.

Multiple attempts at the exam will not be credited toward learning hours. However, if a registrant is unsuccessful at the exam after the first attempt, additional time spent *studying* for an additional attempt or attempts may be claimed over and above the 25 hours. In this case, the registrant will see a note on the assessor's report indicating that the registrant has claimed more than the usual 25 hours and the matter will be directed to the Committee for consideration. The registrant will be expected to submit an explanation for the additional time spent studying, which they may do in writing following receipt of the assessor's report.

Writing the Report on Learning

For registrants who have successfully passed the Drugs in Dental Hygiene Practice exam and included the certificate of completion in their Learning Portfolio, the assessor will consider as "met the requirement" to report on what was learned, changes made to practice, and benefits to clients.

Outcome

This Policy will provide guidance and instructions to registrants as they plan suitable goals and activities for their Learning Portfolio.

2.5 Policy for Placing Registrants into Path Option 3 after Failing to Submit QA Records

Purpose

This policy will allow registrants a final opportunity to comply with the Quality Assurance Peer and Practice Assessment (QA Audit) requirements where the registrant has otherwise chosen not to or was unable to comply. It will facilitate the timely assessment of registrants who have failed to submit their QA records by the deadline.

Background

All registrants are expected to participate in the Quality Assurance Program by maintaining their Quality Assurance records in accordance with the program requirements and the *Guidelines for Continuing Competency*. Registrants are given the opportunity to satisfy the requirements of the program by selecting which of the three available Path Options they prefer when submitting their records for assessment.

→ Path Option 1: Learning Portfolio and Practice Profile

→ Path Option 2: QA Test and Practice Profile

→ Path Option 3: QA Test and Onsite Practice Review

More details about each of the three path options and the requirements for each can be found in the *Requirements of the Quality Assurance Program and Guidelines for Continuing Competency*, available on the CDHO website at www.cdho.org.

Where a registrant has failed to submit their Quality Assurance records by the deadline, the Quality Assurance Committee is unable to assess the registrant's knowledge, skills, or judgment as required. While the Committee does have the ability to refer the matter of non-compliance to the Inquiries, Complaints and Reports Committee (ICRC), this course of action may not be the most effective means of fostering cooperation with the QA Program, and such referrals do not always ensure that registrants are assessed in a timely manner.

To this end, the policy for placing registrants into Path Option 3 will:

- Grant a final opportunity for the registrant to comply with the program requirements, including a modestly extended deadline; and
- Provide the registrant with clear direction by setting their Path Option for them; and
- Protect the public of Ontario by ensuring that all registrants are assessed, and any deficiencies can be identified and remediated in a timely manner.

All registrants are informed of this policy both when they are notified that they have been selected to submit their QA records for assessment, as well as in all reminder notices sent prior to and following the submission deadline.

Process

When a registrant does not submit their Quality Assurance records by the initial deadline, the QA Manager, acting on the Committee's behalf, will:

- Send an initial Past Due notice by email to the email address on file, on or about the first business day following the missed deadline; then
- Send a final Past Due notice ("No Response") by email to the email address on file *and* by mail to the home address on file, on or about 1 week following the missed deadline. This notice will give a final deadline of not less than 14 days to submit the QA records as requested before further action is taken, and will advise the registrant of the Committee's intention to place the registrant into Path Option 3 if the final deadline is not met.

If the registrant does not submit their records as requested by the final deadline, the QA Manager, acting on the Committee's behalf, will assign the registrant to Path Option 3 and send the registrant notice in writing that the registrant is required to:

1. Complete the Quality Assurance written assessment (QA Test) within 30 days of the date of the letter; *and*
2. Contact the QA Manager in writing within 30 days of the date of the letter to confirm that the registrant's contact information on file is correct and to confirm whether the registrant is currently practising dental hygiene in Ontario; *and*
3. Make arrangements to participate in either an onsite practice review (if the registrant is currently practising dental hygiene in Ontario) or the Clinical Competency Evaluation (if the registrant is not currently practising in Ontario). The deadline for the onsite practice review or Clinical Competency Evaluation will be set based on the availability of an assessor/evaluator, but not later than six weeks from the date the registrant has contacted the College per requirement 2 above.

This policy is not intended to prevent the possibility that the Quality Assurance Committee may, upon consideration of the circumstances, grant a registrant an extension or deferral of some or all of the QA requirements, per the *Extension/Deferral Requests Policy*.

This policy does not preclude the Committee from referring a registrant to the Inquiries, Complaints and Reports Committee (ICRC) if the QA Committee is of the opinion that the member may have committed an act of professional misconduct, or may be incompetent or incapacitated. A registrant may be placed into Path Option 3, per this policy, as well as being referred to the ICRC, if the Quality Assurance Committee determines that it is a necessary course of action under the circumstances.

Outcome

This policy will provide rationale and direction for placing registrants who fail to submit their QA records by the deadline in Path Option 3 for their Quality Assurance assessment.

Adopted by the Quality Assurance Committee on January 18, 2022

3. Policy Review Schedule

At a minimum, the Quality Assurance Committee will review these policies per the schedule outlined below. Policies may also be reviewed and/or updated and/or revoked as deemed appropriate by the Committee, as and when circumstances require.

Policy Title	History of Updates / Amendments	Review Schedule
1. Internal Policies		
1.1 Policy for the Removal of Terms, Conditions and Limitations	Adopted 2016-Oct-14 Reviewed 2022-Jan-18	3 years
1.2 Corrections of Practice Deficiencies that May Be Approved by an Assessor	Adopted 2021-May-04 Reviewed 2022-Jan-18	Annual
1.3 Corrections of Learning Portfolio Deficiencies that May Be Approved by an Assessor	Adopted 2022-Jan-18	Annual
2. Policies for Registrants		
2.1 Extension/Deferral Requests	Adopted 2022-Jan-18	3 years
2.2 Accommodation Requests	Adopted 2022-Jan-18	3 years
2.3 Policy for Including the CDHO Jurisprudence Module in the Learning Portfolio	Adopted 2022-Jan-18	Annual
2.4 Policy for Including the CDHO Drugs in Dental Hygiene Practice Refresher Course in the Learning Portfolio	Adopted 2022-Jan-18	Annual
2.5 Policy for Placing Registrants into Path Option 3 after Failing to Submit QA Records	Adopted 2016-Dec-18 Reviewed 2022-Jan-18	Annual

Part C – Appendices

Definitions and References

Accommodation
The College has a duty to accommodate people with disabilities in various aspects of its work. In the context of the Quality Assurance program, requests may be made for accommodations for the QA Test, such as additional time to complete the test. The process to submit an accommodation request, including required documentation, can be found in Part B of this manual (*B.2.ii – Accommodation Requests*).

Assessor / Peer Assessor
A person appointed to complete a QA assessment, as set out in section 81 of the Health Professions Procedural Code (Schedule 2 of the *Regulated Health Professions Act, 1991*). As a peer, an assessor is also a registered dental hygienist who has been through the QA assessment process themselves. Assessors may review a registrant's QA records in the SMILE Portal, participate in a telephone interview to discuss a registrant's practice, complete an onsite practice review, or review client records for a chart audit.

Assessor Report
After completing an assessment, the assessor prepares a report outlining their findings. A copy of the report is given to the registrant for review and the registrant has an opportunity to respond in writing within 30 days, before the Quality Assurance Committee makes any final decisions on the matter. A written response to an assessor's report may include acknowledgment of the deficiency or a rebuttal to the assessor's findings. Registrants are strongly encouraged to provide evidence where appropriate (photos, receipts, copies of policies, samples of client charts, etc.) so that the Committee can verify that any identified deficiencies have been corrected.

Assessment / Audit / Review
The word "assessment" applies broadly and may encompass the review of a registrant's Quality Assurance records, including the Learning Portfolio and/or Practice Profile, or the review of a registrant's practice and/or client records. The QA Test and Clinical Competency Evaluation are also considered assessments for the purposes of the Quality Assurance program. Other phrases meaning assessment that are used throughout the legislation and various CDHO resources include "Peer and Practice Assessment" (used in legislation and formal documents), "QA Audit" (used in the SMILE Portal), or simply "review".

Chart Audit
An assessment of a registrant's client records. A chart audit may be directed by the Quality Assurance Committee as part of the onsite practice review process or directed as a separate assessment of only the client records. When submitting charts for an audit, registrants should submit the full client chart (including initial medical history, periodontal charting, all dental hygiene entries, etc.). Personal information such as the client's name and contact information

must be redacted for privacy reasons. A review of a registrant's client charts can identify whether the registrant follows the dental hygiene process of care and all record keeping requirements. A copy of the template used by assessors to report on a chart audit can be found in the *Appendices* section of this manual.

Clinical Competency Evaluation (CCE)
An in-person clinical assessment that may be used as a substitute for an onsite practice review when a registrant is no longer practicing but has otherwise been directed by the Quality Assurance Committee to complete an onsite practice review. Further details about the CCE, including the Information to Applicants and Dental Hygienists Completing the Evaluation, can be found on the CDHO website.

Committee Decisions
The Quality Assurance Committee is a statutory committee as required by the *Regulated Health Professions Act, 1991*. As the decision-maker, the Committee is responsible for setting the requirements of the Quality Assurance Program, approving policies related to the Committee and/or the program, setting the selection criteria for Peer and Practice Assessments, and for making dispositions on individual registrants' files. When reviewing a registrant's file, the Committee will consider an assessor's report, the registrant's QA records, and any written submissions made by the registrant before making a decision. So as to maintain impartiality, all submissions and decisions are communicated in writing only. CHDO staff act as the liaison between the registrant and the Committee, carry out and monitor compliance with Committee decisions, and provide help and guidance to registrants.

Continuing Education / Professional Development
Courses, workshops, webinars, training, and other sources of learning that help someone to develop their knowledge and skills in a particular career-related area. The Guidelines for Continuing Competency allow for a wide range of learning activities and sources to be used for continuing education and professional development in order to meet the requirements of the Quality Assurance Program. Registrants should review the guidelines for recommended goal-related learning activities, suggested activities for additional (non-goal related) learning, and activities that are not suitable to include in the Learning Portfolio.

Continuing Competence / Continuing Quality Improvement (CQI)
The Health Professions Procedural Code (Schedule 2 of the *Regulated Health Professions Act, 1991*) sets out that a Quality Assurance Program must include continuing education and professional development aimed at promoting continuing competence and continuing quality improvement. The CDHO Dental Hygiene Standards of Practice further require that dental hygienists maintain and improve their level of competence through the continuous upgrading of their knowledge, skills and judgment. Dental hygienists should acknowledge that continual inquiry and learning is paramount to professional practice and client-centered care. Through regular self-assessment, registrants can identify areas for further learning and set goals to help keep them current and competent in an ever-changing healthcare environment.

Deficiency
Anything in an assessment that does not meet the standards of practice, established guidelines, or other related requirements. Deficiencies will be noted in the assessor's report and registrants are given an opportunity to respond to the report in writing before the QA Committee makes any decisions on the matter. Registrants are strongly encouraged to provide evidence where appropriate (photos, receipts, copies of policies, samples of client charts, etc.) so that the Committee can verify that deficiencies have been corrected.

Extension / Deferral
An extension request is asking the Committee to delay the due date for some or all of a registrant's current Quality Assurance requirements. For example, requesting to submit one's 2019, 2020, and 2021 QA records by March 31, 2022, instead of the initial deadline of January 31, 2022. A deferral request is asking the Committee to change assessment years by pushing the entire process out by one year. For example, instead of submitting one's 2019, 2020, and 2021 QA records by January 31, 2022, the registrant would submit records for 2020, 2021, and 2022 by January 31, 2023. Extensions and deferrals are generally only granted in exceptional circumstances. The Committee's extension/deferral request policy, including links to required documentation, can be found in Part B of this manual (*B.2.i – Extension/Deferral Requests*).

Follow-up Assessment / Reassessment
The Committee may direct a follow-up or reassessment when deficiencies have been identified and/or remediation has been directed, with the aim of ensuring that learning has occurred and that positive changes have been made in the registrant's practice and/or client records.

Guidelines for Continuing Competency
The Requirements of the Quality Assurance Program and Guidelines for Continuing Competency is a document that outlines how registrants can satisfy the QA program requirements. It includes useful information about setting learning goals and selecting learning activities, as well as an overview of what to expect for the Practice Profile and a brief look at the QA Test and Onsite Practice Review. The guidelines are set by the Quality Assurance Committee and used by assessors when assessing QA records submissions. More detailed information about using the SMILE Portal, the mandatory annual Self-Assessment, and the QA Test can be found in each of the dedicated guides. These and other resources are available on the CDHO website or can be accessed directly from the dashboard in the SMILE Portal.

Knowledge, Skills and Judgment
All healthcare regulators in Ontario are required to administer a Quality Assurance Program that is designed to evaluate the knowledge, skills and judgment of its members. Knowledge, or "what you know", is assessed either through the submission of a Learning Portfolio or the completion of the QA Test. Skills and judgement, or "what you do", are assessed through the submission of the Practice Profile, participation in a telephone interview with an assessor, and/or completion of an onsite practice review, chart audit, or Clinical Competency Evaluation.

Onsite Practice Review / Onsite Assessment
A registrant may choose to participate in an onsite practice review by selecting path option 3 when they are selected to submit their QA records. More often, a registrant is required to

participate in an onsite practice review when their Practice Profile does not demonstrate that their skills and judgment are satisfactory. An onsite practice review, sometimes referred to as an "onsite assessment", will allow the dental hygienist to demonstrate that their work environment and practices comply with the CDHO Standards of Practice and that their infection prevention and control (IPAC) and record keeping are consistent with current guidelines and regulations. The practice review template and IPAC checklist used by assessors when conducting an onsite visit are included in the *Appendices* section of this manual.

Peer and Practice Assessment
The full name for the Quality Assurance assessment process, as set out in General Regulation Part VI – Quality Assurance, made under the *Dental Hygiene Act, 1991*. Since terms like "assessment", "audit", and "review" are more broadly understood, registrants will normally only see the full phrasing "Peer and Practice Assessment" in formal documents like the email notice of selection to submit their QA records.

Quality Assurance Program
All healthcare regulators in Ontario are required to administer a Quality Assurance Program that evaluates the knowledge, skill and judgment of its members. The Health Professions Procedural Code (Schedule 2 of the *Regulated Health Professions Act, 1991*) sets out that the QA Program must include continuing education / professional development aimed at: promoting continuing competence and continuing quality improvement; addressing changes in practice environments; and incorporating standards of practice, advances in technology, changes made to entry to practice competencies, and other relevant issues. A QA Program must also involve self, peer, and practice assessments, and the College must have a mechanism in place to ensure that registrants participate and comply. The specifics of the CDHO QA Program are outlined in the Requirements of the Quality Assurance Program and Guidelines for Continuing Competency. These and other resources are available on the CDHO website or can be accessed directly from the dashboard in the SMILE Portal.

Quality Assurance Records
Any documentation that must be maintained and/or submitted for the purposes of meeting the Quality Assurance Program requirements. The mandatory annual Self-Assessment, Learning Portfolio, Practice Profile, QA Test Results Report, and anything collected/submitted during an onsite practice review or chart audit are all considered to be Quality Assurance records.

Remediation / SCERP
The Quality Assurance Committee may direct a registrant to complete a specified continuing education or remediation program (SCERP) when deficiencies have been found in their QA records. Registrants may be asked to find a suitable course that meets requirements defined by the Committee (e.g. a record keeping course that is at least 4 hours in duration), or the Committee may direct that a longer, one-on-one course be completed with an approved facilitator. Occasionally, the Committee may ask a registrant to complete a self-directed study as part of a remediation program.

Self-Assessment
The Self-Assessment Tool is an integral part of the Quality Assurance Program. Available on the SMILE Portal, it is designed to help registrant assess their practice as it relates to the *CDHO Dental Hygiene Standards of Practice*. The Self-Assessment tool will help registrants identify areas for further learning by suggesting goals for the Learning Portfolio. All registrants are required to complete the Self-Assessment annually, even if they are not currently practicing dental hygiene in Ontario. Registrants who are not practicing can consider whether they know what the specified standard is and whether they would be meet it if and when they returned to practice. CDHO does not receive or review the responses given during the Self-Assessment; we only receive a report indicating whether or not the Self-Assessment has been completed by the deadline. More detailed information can be found in the Self-Assessment Tool guide.

Submissions / Written Submissions
Registrants who have had deficiencies identified in an assessor's report have the right to make written submissions in response to that report within 30 days, before the Quality Assurance Committee makes a final decision on the matter. A written submission may include acknowledgment of the deficiency or a rebuttal to the assessor's findings. Registrants are strongly encouraged to provide evidence where appropriate (photos, receipts, copies of policies, samples of client charts, etc.) so that the Committee can verify that any deficiencies have been corrected.

Telephone Interview
If an assessor has questions about the information in a registrant's Practice Profile, they may reach out to the registrant for a telephone interview. The conversation normally takes about 15 minutes and gives the registrant the opportunity to clarify or expand on their written submission. Assessors will ask open-ended questions so as not to lead the registrant, and they may ask a question several times in different ways to try to get the information they need. Registrants are encouraged to have a copy of their Practice Profile with them when the interview takes place. If the assessor cannot verify through the written Practice Profile and the telephone interview that a registrant is practicing safely and following all CDHO standards of practice and guidelines, the next step in the assessment process will be to participate in an onsite practice review.

Terms, Conditions or Limitations (TCLs)
Restrictions placed on a certificate of registration, which may include requiring the registrant to cease practicing for a specified time frame or limit the registrant to practicing only under particular circumstances until the conditions have been satisfied. The Quality Assurance Committee may direct the Registrar to impose TCLs only in certain situations, such as when a registrant has been assessed and the Committee has found that the registrant's knowledge, skills, or judgment are unsatisfactory, or when the Committee has directed the registrant to participate in a remediation program and the registrant has not completed that remediation successfully. Terms, conditions and limitations are recorded on the Public Register and employers are notified if the registrant is not permitted to practice while the TCLs are in place.

Quality Assurance Regulation

ONTARIO REGULATION 167/11

made under the

DENTAL HYGIENE ACT, 1991

Made: March 30, 2011
Approved: May 17, 2011
Filed: May 18, 2011
Published on e-Laws: May 20, 2011
Printed in *The Ontario Gazette*: June 4, 2011

Amending O. Reg. 218/94

(General)

Note: Ontario Regulation 218/94 has previously been amended. For the legislative history of the Regulation, see the Table of Consolidated Regulations – Detailed Legislative History at https://www.ontario.ca/laws.

1. Part VI of Ontario Regulation 218/94 is revoked and the following substituted:

PART VI
QUALITY ASSURANCE

GENERAL

16. In this Part,

"assessor" means a person appointed under section 81 of the Health Professions Procedural Code;

"Committee" means the Quality Assurance Committee required by subsection 10 (1) of the Health Professions Procedural Code and includes a panel of that Committee;

"program" means the quality assurance program required by section 80 of the Health Professions Procedural Code;

"stratified random sampling" means a sampling where groups of members are,

(a) removed from the pool of members to be sampled, or

(b) weighted to increase or decrease the likelihood of their being selected.

17. (1) The Committee shall administer the program.

(2) The program shall include the following components:

1. Continuing education or professional development designed to,

i. promote continuing competence and quality improvement among the members,

ii. address changes to practice environments, and

iii. incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues in the discretion of the Council.

2. Self, peer and practice assessments.

3. A mechanism for the College to monitor members' participation in and compliance with the program.

(3) All members shall participate in the program.

18. (1) A panel of the Committee shall be composed of at least three persons, at least one of whom shall be a member of the Council appointed by the Lieutenant Governor in Council.

(2) Two members of a panel of the Committee constitute a quorum if at least one of the two members is a member of the Council appointed by the Lieutenant Governor in Council.

SELF-ASSESSMENT, CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT

19. (1) Each year, members shall participate in self-assessment, continuing education and professional development activities in order to maintain the knowledge, skills and judgment required to practise the profession in accordance with the standards of practice and ethics set by the College.

(2) Members shall keep records of their participation in self-assessment, continuing education and professional development activities in the form and manner approved by the Committee and for the period of time specified by the Committee.

(3) At the request of the Committee, an assessor or an employee of the College, a member shall provide to the Committee accurate information about the member's participation in self-assessment, continuing education and professional development activities and the member's records described in subsection (2).

PEER AND PRACTICE ASSESSMENT

20. (1) Each year, the Committee shall select members to undergo a peer and practice assessment in order to assess the members' knowledge, skills and judgment.

(2) A member may be selected by the Committee to undergo a peer and practice assessment,

(a) at random, including by stratified random sampling;

(b) if a request is made under subsection 19 (3) and the member does not provide accurate information or the member's records do not demonstrate that the member has engaged in adequate self-assessment, continuing education or professional development activities; or

(c) on the basis of criteria specified by the Committee and published on the College's website at least three months before the member is selected on the basis of that criteria.

(3) A peer and practice assessment shall be carried out by an assessor.

(4) A peer and practice assessment may include but is not limited to the following:

1. Reviewing the member's records required by subsection 19 (2).

2. Inspecting the premises where the member practises.

3. Inspecting the member's records of the care of patients.

4. Requiring the member to provide information in respect of the care of patients or in respect of the records of the care of patients.

5. Conferring with the member about the member's practice.

6. Using an evaluation tool designed to help assess the member's knowledge, skills and judgment, if requested by the Committee.

(5) The assessor shall prepare a written report about a peer and practice assessment and shall provide the report to the Committee.

(6) If, after considering the assessor's report and any other relevant information, the Committee is of the opinion that the member's knowledge, skills or judgment are not satisfactory, the Committee shall provide to the member,

(a) notice of the Committee's opinion;

(b) a copy of the assessor's report;

(c) notice of the member's right to make written submissions to the Committee within 14 days of receiving notice of the Committee's opinion or within such longer time period as may be specified by the Committee; and

(d) any other relevant information the Committee used to form its opinion.

(7) After receiving notice of the Committee's opinion under subsection (6), the member shall have 14 days or such longer time period as may be specified by the Committee to make written submissions to the Committee.

(8) If, after considering any written submissions made by the member, the Committee is still of the opinion that the member's knowledge, skills or judgment are not satisfactory, the Committee may exercise any of the powers listed in section 80.2 of the Health Professions Procedural Code.

(9) Regardless of whether the Committee provides notice of its opinion to the member under subsection (6), the Committee shall advise the member of the results of the peer and practice assessment.

2. This Regulation comes into force on the day it is filed.

Made by:

COUNCIL OF COLLEGE OF DENTAL HYGIENISTS OF ONTARIO:

LINDA JAMIESON
President

FRAN RICHARDSON
Registrar

Date made: March 30, 2011.

Appendix 3.1: Quality Assurance Records Assessment – Worksheet 1 – General

Assessor _____ **Assessment Status** ❑ A1 ❑ A3 ❑ A4

Registrant _____

Phone No. (H) _____

Phone No. (C) _____

Email _____

Number of Offices _____

Days / Office 1. _____ **2.** _____ **3.** _____

CDHO Registration Number _____

Registrant Status:

❑ Active ❑ Inactive ❑ Resigned

Path Selected:

❑ 1 ❑ 2 ❑ 3

QA Test:

❑ Passed ❑ Failed ❑ N/A

Practice Profile

- **Process of Care**
  - ❑ Assessment
    - MH
    - Vital signs if required
    - IOE
    - EOE
    - OCS / Soft tissue
    - Hard tissue
    - Perio (Probing +/or PSR, BOP, CAL, Furc, Tissues)
    - Indices
  - ❑ Dental Hygiene Diagnosis
  - ❑ Goals and care plan (client involved)
  - ❑ Implementation
    - Scaling / root planing as required
    - Selective polish
    - Fluoride as required
    - OHE as required
    - Radiographs as Rx
    - Referrals as required
  - ❑ Evaluation

- **Infection Control**
  - ❑ Eye protection (client and operator)
  - ❑ PPE (Clinical attire, mask, gloves)
  - ❑ Hand hygiene
  - ❑ Disposable gowns available
  - ❑ Barriers
  - ❑ Suction lines
  - ❑ Purging waterlines, hand-piece, Cavitron when applicable
  - ❑ Disinfection where applicable
  - ❑ Ultrasonic/washer
  - ❑ Sterilization (wrapped/bagged)
  - ❑ Biohazards/sharps
  - ❑ Appropriate chemical indicators being used (internal and external)
  - ❑ Spore testing (each day the sterilizer is in use and for each cycle)
  - ❑ Recall Policy and tracking being done

- **Record Keeping**
  - ❑ Name / contact of primary care provider
  - ❑ Privacy policy
  - ❑ MH updates
  - ❑ Informed consent/refusal
  - ❑ Protocols, orders if required
  - ❑ Client concerns
  - ❑ Radiograph Rx / findings / areas surveyed
  - ❑ Findings (assessment/evaluation)
  - ❑ DH diagnosis
  - ❑ Goals / care plan
  - ❑ Treatment rendered / time spent
  - ❑ Referrals
  - ❑ Dated
  - ❑ Signed by DH

- **Valid CPR**
  - ❑ Yes
  - ❑ No – Expired or inappropriate level
  - ❑ No – Currently not practising (i.e., inactive, no employment, strictly administrative, on parental leave, etc.)

Expiry Date _____/_____/_____

Goal Related Learning

Year _____

Acceptable hours for year

Year _____

Acceptable hours for year

Year _____

Acceptable hours for year

Total hours from Goal Related Learning (approximate minimum of 60 hours)

Total hours for 3-year period (75 hours)

Non-Goal Related Learning

Notes: _____

_____

_____

_____

_____

_____

_____

_____

Acceptable hours from Non-Goal Related learning for 3-year period (approximately 15 hours allowed)

Assessed Status:

- ❑ A1 – Meets assessment guidelines
- ❑ A2 – Telephone interview required (incl. phone report)

Appointment booked _____/_____/_____ ❑ am ❑ pm

- ❑ A3 – On-Site Practice Review recommended
- ❑ A4 – Practice meets the assessment guidelines but other deficiencies noted:
  - Does not adhere to Continuing Competency Guidelines
    - Insufficient hours spent on CQI
    - Unacceptable activities
    - Unacceptable goals/topics
    - Missing or expired CPR
    - More information required regarding what was learned, changes to practice and/or benefits to clients
    - Other:

_____

_____

_____

Additional notes:

_____

_____

_____

_____

_____

_____

Appendix 3.2: Quality Assurance Records Assessment – Worksheet 1 – Specialty

Assessor _____ **Assessment Status** ❑ A1 ❑ A3 ❑ A4

Registrant _____

Phone No. (H) _____

Phone No. (C) _____

Email _____

Number of Offices _____

Days / Office 1. _____ **2.** _____ **3.** _____

CDHO Registration Number _____

Registrant Status:

❑ Active ❑ Inactive ❑ Resigned

Path Selected:

❑ 1 ❑ 2 ❑ 3

QA Test:

❑ Passed ❑ Failed ❑ N/A

Practice Profile

- **Orthodontic Services**
  - ❑ Follows care plan as per specific order
  - ❑ Uses proper isolation technique in bonding/banding
  - ❑ Follows manufacturer's directions in use of products
- **Restorative Services**
  - ❑ Follows care plan as per specific order
  - ❑ Uses proper isolation technique in bonding/banding
  - ❑ Records full details of materials used
  - ❑ Follows manufacturer's directions in use of products
  - ❑ Finishing restoration(s) and adj. occlusion
- **Periodontal Services**
  - ❑ Med. History (initial and updates)
  - ❑ Perio assessment as required (Probing +/or PSR, BOP, CAL, Furc, Tissues, Mobility, recession)
  - ❑ Indices
  - ❑ OHE as required
- **Infection Control**
  - ❑ Eye protection (client and operator)
  - ❑ PPE (Clinical attire, mask, gloves)
  - ❑ Hand hygiene
  - ❑ Disposable gowns available
  - ❑ Barriers
  - ❑ Suction lines
  - ❑ Purging waterlines, hand-piece, Cavitron when applicable
  - ❑ Disinfection where applicable
  - ❑ Ultrasonic/washer
  - ❑ Sterilization (wrapped/bagged)
  - ❑ Biohazards/sharps
  - ❑ Appropriate chemical indicators being used (internal and external)
  - ❑ Spore testing (each day the sterilizer is in use and for each cycle)
  - ❑ Recall Policy and tracking being done
- **Record Keeping**
  - ❑ Name / contact of primary care provider
  - ❑ Privacy policy
  - ❑ MH updates
  - ❑ Informed consent/refusal
  - ❑ Protocols, orders if required
  - ❑ Client concerns
  - ❑ Radiograph Rx / findings / areas surveyed
  - ❑ Findings (assessment/evaluation)
  - ❑ DH diagnosis
  - ❑ Goals / care plan
  - ❑ Treatment rendered / time spent
  - ❑ Referrals
  - ❑ Dated
  - ❑ Signed by DH
- **Valid CPR**
  - ❑ Yes
  - ❑ No – Expired or inappropriate level
  - ❑ No – Currently not practising (i.e., inactive, no employment, strictly administrative, on parental leave, etc.)

Expiry Date _____/_____/_____

Goal Related Learning

Year _____

Acceptable hours for year

Year _____

Acceptable hours for year

Year _____

Acceptable hours for year

Total hours from Goal Related Learning (approximate minimum of 60 hours)

Total hours for 3-year period (75 hours)

Assessed Status:

- ❑ A1 – Meets assessment guidelines
- ❑ A2 – Telephone interview required (incl. phone report)

Appointment booked _____/_____/_____ ❑ am ❑ pm

- ❑ A3 – On-Site Practice Review recommended
- ❑ A4 – Practice meets the assessment guidelines but other deficiencies noted:
  - Does not adhere to Continuing Competency Guidelines
    - Insufficient hours spent on CQI
    - Unacceptable activities
    - Unacceptable goals/topics
    - Missing or expired CPR
    - More information required regarding what was learned, changes to practice and/or benefits to clients
    - Other:

_____

_____

_____

Non-Goal Related Learning

Notes: _____

_____

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_____

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_____

Acceptable hours from Non-Goal Related learning for 3-year period (approximately 15 hours allowed)

Additional notes:

_____

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_____

College of **Dental Hygienists** of Ontario
Protecting your health and your smile

Assessor: ______________________________

Registrant: ______________________________

CDHO Registration No.: ______________________________

Appendix 3.3: Quality Assurance Records Assessment – Worksheet 2 – Learning Portfolio

Year	#	Goal Topic	Activities	Hours Claimed	Hours Accepted	Comments
			❑ Unacceptable activities ❑ Inappropriate time spent ❑ Bibliography not included ❑ No learning has occurred ❑ No learning related to practice ❑ No positive changes/improved outcomes			
			❑ Unacceptable activities ❑ Inappropriate time spent ❑ Bibliography not included ❑ No learning has occurred ❑ No learning related to practice ❑ No positive changes/improved outcomes			
			❑ Unacceptable activities ❑ Inappropriate time spent ❑ Bibliography not included ❑ No learning has occurred ❑ No learning related to practice ❑ No positive changes/improved outcomes			
			❑ Unacceptable activities ❑ Inappropriate time spent ❑ Bibliography not included ❑ No learning has occurred ❑ No learning related to practice ❑ No positive changes/improved outcomes			
			❑ Unacceptable activities ❑ Inappropriate time spent ❑ Bibliography not included ❑ No learning has occurred ❑ No learning related to practice ❑ No positive changes/improved outcomes			

Appendix 3.4: Peer Assessment – Professional Portfolio / Practice Review (PPPR) – TELEPHONE INTERVIEW REPORT

Assessor: _____

Registrant: _____ **Reg No.:** _____

Date of Interview: _____ **Duration:** _____

Areas of Concern:

1. _____
2. _____
3. _____

Brief Summary of Telephone Interview by Concern:

1. _____
2. _____
3. _____

CONCLUSION: (Select Only One)

After the phone interview, the Registrant's professional portfolio is now:

- ❑ **A1 – The professional portfolio now meets the assessment guidelines.**
- ❑ **A3 – On-Site Practice Review is required. Practice areas that may not meet the assessment guidelines:**

_____

_____

_____

_____

_____

_____

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In addition, deficiencies (non-practice) noted in the professional portfolio are:

_____

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☐ **A4 – The practice <u>now meets</u> the assessment guidelines but other deficiencies noted in the professional portfolio are:**

_____

_____

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Appendix 3.5: Assessment Guidelines for Quality Assurance Practice Review (On-Site)

Registrant's Name: _____ **CDHO Reg. Nº:** _____

Practice Address: _____

_____

Date of Assessment: _____

Assessor's Name: _____

Work Environment

Assessment Guidelines for Identified Deficiencies	Standard	Yes	No	N/A	Comments
1. The office has a written policy for the collection and maintenance of client information.	#1, 2, 5				
2. Current scientifically accepted infection control procedures are in place.	#6, 8				
3. Emergency protocol, emergency supplies, equipment and oxygen are in place.	#6, 8				
4. Registrant has proof of current CPR certification.	#8				
5. Exposing and processing of radiographs and radiation hygiene are consistent with the *Healing Arts Radiation Protection Act*.	#1				
6. Equipment is current and in good repair.	#6				
7. Instruments are sharp and the original design has been maintained.	#6				
8. Equipment, instruments and supplies are sufficient to support the selection and implementation of appropriate dental hygiene services.	#3, 6				

Chart Audit

Assessment Guideline for Identified Deficiencies	Standard	Yes	No	N/A	Comments
9. An initial medical history and updates are in client record.	#8				
10. The clinical assessment is complete* and supports the dental hygiene diagnosis. *client interviews, health, dental and pharmacological history, clinical and radiographic examination.	#8				
11. An individual dental hygiene treatment plan has been established and includes: a) goals/objectives b) sequence of activities c) client participation	#5, 8				
12. The client's informed consent for treatment has been obtained.	#1, 5				
13. The date and particulars of each professional contact with the client is documented in accordance with the CDHO record keeping regulation.	#1, 2, 8				
14. A clinical re-assessment is performed and the dental hygiene treatment plan is reviewed and modified as required.	#8				
15. The client has received appropriate recommendations and instructions in oral self-care.	#8				
16. The registrant consults and/or refers to other health professionals as required.	#1, 5, 7, 8				
17. Other					

Assessor's Signature: _____

Date _____

Appendix 3.6: Infection Prevention and Control (IPAC) Checklist

	✓	Criteria	Comments
Written policies and procedures for infection prevention and control	☐	Does my office have written policies and procedures for infection prevention and control?	• Is there a policy for education and training of staff? • Is there a policy for the recall of improperly reprocessed and faulty equipment including tracing of clients potentially infected as a result? • Is there a policy for disposal and storage of sharps? • Is there a policy for management of needlestick injury? • Is there a policy for scheduled preventive maintenance of cleaning (ultrasonics, automatic washer/disinfectors) and sterilization equipment (autoclaves, sterilizers)? • Is there a policy for the cleaning of spilled bodily fluids (vomit, urine etc.) • Is there a policy for maintaining and updating Materials Safety Data Sheets (MSDS) in accordance with WHMIS? • Is there a policy for the management of hazardous waste? • Is there a policy for suction line maintenance? • Is there a policy for waterline maintenance? • Is there a policy for environmental cleaning (e.g. reception area, toys)?
Are biohazardous wastes segregated and disposed of in accordance with provincial regulations?	☐	Are there puncture-resistant sharps containers at point-of-use AND/OR are sharps transported to the reprocessing area in a covered container (e.g., plastic tray with hard plastic cover) or cassette?	• Sharps containers are not overfilled past the fill line and are appropriately labelled
	☐	Is a biohazardous waste receptacle available for blood-soaked gauze?	
Does the reception area meet Public Health guidelines?	☐	Is there 70%–90% alcohol-based hand rub available at reception?	• Alcohol-based hand rub and hand soap cannot be topped up
	☐	Is there appropriate signage to alert clients to report symptoms of illness (e.g. influenza, fever, cough, vomiting, diarrhea or bad cold) displayed prominently in the reception area?	
Are water and suction lines being properly maintained?	☐	Are water lines being purged when required?	
	☐	Are suction lines being maintained as required?	

	✓	Criteria	Comments
Are clinic areas and high-touch surfaces being cleaned?	☐	Are barriers used when needed?	
	☐	Are approved and appropriate disinfectant products (low-intermediate level) available and used according to manufacturer's instructions?	
	☐	Is there a dedicated hand washing sink and/or is there 70%–90% alcohol hand-based rub used in each operatory?	• Alcohol-based hand rub and hand soap cannot be topped up
Is appropriate personal protective equipment (PPE) available and appropriately used?	☐	Is appropriate PPE available for client care?	• Safety glasses, masks, gloves (latex alternative if required), disposable gowns (if applicable)
	☐	Is appropriate PPE available for the client?	• Safety glasses
	☐	Is clinic attire being worn for direct care being removed before leaving the office?	• Masks removed and disposed of after each client
Is the reprocessing area following appropriate IPAC principles?	☐	Is there a one-way work flow from dirty to clean?	• Reprocessing area is in a designated area that is physically separate from direct client care areas
	☐	Is there a dedicated hand washing sink and/or 70%–90% alcohol hand-based rub available in the reprocessing area?	• Alcohol-based hand rub and hand soap cannot be topped up
	☐	Are PPE supplies available and accessible?	• Not stored under sink
Are instruments being pre-cleaned and cleaned according to IPAC principles?	☐	Are critical and semi-critical instruments either single-use and disposed of, or sterilized?	
	☐	Is gross soil being removed from instruments during or immediately after client care at point of use?	• If gross soil is not removed immediately, the instruments are kept moist
	☐	Are instruments being cleaned?	**Method:** • Scrubbing? • Washer/Disinfector? • Ultrasonic Washer?
	☐	If scrubbing, is the brush used disposed of or sterilized at the end of the day?	• Metal brushes not appropriate to use
	☐	Are instruments rinsed and dried prior to packaging?	• Dried with a lint-free cloth
	☐	Are instruments being disassembled and hinged instruments opened?	• e.g. handpieces and mirrors separated • e.g. ortho pliers opened • MIFU's being followed

	✓	Criteria	Comments
Are items packaged according to IPAC principles?	☐	Are appropriate packages being used and not overloaded for sterilization?	• Pouches or wrapped cassettes • Packaging disposed of after use
	☐	Is there an appropriate external chemical indicator being used for each package?	• Type 1 (minimum)
	☐	Is there an appropriate internal chemical indicator being used for each package?	
	☐	Is there an appropriate label on every package?	Packages appropriately labeled with: • Date processed • Sterilizer used • Load number • Contents (if not visible) • Initials of individual who processed the package
Is sterilizing being done according to IPAC principles?	☐	Are items appropriately loaded in the sterilizer?	• Racks being used if applicable • Packages not overlapping
	☐	Are instruments run for the full sterilization cycle and are they completely dry before removing?	
Are packages being stored according to IPAC principles?	☐	Are packages stored securely in a manner that keeps them clean, dry and prevents contamination?	• Packages are not punctured • Stored away from heat or moisture • Not stored under sink
Are solutions being discarded, monitored and logged appropriately, according to IPAC principles?	☐	If high level disinfectant (i.e., cold soak) is being used, is it being used appropriately?	• Changed every day and logged
	☐	If an ultrasonic is being used, is it being used appropriately and tested?	• Solution changed daily or more often as required and logged • Ultrasonic is tested weekly and logged
	☐	Are biological indicators (BI) being used each day the sterilizer is in use, and for each cycle type and logged appropriately?	• Done in a Process Challenge Device with an appropriate chemical indicator strip inside. Refer to decision tree.
	☐	Are instruments being quarantined pending BI results?	
	☐	Are sterilizer mechanical parameters **or** USB **or** printout checked, verified and signed for each cycle by the individual sterilizing the instruments?	
Miscellaneous	☐	Are instruments being transported to the reprocessing area in a covered container (e.g., plastic tray with hard plastic cover) or cassette?	
	☐	Is there a plumbed or self-contained eyewash station within a 10-second walk (16 to 17 metres [55 feet]) of the reprocessing area?	
	☐	Is food stored in a separate refrigerator from medications and or client care items.	• e.g. alginate impressions