COLLEGE OF DENTURISTS OF ONTARIO

Agenda Item 2.0

98th Council Meeting

Friday, December 6, 2019 – 9:00 a.m. to 3:30 p.m.

HELD AT

365 Bloor Street E., Suite 1606, Toronto, ON M4W 3L4

AGENDA

Item		Action	Page #
1.	**Call to Order**		
2.	**Approval of Agenda**	Decision	**1**
3.	**Declaration of Conflict(s)** Comments on Conflict of Interest Rebecca Durcan, College Counsel, Partner, Steinecke Maciura LeBlanc	Decision	
4.	**College Mandate**	Information	
5.	**Consent Agenda**	Information/ Decision	
	5.1 Minutes of the 97th Council meeting held on September 6, 2019		**5**
	5.2 Council Meeting Feedback Survey Results		
	5.2.1 96th Council meeting held on June 14, 2019		**11**
	5.2.2 97th Council meeting held on September 6, 2019		**17**
	5.3 Executive Committee Report		**27**
	5.4 Inquiries, Complaints and Reports Committee Report		**29**
	5.5 Discipline Committee Report		**31**
	5.6 Fitness to Practise Committee Report		**33**
	5.7 Quality Assurance Committee – Panel A Report		**35**
	5.8 Quality Assurance Committee – Panel B Report		**37**
	5.9 Qualifying Examination Committee Report		**39**
	5.10 Qualifying Examination Appeals Committee Report		**41**
	5.11 Registration Committee Report		**43**
	5.12 Patient Relations Committee Report		**45**
	5.13 President's Report – Verbal		
	5.14 Registrar's Report		**47**
	5.15 Financial Report Memo and YTD Income - Expenses – April 1, 2019 to October 31, 2019		**53**
	5.16 Update on Strategy Map 2017-2020 Progress		**57**

	5.17 Items of Interest: 5.17.1 Legislative Update 5.18 Correspondence 5.18.1 November 14, 2019 – DAO President and Board 5.18.2 Email Response 5.18.1		 **61** **67** **71**
6.	**Waiving the Fee Increase for 2020-2021 – By-law Article 31.05** 6.1 Briefing Note	Decision	 **73**
7.	**Consideration of the Draft of the College's 2018-2019 Annual Report** 7.1 Draft 2018-2019 Annual Report	Information	 **75**
8.	**Presentation: The Citizen Advisory Group: Exploring the Public Opinion in Regulation** Dr. Glenn Pettifer, Registrar & CEO	Decision	
9.	**Draft Infection Prevention and Control Guidelines** 9.1 Briefing Note 9.2 Draft Infection Prevention and Control Guidelines	Decision	 **113** **115**
10.	**Health Profession Regulatory Bodies – Governance Updates – BC Government Considers Bold Modifications to Health Profession Regulation** Ms. Rebecca Durcan, Partner, Steinecke Maciura Leblanc, CDO Counsel 10.1 Consultation Paper – Modernizing Health Profession Regulation – British Columbia	Information	 **147**
11.	**Standard of Practice: Record Keeping – Revisions to the Standard** 11.1 Briefing Note 11.2 Current Standard of Practice: Record Keeping 11.3 Draft Revised Standard of Practice: Record Keeping 11.4 Current Guide to the Standard of Practice: Record Keeping 11.5 Draft Revised Guide to the Standard of Practice: Record Keeping 11.6 Draft FAQs for the revised Standard of Practice: Record Keeping	Decision	 **173** **175** **183** **185** **193** **199**
12.	**Standard of Practice: Professional Boundaries** 12.1 Briefing Note 12.2 Draft Standard of Practice: Professional Boundaries 12.3 Draft Guide to the Standard of Practice: Professional Boundaries	Decision	 **205** **207** **209**
	LUNCH BREAK		
13.	**Standard of Practice: Procedures – Retirement?** 13.1 Briefing Note 13.2 Draft Standard of Practice: Procedures	Decision	 **217** **219**

14. Draft Policy: Revised Language Proficiency Requirements 14.1 Briefing Note 14.2 Draft Revised Policy	Decision	 **229** **231**
15. Draft Policy: Academic Credential Authentication 15.1 Briefing Note 15.2 Current Credential Authentication Policy 15.3 Draft Revised Policy 15.4 Draft Academic Credential Authentication – Process Guidelines	Decision	 **235** **237** **239** **241**
16. Draft Policy: Insufficient or Incomplete Documentation 16.1 Briefing Note 16.2 Draft Revised Policy 16.3 Current Policy	Decision	 **243** **245** **247**
17. Next Meeting Date 99th Council Meeting – Friday, March 27, 2019	Information	
18. Adjournment		

COLLEGE OF DENTURISTS OF ONTARIO

97th Council Meeting
In-Person

365 Bloor Street East, Suite 1606, Toronto, ON M4W 3L4
Friday, September 6, 2019 – 9:00 a.m. to 3:30 p.m.

MINUTES

Members Present:	Mr. Hanno Weinberger	➢ President
	Dr. Ivan McFarlane	➢ Vice President, Past President
	Mr. Abdelatif Azzouz	
	Ms. Kristine Bailey	
	Ms. Anita Kiriakou	
	Ms. Wangari Muriuki	
	Mr. Christopher Reis	
	Mr. Michael Vout, Jr.	
Regrets:	Mr. Jack Abergel	
	Ms. Alexia Baker-Lanoue	
	Mr. Keith Collins	
	Mr. Robert C. Gaspar	
Auditor:	Mr. Blair MacKenzie, Hilborn LLP	
Legal Counsel:	Ms. Rebecca Durcan, Steinecke, Maciura and LeBlanc	
Staff:	Dr. Glenn Pettifer, Registrar and CEO	
	Ms. Megan Callaway, Manager, Council and Corporate Services	
	Ms. Catherine Mackowski, Manager, Professional Conduct	
	Ms. Jennifer Slabodkin, Manager, Registration, Quality Assurance and Policy	
	Mr. Roderick Tom-Ying, Manager, Strategic Initiatives	

1. **Call to Order**
   The President called the meeting to order at 9:04 a.m.; however, no motions were made until quorum was met at 9:28 a.m.

   Mr. Reis and Mr. Azzouz joined the meeting at 9:15 a.m. and 9:28 a.m. respectively.

2. Approval of Agenda

MOTION: To adopt the agenda as presented.

MOVED: W. Muriuki
SECONDED: C. Reis

CARRIED

3. Declaration of Conflict(s)

No conflicts of interest were declared.

4. College Mandate

The President drew Council members' attention to the College Mandate and the College Mission, which were provided.

5. Draft Audited Financial Statements

Mr. Blair MacKenzie, Hilborn LLP presented the 2018-2019 Draft Audited Financial Statements and Post-Audit Communication.

MOTION: To approve the draft audited financial statements as presented.

MOVED: A. Kiriakou
SECONDED: W. Muriuki

CARRIED

6. Consent Agenda

Items 6.12: President's Report, 6.13: Registrar's Report, and 6.16.1: Legislative Update were removed from the Consent Agenda.

MOTION: To accept the consent agenda as amended.

MOVED: K. Bailey
SECONDED: A. Kiriakou

CARRIED

Mr. Weinberger expressed thanks and appreciation to Ms. Muriuki for her contribution to the College as a public appointee. Ms. Muriuki's appointment ends on September 27, 2019. It was also reported that Mr. Weinberger's appointment ends on December 4, 2019.

Ms. Rebecca Durcan, College Counsel, and Partner, Steinecke Maciura LeBlanc, provided comments on what could occur if Council were to be unconstituted.

MOTION: To accept the President's Report.

MOVED: W. Muriuki
SECONDED: I. McFarlane

CARRIED

In addition to the report provided, the Registrar reported the following:

- The nomination period for the By-election in District 2 closed on September 2, 2019 and no nominations were received. Another By-election will be called in the near future.
- Regarding the proposed amalgamation of the College of Denturists of Ontario (CDO), the College of Dental Hygienists of Ontario (CDHO) and the College of Dental Technologists of Ontario (CDTO), the Colleges are looking at ways to collaborate without legislative change at this time. An opportunity has been identified to receive some French language support from CDHO staff in the event that an inquiry or complaint is received by the College in French.
- The College has identified a source of government funding that will support translation from English to French of some of the materials currently published on the College's website.

MOTION: To accept the Registrar's Report.

MOVED: A. Kiriakou
SECONDED: K. Bailey

CARRIED

Ms. Rebecca Durcan provided comments on the Wetlaufer Inquiry Report: Implications for Regulators.

MOTION: To accept the Legislative Update.

MOVED: K. Bailey
SECONDED: A. Kiriakou

CARRIED

7. Council Governance Training

Ms. Rebecca Durcan presented, "Considerations in Being an Effective Council Member, Committee Member and Chair".

Mr. Vout joined the meeting at 10:34 a.m.

8. Standard of Practice: Denturism Educators

MOTION: To approve the draft Standard and Guide and set a date of January 1, 2020 for implementation of the Standard.

MOVED: A. Kiriakou
SECONDED: I. McFarlane

CARRIED

9. Draft Revised Registration Regulation

MOTION: To adopt the proposed amendments to the revised Registration Regulation and approve the draft for stakeholder consultation.

MOVED: W. Muriuki
SECONDED: M. Vout, Jr.

CARRIED

10. Draft Revised Professional Misconduct Regulation

MOTION: To adopt the proposed amendments to the revised Professional Misconduct Regulation and approve the draft for stakeholder consultation.

MOVED: A. Azzouz
SECONDED: M. Vout, Jr.

CARRIED

11. Amendments to Schedule 7 of the By-laws: Administrative Fees for Retired Status

MOTION: That the suggested fees and associated amendments to Schedule 7 of the College By-laws be approved and implemented.

MOVED: A. Kiriakou
SECONDED: I. McFarlane

CARRIED

12. Revision of the Design of the College's Certificate of Registration

MOTION: That staff be directed to prepare some options (which may include examples from other Colleges) of possible Certificate of Registration designs for Council's consideration at the next meeting.

MOVED: M. Vout, Jr.
SECONDED: A. Kiriakou

CARRIED

13. Self-Assessment Tool – Continuing Professional Development

Ms. Jennifer Slabodkin provided a demonstration of the Self-Assessment Tool.

14. In Camera Meeting of Council, pursuant to Schedule 2, the Health Professions Procedural Code of the Regulated Health Professions Act (1991), Section 7 ss (2) (d) of the Regulated Health Professions Act (1991).

MOTION: To move the meeting in camera.

MOVED: M. Vout, Jr.
SECONDED: A. Kiriakou

CARRIED

The in-camera meeting of Council ended at 12:09 p.m.

15. Proposed Revised College Sexual Abuse Prevention Plan

The following motion was made with the understanding that should the phrase "Sexual Abuse Officer" appear in the revised Sexual Abuse Prevention Plan, it will be changed to "Sexual Abuse Liaison".

MOTION: To approve the revised Sexual Abuse Prevention Plan and direct staff to post the new Plan on the College's website and inform members and stakeholders of the revised plan.

MOVED: W. Muriuki
SECONDED: I. McFarlane

CARRIED

16. Patient Sexual Abuse Frequently Asked Questions (Draft)

Staff were directed to make the following changes to the draft Patient Sexual Abuse Frequently Asked Questions (FAQs):

- Under "Why Report?", add that "the law may have been broken".
- Under "Why Report?", consider rephrasing the first bullet point to include that reporting could help to affect change in the members' behaviour.
- Under "How can I recognize sexual abuse?" revise the second bullet point to read, "Sexual touching, (e.g. touching your buttocks, breasts, or genitals~~ or any other area in a way that is not appropriate for treatment or assessment~~)".

MOTION: To request amendments to the FAQs and approve the amended draft FAQs for publication on the College's website.

MOVED: M. Vout, Jr.
SECONDED: A. Kiriakou

CARRIED

17. Patient Rights Document (Draft) – Patient Relations Committee

MOTION: To approve this document for release on the College website in a downloadable format accompanied by communication to Registered Denturists regarding the intended use of this document.

MOVED: M. Vout, Jr.
SECONDED: A. Azzouz

CARRIED

18. Code of Ethics – Denturism Profession

MOTION: To approve the draft Code of Ethics for stakeholder consultation.

MOVED: W. Muriuki
SECONDED: A. Kiriakou

CARRIED

19. Next Meeting Date

It was noted that the 98th Meeting of Council will be held on Friday, December 6, 2019.

20. Adjournment

The meeting was adjourned at 1:39 p.m.

Mr. Hanno Weinberger
President

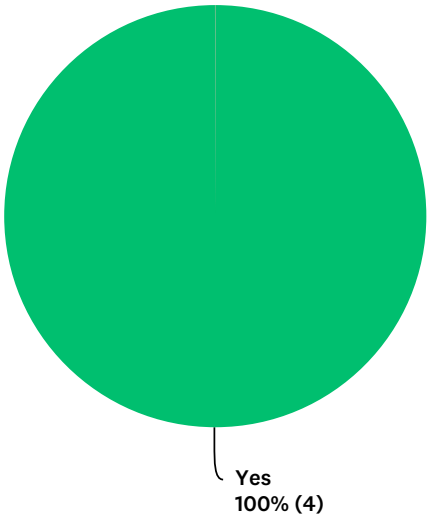
Date

Dr. Glenn Pettifer
Registrar and CEO

Date

Q1 I received appropriate, supportive information for this Council meeting.

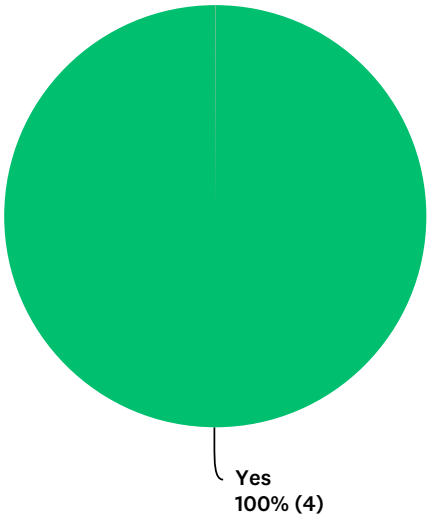
Answered: 4 Skipped: 0



#	COMMENTS	DATE
	There are no responses.	

Q2 I received this supportive information in a timely manner.

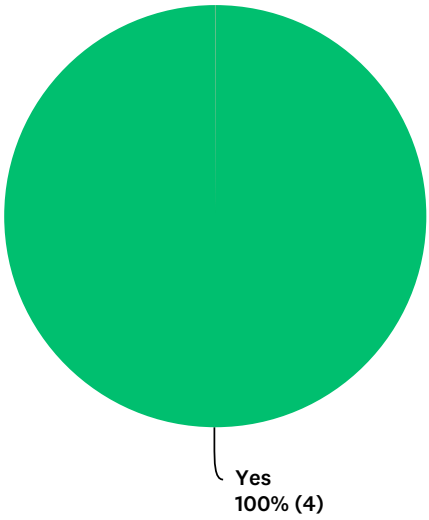
Answered: 4 Skipped: 0



#	COMMENTS	DATE
	There are no responses.	

Q3 This meeting was effective and efficient.

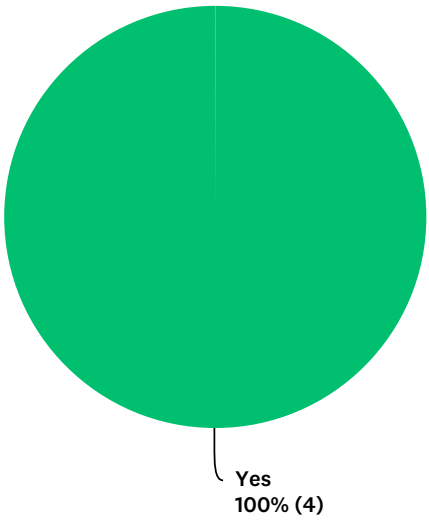
Answered: 4 Skipped: 0



#	COMMENTS	DATE
	There are no responses.	

Q4 The President chaired the meeting in a manner that enhanced Council's performance and decision-making.

Answered: 4 Skipped: 0

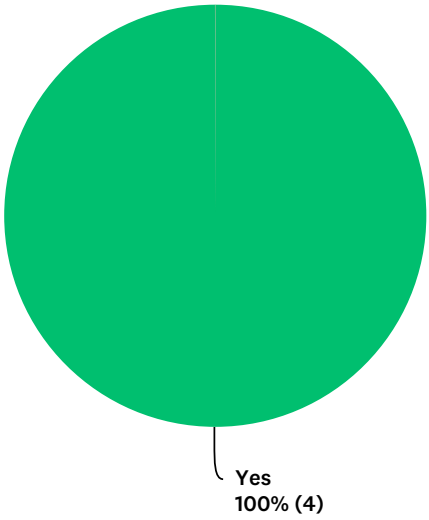


#	COMMENTS	DATE

1	Very early in the proceedings there was a very smooth transition from the old regime to the new one. That was most noteworthy.	7/10/2019 8:15 AM

Q5 I felt comfortable participating in the Council discussions.

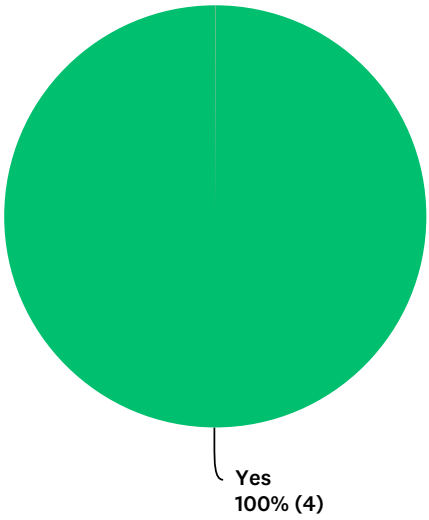
Answered: 4 Skipped: 0



#	COMMENTS	DATE
1	I did find it odd that a public member found a discussion item uncomfortable. This may have been handled differently to avoid this type of outcome.	7/10/2019 11:31 AM
2	Notwithstanding an issue regarding the use of Facebook which breached the patient's privacy, it was instructive to have the matter aired and the legal position stated forcefully. It is vitally necessary to have CDO's legal counsel continuously reinforce the standards. Councillors must measure their words and the use of words carefully.	7/10/2019 8:15 AM

Q6 The public interest was considered in all discussions.

Answered: 4 Skipped: 0



#	COMMENTS	DATE
	There are no responses.	

Q7 List two strengths of this meeting.

Answered: 2 Skipped: 2

#	RESPONSES	DATE
1	adherence to time fullness of discuss	7/10/2019 11:31 AM
2	1. Agenda items and discussions were all geared to consulting the public interest. 2. There was always a fair hearing of views.	7/10/2019 8:15 AM

Q8 List two ways in which Council meetings could be improved.

Answered: 2 Skipped: 2

#	RESPONSES	DATE
1	consider areas that "may" be contentious and decide, in advance, as to how to best handle the discussion for maximum input of discussion and outcome of results	7/10/2019 11:31 AM
2	n/a	7/10/2019 8:15 AM

Q9 Additional Comments

Answered: 0 Skipped: 4

#	RESPONSES	DATE
	There are no responses.	

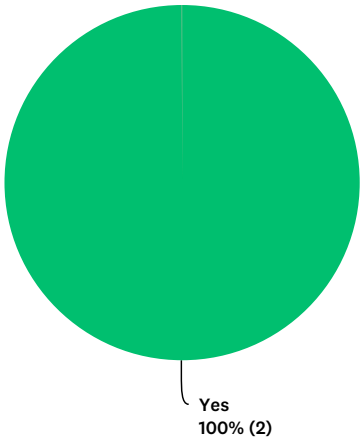
Q10 Other Questions that Council should be asking in a feedback survey?

Answered: 1 Skipped: 3

#	RESPONSES	DATE
1	None comes to mind	7/10/2019 8:15 AM

Q1 I received appropriate, supportive information for this Council meeting.

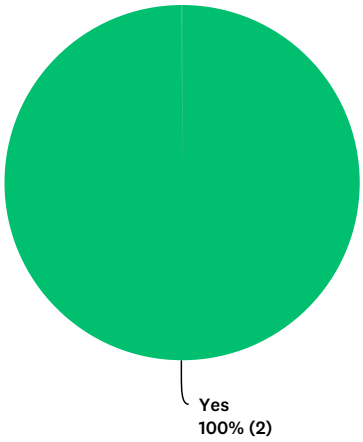
Answered: 2 Skipped: 0



#	COMMENTS	DATE
	There are no responses.	

Q2 I received this supportive information in a timely manner.

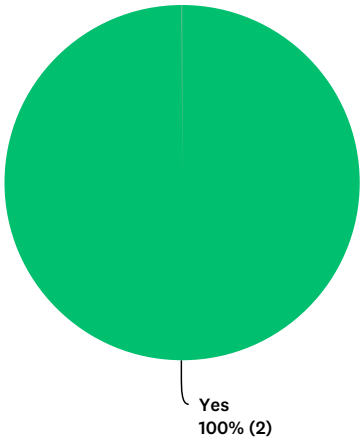
Answered: 2 Skipped: 0



#	COMMENTS	DATE
	There are no responses.	

Q3 This meeting was effective and efficient.

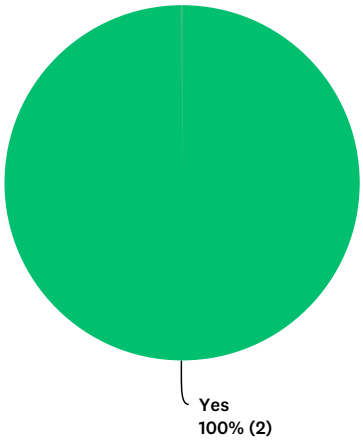
Answered: 2 Skipped: 0



#	COMMENTS	DATE
	There are no responses.	

Q4 The President chaired the meeting in a manner that enhanced Council's performance and decision-making.

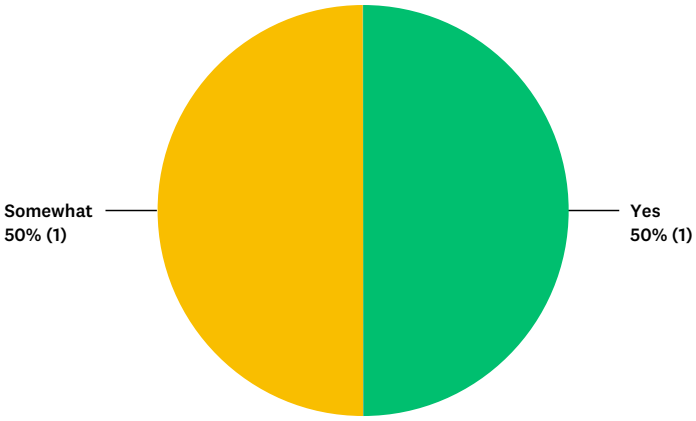
Answered: 2 Skipped: 0



#	COMMENTS	DATE
	There are no responses.	

Q5 I felt comfortable participating in the Council discussions.

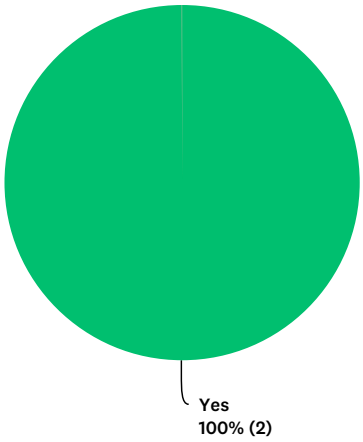
Answered: 2 Skipped: 0



#	COMMENTS	DATE
	There are no responses.	

Q6 The public interest was considered in all discussions.

Answered: 2 Skipped: 0



#	COMMENTS	DATE
	There are no responses.	

Q7 List two strengths of this meeting.

Answered: 2 Skipped: 0

#	RESPONSES	DATE
1	1. Agenda items most relevant. 2. Chair and advisers provided clarity on troubling issues.	9/18/2019 9:30 PM
2	Information was appropriate. Discussion length was appropriate.	9/18/2019 8:40 PM

Q8 List two ways in which Council meetings could be improved.

Answered: 2 Skipped: 0

#	RESPONSES	DATE
1	1. PSA must fill the complement of public members. 2. Some members should listen more and talk less.	9/18/2019 9:30 PM
2	There is a lot of info to cover. IF, info has been discussed before and there is additional info, could the original be referenced (date / time / item#) and that which is NEW, itemized as such.	9/18/2019 8:40 PM

Q9 Additional Comments

Answered: 2 Skipped: 0

#	RESPONSES	DATE
1	Keep up the good work in protecting the public interest.	9/18/2019 9:30 PM
2	What I said in #8 would apply to committee info as well.	9/18/2019 8:40 PM

Q10 Other Questions that Council should be asking in a feedback survey?

Answered: 1 Skipped: 1

#	RESPONSES	DATE
1	tbd	9/18/2019 9:30 PM

COLLEGE OF DENTURISTS OF ONTARIO

COMMITTEE REPORT TO COUNCIL

Name of Committee: **Executive Committee**

Reporting Date: **December 6, 2019**

Number of Meetings since last Council Meeting: **1**

The Executive Committee met by teleconference on Wednesday, November 27, 2019 to consider customary items and:

- The current financial statements for April 1, 2019 to October 31, 2019
- 5 Clinic Name Registration Applications
- A request for in-clinic dental hygiene equipment.

Respectfully submitted by Mr. Hanno Weinberger
President and Chair of the Executive Committee

COLLEGE OF DENTURISTS OF ONTARIO

COMMITTEE REPORT TO COUNCIL

Name of Committee: **Inquiries, Complaints and Reports Committee**

Reporting Date: **December 6, 2019**

Number of Meetings since last Council Meeting: **3**

Role of the Committee

The Inquiries, Complaints and Reports Committee supports the College's commitment to the public interest in safe, competent and ethical care and service. It receives and considers complaints and reports concerning the practice and conduct of Registered Denturists.

Executive Summary

Since the September 6, 2019 Council meeting, the ICRC has considered 10 complete investigations and made final dispositions in 8 matters (8 complaints investigations).

Decisions Finalized:

Complaints	**8**
Registrar's Reports	**0**
Total	**8**

Dispositions (some cases may have multiple dispositions or multiple members)

No Further Action	5
Advice/Recommendation/Reminder	1
SCERP (incl. Coaching and Training)	1
Cautions	
Referral to Health Inquiry Panel	1
Referral to Discipline	
Undertaking	
Deferred	2

Practice Issues (identified by ICRC at the time the decision is made)
**** Some cases may not have a Secondary Issue***

Practice Issue	Primary Issue	Secondary Issue
Patient harm/Patient Safety	1	
Clinical knowledge/understanding		
Clinical Skill/Execution	3	
Communication	3	
Relationship with Patient	1	
Professional Judgment		
Legislation, standards & ethics		
Laboratory Procedures		
Practice Management		1

Cases Considered by the Committee:

Complaints	**9**
Registrar's Reports	**2**
Health Inquiries	**0**
Health Inquiries (hold)	**1**

New Files Received during this period:

Complaints	**2**
Registrar's Reports	**1**
Health Inquiries	**1**

HPARB appeals

Total Appeals pending	5
New Appeals	1
ICRC Decision confirmed – case closed	1
ICRC Decision returned to ICRC	0
Appeal withdrawn – case closed	0
Files 150 days	0
Files 210 days	0
Files 210+ days	1

Respectfully submitted by Ms. Barbara Smith
Chair of the Inquiries, Complaints and Reports Committee

COLLEGE OF DENTURISTS OF ONTARIO

COMMITTEE REPORT TO COUNCIL

Name of Committee: **Discipline Committee**

Reporting Date: **December 6, 2019**
Number of Meetings since last Council Meeting: **1**

Introduction: Role of the Committee
The Discipline Committee supports the College's commitment to the public to address concerns about practice and conduct.

Executive Summary
Since the September 6, 2019 Council meeting, a Panel of the Discipline Committee participated in a pre-hearing teleconference.

A. Panel Activities

1. The Panel had a teleconference October 29, 2019 to discuss procedural and administrative items prior to a scheduled hearing November 18, 2019, the hearing was adjourned November 5, 2019 and is being rescheduled to early 2020.

B. Discipline Committee Meetings

The Discipline Committee did not have a meeting in this quarter.

Respectfully submitted by Mr. Hanno Weinberger
President and Chair of the Discipline Committee

COLLEGE OF DENTURISTS OF ONTARIO

COMMITTEE REPORT TO COUNCIL

Name of Committee: **Fitness to Practise Committee**

Reporting Date: **December 6, 2019**

Number of Meetings since last Council Meeting: **0**

Activities during the quarter:

There was no activity to report for this quarter.

Respectfully submitted by Mr. Michael Vout, Jr.
Chair of the Fitness to Practise Committee

COLLEGE OF DENTURISTS OF ONTARIO

COMMITTEE REPORT TO COUNCIL

Name of Committee: **Quality Assurance Committee – Panel A**

Reporting Date: **December 6, 2019**

Number of Meetings since last Council Meeting: **2**

Role of the Committee

Panel A of the Quality Assurance Committee (QAC-A) considers Peer & Practice Assessment reports as an indicator of whether a member's knowledge, skill and judgement are satisfactory. The Committee also monitors member compliance with the CPD program and develops tools, programs and policies for the College's Quality Assurance Program.

QAC-A met in-person on October 18, 2019 and via teleconference on October 30, 2019.

Meeting: October 18, 2019

Requirement Considered	Result
2018-19 Peer & Practice Assessments	• 1 - Satisfactory • 1 – Remedial action required
2019-20 Peer & Practice Assessments	• 13 – Satisfactory • 3 - Satisfactory Modified Non-Clinical Peer & Practice Assessments • 1 - Ordered to participate in a Modified Non-Clinical Peer & Practice Assessment • 7 – Remedial action required
2018-19 Annual CPD Requirements	• 3 - Extensions granted
2016-2019 CPD Cycle Requirements	• 3 – Extensions granted • 2 – Ordered to Participate in Peer & Practice Assessment

Meeting: October 30, 2019

Requirement Considered	Result
2018-19 Peer & Practice Assessments	• 1 - Remedial submission considered and deemed satisfactory

Peer & Practice Assessment Report Summary:

Renewal Period	Satisfactory	Remediation	Reassessment Ordered for Remediation	Modified Non-Clinical Assessment	Referral to ICRC	Resigned	Files Still In Progress
2016-17 (Total = 37)	19	12	1	3	1	2	0
2017-18 (Total = 35)	17	17	0	1	0	0	0
2018-19 (Total = 36)	17	11	2	3	0	1	2
2019-20 (Total = 80)	13	7		4			56

CPD Compliance Summary:

Renewal Period	Extensions Granted	CPD Audit Ordered	Peer & Practice Assessment Ordered	Referred to ICRC for Non-Compliance
2016-17	7	7	0	1
2017-18	2	4	0	0
2018-19	5	3	TBA	TBA

Program Development:

The Committee reviewed legal advice and discussed additional strategies to further improve member compliance rates for the 2019-2022 CPD cycle and annual requirements.

Peer Circles were held at the annual Perfecting Your Practice Conference where a total of 35 members participated. The events were very well-received, where 100% of participants indicated they would recommend the activity to a colleague. The Self-Assessment Tool Pilot launched October 25, 2019.

The Self-Assessment Tool Pilot launched on October 25th, 2019; 6 members have completed the pilot testing to date and preliminary feedback is extremely positive.

The Committee will be meeting in early 2020 for further review of Peer & Practice Assessment reports, and CPD compliance matters.

Respectfully submitted by Mr. Keith Collins
Chair of the Quality Assurance Committee – Panel A

COLLEGE OF DENTURISTS OF ONTARIO

COMMITTEE REPORT TO COUNCIL

Name of Committee:	**Quality Assurance Committee – Panel B**
Reporting Date:	**December 6, 2019**
Number of Meetings since last Council Meeting:	**2**

QAC-B met via teleconference on October 3, 2019 and in-person on November 1, 2019.

At the October 3rd teleconference, the Committee considered preliminary draft guidelines for infection prevention and control.

At the November 1st meeting, the Committee considered revised draft guidelines for infection prevention and control in addition to a newly developed checklist for Core Elements in a Denturist Practice. The Committee also considered the following documents:

- Guide to Closing, Selling or Leaving a Practice
- Guide to Dual Registration
- Standard of Practice: Professional Boundaries
- Standard of Practice: Record Keeping, and
- Standard of Practice: Procedures

The Committee will meet in the New Year to consider additional practice documents for development and revision.

Respectfully submitted by Ms. Noa Grad
Chair of the Quality Assurance Committee – Panel B

COLLEGE OF DENTURISTS OF ONTARIO

COMMITTEE REPORT TO COUNCIL

Name of Committee: **Qualifying Examination Committee**

Reporting Date: **December 6, 2019**

Number of Meetings since last Council Meeting: **0**

Activities during the Quarter:

There was no activity to report for this quarter.

Respectfully submitted by Mr. Michael Vout, Jr.
Chair of the Qualifying Examination Committee

COLLEGE OF DENTURISTS OF ONTARIO

COMMITTEE REPORT TO COUNCIL

Name of Committee: **Qualifying Examination Appeals Committee**

Reporting Date: **December 6, 2019**

Number of Meetings since last Council Meeting: **0**

Activities during the Quarter:

There was no activity to report for this quarter.

Respectfully submitted by Dr. Ivan McFarlane
Vice President and Chair of the Qualifying Examination Appeals Committee

COLLEGE OF DENTURISTS OF ONTARIO

COMMITTEE REPORT TO COUNCIL

Name of Committee: **Registration Committee**

Reporting Date: **December 6, 2019**

Number of Meetings since last Council Meeting: **3**

The Registration Committee (RC) met three times since its last report to Council on September 6, 2019.

At the September 26th, 2019 meeting, the Committee considered a currency matter.

At the November 7th, 2019 meeting, the Committee considered 2 requests for an academic assessment and approved Terms, Conditions and Limitations for an application for a Certificate of Registration. Additionally, the Committee considered amendments to the following policies:

- Language Proficiency Requirements Policy
- Credential Authentication Policy
- Insufficient and/or Incomplete Documentation Policy; and
- Referral of a Registration Application to the Registration Committee Policy.

At the November 28th, 2019 meeting, the Committee considered 9 requests for an academic assessment.

The Committee will continue policy consideration and revision at the next in-person meeting which will be scheduled for January/February 2020.

Respectfully submitted by Ms. Elizabeth Gorham-Matthews
Chair of the Registration Committee

COLLEGE OF DENTURISTS OF ONTARIO

COMMITTEE REPORT TO COUNCIL

Name of Committee: **Patient Relations Committee**

Reporting Date: **December 6, 2019**

Number of Meetings since last Council Meeting: **1**

The Patient Relations Committee met on September 27, 2019. At this meeting, the Committee considered a recent Independent Review of the Sexual Abuse Processes of the College of Physicians and Surgeons of Nova Scotia, and whether any of the recommendations should be implemented by the CDO.

The Committee has now developed a number of sexual abuse prevention tools, and a revised Sexual Abuse Prevention Plan, Frequently Asked Questions for Patients and Denturists, and a Patients' Rights Document were approved by Council in September.

In the future, the Committee will focus its efforts on:

- Identifying methods to enhance and support sexual abuse prevention education in denturism program curricula;
- Developing baseline competencies for sexual abuse prevention that could potentially be woven into the baseline competencies for denturists;
- Identifying public education possibilities; and
- Identifying methods for evaluating and reporting on the effectiveness of the Patient Relations Program.

Respectfully submitted by Ms. Alexia Baker-Lanoue
Chair of the Patient Relations Committee

COLLEGE OF DENTURISTS OF ONTARIO

Agenda Item 5.14

To: **Council**

From: **Dr. Glenn Pettifer**

Date: **December 6, 2019**

Subject: **Registrar's Report**

I am pleased to provide this report to Council.

STAFF STAKEHOLDER REPRESENTATION

August 26, 2019 – CDO Staff met with representatives from the Office of the Fairness Commissioner to discuss the College's Examination and Registration processes specifically looking at accessibility, fairness and transparency of these processes and related policies.

August 27, 2019 – Meeting of the Ministry of Health's College Performance Measurement Framework Working Group

August 29, 2019 – Staff attended Public Health Ontario, IPAC Knowledge Exchange Working Group

September 12/13, 2019 – Staff attended DAO PYP Continuing Education Event and provided an update on College initiatives and administered the Peer Circle Program.

September 19 – 21 – Staff attended CLEAR Annual Education Conference, Minneapolis, MN

October 8, 2019 – meeting of the Federation of Health Regulatory Colleges of Ontario (now the Health Professions Regulators of Ontario)

October 10, 2019 – staff attended FHRCO Investigations and Hearings Network Symposium

October 18, 2019 – attended Ministry of Health and FHRCO combined meeting regarding College Performance Measurement Framework

October 21, 2019 – moderated seminar presented by the Senior Advisory Volunteer Initiative of the Taddle Creek Family Health Team

October 21 & 25, 2019 – New College Registrant Orientation webinars provided to introduce individuals to the College processes, initiatives and the relationship between Registered Denturists and the College.

October 27 – 31, 2019. Attended Annual Conference of the Canadian Network of Agencies for Regulation, Quebec City.

> Co-Chaired: Regulatory SOS Workshop – Fundamentals of Professional Regulation
> Presented: "Challenges to Good Governance and Potential Remedies
> Presented: Lunch 'n Learn Session - "What the Citizen Advisory Group Tells Us: The Public's View of Regulatory Matters" with Lisa Pretty, Director of Communications, College of Physiotherapists of Ontario.

November 13, 2019 – staff attended RCDSO Sponsored Symposium on "Access to (Dental) Care".

November 14, 2019 – staff attended and spoke at the Continuing Education Event of the Denturist Group of Ontario.

November 19, 2019 – staff attended and spoke on the CDO's consultation process at the FHRCO Sponsored "Communications Day"

November 26, 2019 – staff spoke to the graduating class of the GBC Denturism program. The presentation included information related to professional self-regulation, the College's structure and its role in healthcare profession regulation, and details concerning the Qualifying Examination and Registration processes.

STAKEHOLDER COMMUNICATIONS

Published "Practice Advisory – Medical Devices and Health Canada Licensure" for Registered Denturists, September 12, 2019.

Published "College Update" – October 30, 2019.

FINANCE

Summary financial statements for the period April 1, 2019 – October 31, 2019 are presented in the meeting package.

COUNCIL PUBLIC APPOINTEES

Expiring Public Appointments

The appointment of President Hanno Weinberger expires on December 4, 2019 and there is no indication that Mr. Weinberger will be re-appointed.

New Appointments

Ms. Lileath Claire was appointed to the CDO Council by the Lieutenant-Governor in Council on September 27, 2019. Her appointment is effective for 1 year. (The current government seems to be confining its appointments to 1-year terms). Lileath makes her home in Oakville. She brings a wealth of knowledge (MBA-York, MSc-Logistics and Operations Mgmt-Liverpool) and subsequent experience with Sanofi, a global Biotechnology/Pharmaceutical firm where her key focus included business information technology strategy development and execution, portfolio execution and business continuity. Lileath also worked with Sanofi in France where she focused on globalization of the organization's Information Technology methods and processes for corporate Supply Chain Integration.

Mr. Gord White was appointed to the CDO Council by the Lieutenant-Governor in Council on November 28. 2019. His appointment is effective for 1 year. Mr. White brings extensive experience in Board Governance, Association Management, Strategic Planning, and Financial Management to the Council table as a result of his work as Executive Director of the Association of Local Public Health Agencies, CEO of the Ontario Retirement Home Association, and CEO of the Professional Geoscientists of Ontario. Most recently, Mr. White has served on the Council and Committees of the College of Opticians of Ontario. Mr. White makes his home in Mississauga.

COUNCIL ELECTIONS

A By-election to fill the vacant District 2 seat on Council was called for Thursday October 17, 2019. No nominations were received. Another By-election to fill this vacant seat has been called for March 5, 2020. By-elections are conducted pursuant to Articles 14.02 and 21.07 of the College By-laws.

REGISTRATION

The College currently has 742 registrants. This is an increase of 19 Registered Denturists since the September 6, 2019 Council meeting.

ICRC

Since the September 6, 2019 Council meeting, the ICRC has considered 10 complete investigations and made final dispositions in 8 matters (8 complaints investigations). In this period, the Committee received 2 new Complaint files, 1 Registrar's report and 1 referral to a Health Inquiry Panel. There are currently 5 appeals pending with the Health Professions Appeal and Review Board. HPARB upheld one appealed ICRC decision.

QUALITY ASSURANCE – WEBINARS

The fall webinar series is in progress. The summary statistics for the current session are below. The second table contains the statistics for all webinars since the program began.

Topic	# of Sessions	Attendance	On-Demand Views
Advertising	2	46	4
Conflict of Interest	2	31	3
Record Keeping	2	27	4
Informed Consent	2	20	1
Confidentiality/Privacy	2	32	5
Restricted Title	2	61	3
Professional Collaboration	2	98	n/a

Topic	# of Sessions	Attendance	On-Demand Views
Advertising	16	380	85
Conflict of Interest	22	223	151
Record Keeping	27	632	141
Informed Consent	22	375	110
Confidentiality/Privacy	20	355	236
Restricted Title	4	167	8
Professional Collaboration	2	98	n/a

PROGRAM AND POLICY DEVELOPMENT – SELECTED ITEMS

Peer Circle Project

The Peer Circle Project was first piloted in November 2018 at the DAO PYP. Since then, other Peer Circle events have been held in Windsor (May 22, 2019), Ottawa (June 6, 2019), Sudbury (June 22, 2019) and again at the DAO PYP (September 13, 2019). The feedback has been very positive. The College has offered to provide the Peer Circle event at a DGO event but, to date, this has not been scheduled. For individuals who are unable to attend a live event, staff are currently investigating how the Peer Circle format can be delivered online.

Infection Prevention and Control Guidelines

The draft IPAC Guideline document is completed, has been reviewed by Quality Assurance – Panel B and will be presented to Council for consideration. In addition to the Guidelines document, a series of IPAC checklists will be developed. Checklists will summarize IPAC information for specific areas in denturism practice.

Regulation Revisions

The draft revised Registration Regulation and new Quality Assurance Regulation have been posted for final comment.

Document Management Project

The current College documentation is being sorted and migrated to the new document management program. This work will take us into 2020. The SharePoint configuration to provide for online access to meeting materials (thereby negating the need to send out emails with links or materials attached) is nearing completion.

Self-Assessment Tool.

The self-assessment tool was demonstrated to Council at its last meeting. The tool is currently being piloted to a small group of members of the profession. Once this piloting is complete, the tool will be piloted to all Registered Denturists over the next three years to coincide with the Continuing Professional Development cycle.

STAFF PROFESSIONAL DEVELOPMENT ACTIVITIES

Staff attended the Weir-Foulds seminar "Professional Self-Regulatory Bodies Fall Seminar: Hot Topics for Regulators" on November 22, 2019.

Catherine is completing an on-line Masterclass with the McMaster Health Forum – "The Conduct and Use of Patient-Oriented Research"

Megan is completing a Certificate in Records and Information Management with Mohawk College and a series of online modules which present issues and strategies for accommodation and accessibility for differently abled individuals (the public, students, employees, members of the profession).

Jennifer is completing courses in fulfillment of her Master's in Public Administration (Management) and recently completed a course in Creative Writing at the University of Toronto.

Rod attended the "Access to Care" Symposium sponsored and presented by the Royal College of Dental Surgeons of Ontario.

COLLEGE OF DENTURISTS OF ONTARIO

MEMO

To: **Council**

From: **Dr. Glenn Pettifer, Registrar and CEO**

Date: **December 6, 2019**

Subject: **Financial Report Memo – April 1, 2019 to October 31, 2019**

Financial Reports are attached for the period April 1 – October 31, 2019.

You will find revenue and expenditure summaries. I direct your attention to the column "YTD as Percentage of Budget" which indicates the percentage of the budgeted amount that has been spent or, in the case of revenue, received. Since this report covers the first 7 months of the fiscal year, we expect that approximately 60% of a budgeted amount is spent or, in the case of revenue, received.

Revenue:
Most revenue comes from Registration renewal (ends on April 15) and associated activities. The total revenue at this point in the current fiscal year is 96% of the budgeted amount. Remaining revenue will come from examination fees from the January 2019 sitting of the Qualifying Examination.

Expenses:

Some line items are not expensed over time but are lump sum payments. These items will show a YTD percentage of budget greater or less than 60%, depending on when the lump sum items are invoiced. Some items, such as credit card processing, are expenses that largely occur at one time in the fiscal year. Credit card fees arise during the renewal period (March 1 – April 15) when members renew their Certificates of Registration or Certificates of Authorization for Health Professions Corporations and pay by credit card. The processing fees are then invoiced and posted in April/May during the first quarter of the fiscal year. This large lump sum expense related to credit card processing fees is reflected in the Office and General Expense line that is above the anticipated 60% expenditure level.

While well below the budgeted amount for this point in the fiscal year, line 18, Professional Fees, includes legal fees and the legal costs related to support of the Patient Relations Committee. While not reflected in the aggregate expense amount, these fees are well above the anticipated level of

expenditure for this point in the fiscal year (approximately 200% the budgeted amount). This excess reflects the significant work that the PRC has undertaken during the first part of 2019 after a period of relative inactivity. The legal fees represent Committee orientation, developing Terms of Reference for the Committee, developing policy around funding for therapy and counselling support and assistance drafting a new sexual abuse prevention program. All these elements are important pieces of the work of the PRC. Not all these items were planned at the time that the 2019-2020 budget was developed, and the overage reflects the hard work and momentum of the Committee.

Overall the percentage of total expenditures related to the total expense budget is well below (53%) where one would predict it to be at this point in the fiscal year.

1	**College of Denturists of Ontario**				
2	Income Statement (April 1- October 31, 2019)				
3					
4					
5	**YTD Budget to Actual**	**2019-2020**	**October 31/19**	**YTD as Percentage**	**Remainder or In Excess**
6		**BUDGET**	**YTD Totals**	**of Budget**	**of Budgeted Amount***
7	**REVENUE**				
8	Professional Corporation Fees	$ 67,500.00	$ 57,150.00	85%	$ 10,350.00
9	Registration Fees	$ 1,418,000.00	$ 1,449,506.00	102%	$ 31,506.00[3]
10	Other Fees	$ 10,100.00	$ 6,577.00	65%	$ 3,523.00
11	Qualifying Examination Fees	$ 280,125.00	$ 182,150.00	65%	$ 97,975.00
12	Other Income	$ 16,000.00	$ 17,997.15	112%	$ 1,997.15*
13	**TOTAL REVENUE**	**$ 1,791,725.00**	**$ 1,713,380.15**	**96%**	**$ 78,344.85**
14					
15	**EXPENDITURES**				
16	Wages & Benefits	$ 553,280.60	$ 345,694.67	62%	$ 207,585.93
17	Professional Development	$ 40,000.00	$ 24,183.15	60%	$ 15,816.85
18	Professional Fees	$ 243,500.00	$ 70,966.28	29%	$ 172,533.72
19	Office & General	$ 153,200.00	$ 106,233.63	69%	$ 46,966.37
20	Rent	$ 117,756.80	$ 72,868.38	62%	$ 44,888.42
21	Qualifying Examination	$ 303,150.00	$ 169,301.37	56%	$ 133,848.63
22	Council and Committees	$ 46,500.00	$ 29,212.41	63%	$ 17,287.59
23	Quality Assurance				
24	QA Panel A	$ 6,000.00	$ 2,535.10	42%	$ 3,464.90
25	QA Panel B	$ 5,000.00	$ 653.71	13%	$ 4,346.29
26	QA Assessments	$ 37,650.00	$ 25,121.98	67%	$ 12,528.02
27	Complaints & Discipline				
28	Complaints	$ 126,000.00	$ 38,743.31	31%	$ 87,256.69
29	Discipline	$ 45,000.00	$ 8,914.22	20%	$ 36,085.78
30	Capital Expenditures	$ 15,000.00	$ 1,475.00	10%	$ 13,525.00
31	**TOTAL EXPENDITURES**	**$ 1,692,037.40**	**$ 895,903.21**	**53%**	**$ 796,134.19**
32					
33	**NET INCOME**	**$ 99,687.60**	**$ 817,476.94**		

COLLEGE OF DENTURISTS OF ONTARIO

BRIEFING NOTE

To: **Council**

From: **Dr. Glenn Pettifer, Registrar & CEO**

Date: **December 6, 2019**

Subject: **Update on Strategy Map 2017-2020 progress**

Priority 1 – Enhanced Communication and Stakeholder Engagement

The Peer Circle Project was piloted in November 2018 at the DAO PYP. This component of the QA program is very well received by members of the profession. Peer Circle events were held in Windsor (May 22, 2019), Ottawa (June 6, 2019), Sudbury (June 22, 2019 at the fall DAO PYP Conference (September 13, 2019). The College has offered to provide the Peer Circle event at a DGO event but, to date, this has not been scheduled. The feedback on the Peer Circle events is very positive. Staff continue to explore ways in which we can leverage technology to allow us to provide the Peer Circle tool for Registered Denturists who are not located near a centre where the Peer Circle Project is offered in person.

CAG has provided feedback on website accessibility. This feedback has been assessed and catalogued and a work plan for website modifications and select communication initiatives has been drafted. Some of the website modifications have been completed. Amendments to the design of the public register to add to its accessibility have been completed.

Educational webinars and self-directed learning assignments have been developed and continue to be developed for existing and new Standards of Practice. Members who attend the webinars have the option to complete self-directed learning assignments for additional CPD credit. Staff have developed on-demand modules for each of these Standards (Strategic Plan Priority 1).

The number of sessions, attendance and on demand views for webinars since inception are detailed below:

Topic	# of Sessions	Attendance	On-Demand Views
Advertising	16	380	85
Conflict of Interest	22	223	151
Record Keeping	27	632	141
Informed Consent	22	375	110
Confidentiality/Privacy	20	355	236
Restricted Title	4	167	8
Professional Collaboration	2	98	n/a

Interprofessional collaboration has been an item of discussion at meetings with the Registrars of the CDHO and CDTO. The Standard of Practice: Professional Collaboration was approved by Council for January 1, 2020 Implementation.

The draft IPAC Guidelines document has been completed. This document was completed with input from Public Health Ontario. To complement the Guidelines document, a series of IPAC checklists that will summarize IPAC information for specific areas in denturism practice will be developed. The Guidelines have been reviewed by Panel B of the Quality Assurance Committee and will be presented to Council for consideration at its December 6, 2019 meeting. In the interim, the College continues to provide information support to Registered Denturists who have questions regarding this area of clinical practice. A single page information sheet on hand-washing protocols was developed and provided to Peer Assessors for use in their discussions with members of the profession who undergo a Peer and Practice Assessment.

Priority 2 – Excellence in Governance

Council, Committee Members and Peer Advisors have engaged in training sessions on Unconscious Bias. Training on financial literacy was provided by Blair MacKenzie at the June 2018 Council meeting. A presentation on the College's Inquiries, Complaints and Reports, Discipline and Fitness to Practise Committees was provided by College counsel at the June 14, 2019 meeting. College counsel provided training on "Considerations in Being an Effective Council Member, Committee Member and Chair" at the September 6, 2019 Council meeting.

The mentoring process for new Council members is under development.

Policy Coordination has been introduced to both the Registration, Quality Assurance and Qualifying Examination Committees. Schedules for policy review in these areas have been developed and approved. A revision schedule for the Standards of Practice will be developed once all the Standards are developed and implemented. This will be expanded across all policy areas of the College.

Included under this policy coordination initiative is the development of a document management strategy. The needs assessment was completed in April 2018. The document classification structure was developed. A software program for document management was identified, purchased and installed on the College servers. The current College documentation is being sorted and migrated to the new document management program. This will take us into 2020. The SharePoint configuration to provide for online access to meeting materials (thereby negating the need to send out emails with links or materials attached) is near completion.

Priority 3 – Enhanced Relations with Educational Institutions

College staff continue to attend all 3 academic institutions to deliver presentations on the College, its role in the regulation of the profession of denturism, registration requirements, qualifying examination processes and opportunities for engagement.

The College also provides presentations to current denturism students on Standards of Practice of the College.

The College has engaged each of Ontario's Denturism Program administrators in this conversation around academic program accreditation. Council ultimately selected EQual as the accreditor for denturism academic programs in Ontario. Alberta and British Columbia denturism regulators have also chosen EQual as their academic program accreditation body.

The CDO has also engaged with the Alberta and British Columbia regulators to undertake a national level review of the National Competency Profile. The survey and data analysis for this revision is in progress.

Coincident with this combined National Competency Profile revision effort, is an effort to nationalize the entry to practice Qualifying Examination. In conjunction with the College's regulatory counterparts in Alberta and British Columbia, the CDO is currently exploring the first step in the nationalization of the Qualifying Examination, developing a common multiple-choice component of the examination.

Prepared by Richard Steinecke

In this Issue:

Bonus Features:

Ontario Bills

(See: https://www.ola.org)

Bill 136, *Provincial Animal Welfare Services Act, 2019* – *(government Bill, passed first reading)* Bill 136 replaces the privately-run Ontario Society to Prevent Cruelty to Animals with a government official, the Chief Animal Welfare Inspector. The Chief Animal Welfare Inspector has numerous administrative powers (e.g., inspections, demand for information, right to take action to protect animals) and provincial offence enforcement powers. Of broader interest is the complaints mechanism available for anyone who thinks the new agency is acting contrary to its Code of Conduct.

Bill 116, *Foundations for Promoting and Protecting Mental Health and Addictions Services Act, 2019* – (*government Bill – passed second reading)*. The Bill establishes a centre of excellence to address mental illness and addictions and makes it easier for the government to sue manufacturers and wholesalers of opioids.

Proclamations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

There were no relevant proclamations this month.

Regulations

(See www.ontario.ca/en/ontgazette/gazlat/index.htm)

Film Classification Act, 2005, uses the British Columbia film classification regime for Ontario movies as part of sudden disbanding of the regulatory authority established in Ontario for classifying films (Ontario Regulation 325/19 Gazetted October 19, 2019).

Proposed Regulations Registry

(See http://www.ontariocanada.com/registry)

Ontario Drug Benefit Act – The proposal is to reduce the payments to pharmacies for publicly funded dispensing of drugs. These reductions have been negotiated with the professional associations representing pharmacies in Ontario. Comments are due by November 30, 2019. At the same time, there is a parallel consultation on reducing the complexity of the technical requirements for submitting claims for publicly funded dispensing of drugs. Comments are due by November 27, 2019.

Nursing Act – The proposal is to enact regulations permitting RNs and RPNs to self-initiate the performance of the controlled act of providing psychotherapy. In a parallel consultation, the proposal is to enact regulations permitting "RNs to perform two new controlled acts of prescribing drugs for certain non-complex conditions [i.e., Immunization, Contraception, Wound care, Travel health, Smoking cessation, and Over-the-counter medications] and communicating a diagnosis for the purposes of prescribing." Comments on both consultations are due by November 17, 2019.

Bonus Features

(Includes Excerpts from our Blog and Twitter feed found at www.sml-law.com)

Some Protected Titles May be Unconstitutional

Many regulators have two types of title protection provisions. The first reserves a title associated with a profession for use only by those registered with the regulator. No unregistered person can use the title in any context. The second prohibits the use of any title that can confuse the public as to whether the individual is qualified or competent to practice the profession.

In a case that played prominently in the media, the first provision has been found to be an unconstitutional infringement of the freedom of expression protections contained in the *Canadian Charter of Rights and Freedoms*: *College of Midwives of British Columbia v MaryMoon*, 2019 BCSC 1670, http://canlii.ca/t/j2nn8. Ms. MaryMoon, who assisted individuals and families through the dying process, called herself a "death midwife". The regulator for midwives sought an injunction to prevent her from using the title "midwife". She opposed the restraining order on the basis that her use of the term had nothing to do with the practice of midwifery. She argued that no member of the public would be confused by her use of the title.

The Court concluded that the provision did infringe on Ms. MaryMoon's freedom of expression. The Court also found that there was insufficient evidence justifying the necessity for the provision that did not mislead the public. In its reasoning, the Court found that the public was adequately protected by the other provision prohibiting anyone from using a title or designation suggesting the person was

qualified or competent to practice the profession while unregistered. The Court not only declined to issue the injunction, but also declared the provision to be unconstitutional.

Undoubtedly, there will be more litigation on this issue as proving that a person using a title implying that they are qualified or competent to practice the profession is not always easy.

Curing Procedural Deficiencies

Procedural missteps by a regulator can often be cured. In *Volochay v College of Massage Therapist*, 2019 ONSC 5718, http://canlii.ca/t/j2np8, serious allegations of sexual abuse were set aside because the regulator did not follow the specified complaints procedure. However, the matter was sent back and was investigated following a proper procedure, resulting in a referral to discipline. The Court held that the referral was now valid.

The Court also declined to receive "fresh evidence" that was available at the time of the hearing, the authenticity and relevance of which was questionable. The Court further held that the 30-month period taken to investigate the matter was not unduly long, particularly since the practitioner was able to practise in the interim and no specific prejudice was established.

The Court also found that the credibility findings were adequately explained in the reasons for the panel's decision, when read as a whole. The reasons included the basis for finding that the practitioner's evidence was not credible.

Accessing Files When Responding to a Complaint Is not a Privacy Breach

Prior to the enactment of private sector privacy legislation over the past couple of decades, it was generally accepted that the filing of a complaint provided implied consent for the practitioner to review their files and make a response. This was true even if the access and response involved confidential client information. In *JK v Gowrishankar*, 2019 ABCA 316, http://canlii.ca/t/j26r6, the issue was whether privacy legislation altered this approach. In that case, a patient made complaints against two practitioners about their treatment: one to the health facility and one to the regulatory body. For the complaint to the regulatory body, the patient provided consent for the regulatory body to have access to the patient's personal health information. However, the practitioners themselves accessed the patient's files to respond to the complaint.

The patient then made a complaint to the Information and Privacy Commissioner about the practitioners accessing the patient's personal health information to respond to the complaints. The designated delegate of the Commissioner found in favour of the patient. However, on judicial review, both levels of the Court reversed the finding and held that the practitioners had not breached the privacy legislation. They relied on the statutory exception permitting use for "conducting investigations, discipline proceedings, practice reviews or inspections relating to the members of a health profession or health discipline".

The Court of Appeal concluded that the practitioners were covered by the exception because the use of the information was related to the investigation and was not for their personal use:

> Any investigation requires the gathering of relevant information. An investigation is also contextual in that the information gathered will depend on the nature of the matter being investigated. At a minimum, it requires information surrounding the matter under investigation. It also assists the investigation if the person being investigated provides their response to the matter at issue. The response of the person being investigated is not for their personal benefit but for the benefit of the investigation as a whole.

The Court warned that the access and use of the information would have to relate to the scope of the investigation and not go beyond that.

The Court also held that the consent signed by the patient for the regulator to have access to the patient's personal health information also authorized the actions of the practitioners.

The Court concluded:

> A reasonable interpretation of the [privacy statute] requires a balancing of the competing values identified in s 2 of the Act. The adjudicator's interpretation gives prominence to the privacy of the individual over appropriate sharing and access of health information to manage the health system. A complaint to a professional governing body, like the College, engages potentially serious consequences to a physician including the loss of his or her license to practice. While the jeopardy faced by the physician is not that of a criminal proceeding, the physician must be able to respond to the complaint: [case citation omitted]. An interpretation that fails to balance competing values is unreasonable: [case citation omitted].

While the pathway of legal reasoning is different from what existed before private sector privacy legislation, the outcome seems quite similar. In fact, the approach taken in this case might even support practitioners accessing and using personal client information where the complaint is made by someone other than the client.

Rare Order Stays Investigation of a Complaint

There is little doubt that it is rare for a Court to stay the simple investigation of a complaint pending the outcome of an application for judicial review challenging the investigation. However, *Fawcett v College of Physicians and Surgeons of the Province of Alberta*, 2019 ABQB 788, http://canlii.ca/t/j2s0s, is such an exceptional case.

There, a lengthy and detailed complaint by a co-worker was made against a physician to her employer, a hospital. After a thorough investigation, the hospital dismissed the complaint. The co-worker then complained to the regulator for the physician. The regulator formally decided not to investigate the complaint being of the view it was primarily about work-related issues and did not, on its face, reveal any professional misconduct. The complainant appealed to the regulator's internal Complaints Review Committee which determined that the complaint warranted investigation. The physician sought judicial review of that decision and requested a stay of the investigation while the judicial review was pending.

The Court granted the stay. It viewed the burden on the physician of responding to the detailed complaint as causing her irreparable harm:

> … I am persuaded that a written response other than a blanket denial would be a time-consuming and repetitive exercise. Time alone is a precious commodity, and Dr. Fawcett is statutorily barred under the [the enabling statute] from seeking compensation from the College for either time or mental distress.

Given the above and given the delay in the matter reaching the College, the Court concluded that, as between the physician and the College, the balance of convenience favoured the physician.

The outcome might have been different if there had not been an initial decision by the regulator that the complaint was not worth investigating.

No Discrimination Found

A lawyer was found at discipline to have "been dishonest with the Court, made misrepresentations to the Court, demonstrated a significant lack of candour, was deliberately dishonest, failed to properly investigate client files, and failed to recognize conflicts of interest". He was disbarred. On appeal, the practitioner argued that the investigation and prosecution was tainted by racial discrimination and that he had been subject to differential treatment throughout his dealing with the regulator. The Court found that the hearing panel had carefully reviewed and considered the evidence it received over the course of 66 days. There was no legal error in the panel's conclusion that the regulator was acting in response to legitimate concerns without discrimination.

The Court also found that the allegation of appearance of bias by one of the panel members on the basis of a pecuniary advantage in eliminating a competitor was, in the circumstances, without merit. The Court agreed with the panel that:

> … "the impact of reducing the pool of criminal lawyers by one would have such a minimal impact on the number of clients for [the panel member] as to be insignificant. This cannot form the basis of a reasonable apprehension of bias by a reasonable person. [It] cannot form the basis to rebut the presumption of impartiality."

Registrar of Regulator Testifies as an Expert Witness

Courts give regulators deference. In some cases, that deference is quite broad. An example of broad deference is found in *Pomarenski v Saskatchewan Veterinary Medical Association Professional Conduct Committee*, 2019 SKQB 264, http://canlii.ca/t/j2x9z. The case dealt with a veterinarian's care for an injured dog. During the hearing, the Registrar, who was also a veterinarian, testified about the standard of practice that should have been applied. Despite the absence of notice of the expert testimony, the Court deferred to the tribunal's admission of the evidence both because the tribunal was not bound by the civil rules of evidence and because the tribunal would have had its own expertise to apply to the facts of the case.

The Court also held that there was no double jeopardy as the five headings of misconduct were simply particulars of one allegation of professional misconduct.

The Court did set aside the costs order for paying all of the costs (totalling $42,000) because the hearing panel did not follow a fair procedure in hearing evidence and receiving submissions justifying the specific amount because the amount exceeded past precedents and because the panel did not give reasons explaining how it arrived at its conclusion. The issue of costs was returned for a fresh decision.

Precautionary Principle Does Not Prevail

What should a regulator do where:

1. A novel procedure (in this case dealing with the disposition of deceased human bodies) is not being operated safely and ethically at the time of an inspection; and
2. The procedure has not been established to be safe and has a potential risk associated with it?

In *Registrar, Funeral, Burial and Cremation Services Act*, 2019 ONSC 6091, http://canlii.ca/t/j2z22, the regulator applied the precautionary principle and proposed to revoke the crematorium operator licence. The Licence Appeal Tribunal declined to revoke the licence.

On appeal, the Court upheld the tribunal's decision. On the first concern, the Court held that the premises was now operating in accordance with the rules and concerns about future non-compliance were speculative. On the second concern, the Court disposed of the matter on the basis of the regulator carrying the onus proof. The regulator had to provide evidence of risk of harm despite the absence of research on the method of disposition rather than the licensee having to provide evidence of its safety. The precautionary principle did not prevail.

It will be interesting to see if there is a further appeal in the matter.

THE DENTURIST ASSOCIATION OF ONTARIO

November 14, 2019

Dr. Glenn Pettifer, Registrar
College of Denturists of Ontario
365 Bloor Street East, Suite 1606
Toronto, ON M4W 3L4

Via Email

RE: Further response to 2018 CDO By-Law Amendments

Dear Dr. Pettifer,

We write further to our exchange of correspondence earlier this year, and subsequent discussions, regarding CDO By-law amendments to permit appointment of "persons" to committees and the selection of Ms. Barbara Smith as Chair of the Inquiries, Complaints and Reports Committee ("ICRC") of the College following the expiry of her public appointment by the Lieutenant Governor in Council ("LGC")

Other Colleges Are Not Following this Practice

We have followed up on some of the information you provided regarding the College of Nurses and the College of Teachers, but have not been able to verify what you said. You said in your letter dated April 12, 2019 that the College of Nurses and the College of Teachers were no longer electing professional members. We spoke with the College of Teachers, and they said that was not true. Similarly, our review of their websites does not seem to reflect such a change.

Certainly, their statutory committees are comprised only of professional members or Public Appointments, appointed by the LGC. In fact, the same is true for every College we checked.

As far as we have been able to determine, ours is the ONLY College in the province circumventing the LGC in placing public "persons" who are not appointed by the LGC on a statutory committee.

We notice that the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario seems to have similar "persons" language now in their by-law. However, as we understand that they are also advised by the same legal counsel, Ms. Rebecca Durcan, we do not view that as any independent source of support for our College's position and currently that College does not appear to have any such "person" serving on any statutory committee.

The By-law is Contrary to the Spirit and Intention of the *RHPA* and the Model of Self-Governance Under Government Oversight

As expressed in our original letter of March 14, 2019, our concern is not personal to Ms. Smith. We agree that she was a valuable participant on Council and the committees during her tenure as a Public Appointment appointed by the LGC.

However, we remain gravely concerned about this precedent, and disagree that the College's actions in this regard are permissible under the Regulated Health Professions Act ("RHPA").

By-laws regarding the composition of committees must be consistent with the spirit and intention of the RHPA.

Under the CDO By-laws "Member" means a "person registered with the College". Public Member" means a "person described in clause 6(1)(b) of the RHPA [appointed by the LGC]".

Members are accountable to the College and Public Members are accountable to government.

For these reasons, committees composed of Public Members and Members (members elected to Council and non-Council members) respect the spirit and intent of the RHPA and reflect the committee composition of all the other health regulatory colleges in Ontario.

In response to the suggestion that there is no difference between the Council selecting a "public person" and a non-council "member" to serve on a statutory committee, we disagree. The RHPA model is one of self-regulation. Thus, non-council "members" serving on statutory committee is entirely consistent with the model.

The Public Appointments are there to provide government oversight of the self-regulated model.

However, "public persons" serve no such function and are in no way consistent with the self-regulation model or the spirit or intention of the RHPA. As noted below, in fact, the practice creates a conflict of interest and sets a dangerous precedent.

Non-council members are subject to the jurisdiction of the College. "Public persons" are not. Moreover, By-law 24.13 sets out numerous criteria for members before they can serve on committees; there are absolutely no criteria mentioned in the by-law for "persons". "A person" or "public person" is not even defined in the CDO By-laws.

Public Appointments through the LGC are "public servants", subject to the Public Service of Ontario Act, 2006, and serve pursuant to an express and required allegiance to the Crown.

"Persons" owe allegiance only to Council, who appointed him/her, and are not subject to any statutory authority or control.

The By-law Creates Conflicts of Interest That Threaten Other College Decisions

As explained in our letter of March 14, 2019, the placement of Ms. Smith as a member of the public (not a public member) on the ICRC erodes public trust and accountability, and creates confusion in the minds of members and the public.

In addition to the issues and concerns raised in our previous correspondence, which we will not repeat here, the concern has been raised that all decisions of the ICRC rendered while Ms. Smith is part of the committee could be challenged on the basis that it is unlawfully and improperly constituted. Any decision by the ICRC to refer a member to discipline while Ms. Smith is on the committee could be open to challenge. Obviously, this would result in a great deal of upheaval and expense to the College, and by extension its members. Creating this potential risk is not in the public interest, and does not demonstrate responsible stewardship of the College's resources.

We are also concerned that Council's vote on this by-law was improper in that all Public Appointments on Council ought to have declared a conflict of interest, and should not have participated in the vote. All of them stand to benefit from this decision as, even after their terms have expired, they can lobby the Executive Committee and Council to continue their position. This is inconsistent with CDO By-laws 26.01, 27.01 and 27.02 and could be viewed as rendering the vote invalid to approve the by-laws amendments.

Moreover, allowing Council to decide who of the Public Appointments should remain after their term has expired raises conflicts of interest that could call into question any decision by Council. As mentioned in our first letter, those "public persons" are no longer accountable or responsible to the government. Rather, they are beholding to Council who put them on the committees. Therefore, there is an obvious conflict of interest, as those Public Appointments may be motivated to vote along with the members of Council in order to secure placement on a statutory committee in the future.

We continue to consider our path forward with respect to this issue but wanted to ensure that our ongoing opposition to the practice is clear to the College.

On behalf of the Board of Directors

Regards,

Frank Odorico, B.Sc., DD
President
The Denturist Association of Ontario

From: Glenn Pettifer
To: Frank Odorico (frankodorico@msn.com); Yolanda Baldesarra
Cc: Megan Callaway; Hanno Weinberger (weinbergerhk@gmail.com)
Subject: Response to DAO"s November 14, 2019 Correspondence
Date: November 29, 2019 1:15:33 PM

Dear Frank;

Thank you for the letter on behalf of the Association's Board of Directors dated November 14, 2019.

At the outset, please note that when I wrote to you in April 2019 the Ontario College of Teachers had voted to recommend the abandonment of elections of professional members. Since that time the Council has since decided to maintain the election process. However, the College of Nurses still recommends an abandonment of the election process. The Ministry of Health has not yet passed legislation reflecting the College of Nurses' recommendation. However, the College of Denturists of Ontario takes note of the regulatory trends which are asking for more public input into the regulation of professions. I attach a link to a Toronto Star article explaining the decision of the College of Nurses and the rationale for such change.
https://www.thestar.com/news/canada/2018/03/25/the-radical-paradigm-shift-thats-changing-ontarios-oversight-system-for-health-professionals.html

Despite the fact that the Ontario College of Teachers has decided to maintain the election process, their Council has decided to reduce the size of their Council and achieve parity between the public and professional members on Council. The College of Nurses of Ontario has also made similar requests. These requests reflect their belief that self-regulation is evolving and that an increased public voice is required in order to maintain the confidence of the public.

You should note that the College of Naturopaths of Ontario has also included language in their bylaws to permit persons on certain College committees. To be transparent, Ms. Durcan also provides general counsel advice to that College. However, the College of Denturists of Ontario was the first College to create this avenue that allows an increased voice of the public. The College is proud of this initiative and looks forward to seeing other Colleges follow suit. We can also advise that the Ministry of Health has been advised of this initiative and has taken no issue with the College's interpretation or actions in this regard. The Ministry of Health delegates the power to regulate the profession to the College. Therefore, although the DAO may not be supportive of this initiative, the College is mindful and respectful of the Ministry's position on this issue. We are sure you can understand.

I do not think it is necessary to repeat the response already provided to you by the College on the rationale for this initiative. This has already been provided. The College is confident of the

legality and the propriety of the amendments. However, we would encourage the DAO to take note of the regulatory trend across the country to increase the public voice in regulation. It is increasingly becoming clear that self-regulation is not predicated on the profession members outweighing members of the public. It is predicated on ensuring that the government is confident that the regulator is regulating the profession in the public interest and ergo not requiring the government to regulate the profession directly.

As evidence of this evolving, current trend, I will also point to the recent announcement by the government of the province of British Columbia of major changes to the health profession regulation in B.C. The full report is available on the web (https://engage.gov.bc.ca/app/uploads/sites/578/2019/11/Modernizing-health-profession-regulatory-framework-Consultation-Paper.pdf), but at a high level it covers four key themes:

1. Governance reform: eliminating board elections and replacing them with a transparent, competency-based appointment process
2. Introducing an oversight body to increase accountability and consistency of regulatory colleges
3. Simplifying the complaints and discipline process to provide a clear focus on patient safety and public protection
4. Reducing the number of regulatory colleges from 20 to 5:
    a. Nurses and Midwives
    b. Physicians and Podiatric Surgeons
    c. Oral health professionals
    d. Pharmacists
    e. The remaining colleges under a single umbrella

I'm sure you will agree that these recommendations reflect very significant changes to health profession regulation and they may portend similar changes in other jurisdictions.

I will be enclosing a copy of your letter and this response in the upcoming Council package. As you are aware, the Council package will be posted on the College website.

Best regards,

Dr. Glenn Pettifer
Registrar and CEO
College of Denturists of Ontario • 365 Bloor Street East, Suite 1606 • Toronto, ON M4W 3L4 •
T 416-925-6331 ext. 230 • F 416-925-6332 • Toll free 1-888-236-4326
• www.denturists-cdo.com

COLLEGE OF DENTURISTS OF ONTARIO

Agenda Item 6.1

BRIEFING NOTE

To: **COUNCIL**

From: **Dr. Glenn Pettifer, Registrar & CEO**

Date: **December 6, 2019**

Subject: **Waiving Fee Increase – By-law Article 31.05**

Background

Article 31.05 of the College By-laws states:

"31.05 Fee Increases

Each year each fee described in Schedule 7 shall be increased by the percentage increase in the Consumer Price Index for goods and services in Canada as published by Statistics Canada or any successor organization unless Council decides to waive a fee increase for that year".

This fee increase has not been applied from 2014-2019. As the increase is scheduled to occur annually, a decision regarding the fee increase for the 2020-2021 fiscal year is requested of Council.

Options

In consideration of the financial position of the College presented in the financial statements that were adopted at the September 6, 2019 meeting (included in the draft Annual Report included in the December 6, 2019 agenda), Council may elect to:

1. Waive the fee increase prescribed by By-law Article 31.05 for the 2020-2021 fiscal year
2. Implement the fee increase prescribed by By-law Article 31.05 for the 2020-2021 fiscal year.
3. Request further information before deciding.
4. Other

ANNUAL REPORT

2018-2019

COLLEGE OF DENTURISTS OF ONTARIO


GOVERNANCE
agile
professionalism
COMPETENCE
transparent
PUBLIC INTEREST
consistent
ENGAGED
accountable
PROPORTIONATE
targeted
DRAFT
ARS ET SCIENTIA
COLLEGE OF DENTURISTS OF ONTARIO

TABLE OF CONTENTS

ABOUT THE COLLEGE

As a regulatory body, the College of Denturists of Ontario (CDO) supports the public's right to safe, competent and ethical Denturism care.

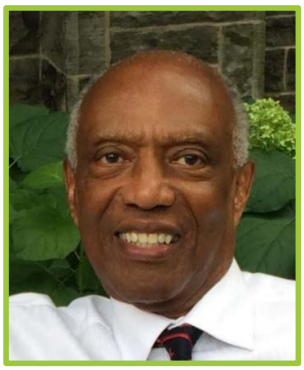
Under Ontario law, 26 health regulatory Colleges are entrusted with regulating a wide variety of health professions, all acting in the public interest.

The CDO does this by:

- Setting the requirements that must be met for an individual to practise Denturism in Ontario.
- Issuing Certificates of Registration to Denturists who meet these professional requirements. Once an individual has obtained a Certificate of Registration, they may practise Denturism.
- Establishing comprehensive Standards of Practice and policies that every Registered Denturist must follow.
- Developing and administering a Quality Assurance Program that helps Registered Denturists stay current and develop their knowledge and skills throughout their respective careers.
- Giving the public a way to raise issues and hold Registered Denturists accountable for their conduct and practice.

With the CDO's governing Council, Committees, and staff all working to serve the public interest first, the people of Ontario can have confidence in the care they receive from Registered Denturists.

MESSAGE FROM THE PRESIDENT



Dr. Ivan McFarlane

The College's mission is to regulate the profession of Denturism in the public interest.

I have the distinct honour to report that our College, led by Council, continued to work assiduously and succeeded in adhering to our mission during this past year of my presidency.

In the past, Council benefitted immensely from having sessions in governance training led by the College's Legal Counsel, and the College's Auditor. Our Legal Counsel addressed the topic 'What They Do and How They Do It' focusing on ICRC, Discipline, and the Fitness to Practice Committees.

The College Auditor provided the session on 'Financial Literacy'. These sessions, combined with College involvement and responses to shareholder consultations, informed Council and contributed immensely to its deliberations.

Based on all of this, your Council determined and approved a very important list of accomplishments which I am pleased to bring to your attention.

Here's a list of those policy accomplishments:

- Standards of Practice implemented; Conflict of Interest and Advertising (revised);
- Language Proficiency Requirements Policy amended;
- Criminal Record and Judicial Matters Check Policy amended;
- Clinical Supervision of Students, Examination Candidates, and Potential Examination Candidates Policy amended;
- Peer Assessment Eligibility and Appointment Policy amended;
- Peer Circles expanded, and
- Total funds restricted for Therapy and Counselling for victims of alleged sexual abuse increased to $160,000.00.

The list of professionals grew to an historic high – 724 – increasing access to the high standard of care Registered Denturists provide to the people of Ontario.

The College of Denturists of Ontario is well poised to face the future as Council continued to attend to the initiatives articulated in the College's Strategic Map, first adopted in 2017. Council looks forward to continually promoting a culture of transparency and regulatory excellence in all its ventures.

Forming one of the main priorities in its Strategic Plan, Council is determined to enhance communication and stakeholder engagement by ensuring both the Public and Registered Denturists alike can easily access the website, by ensuring the Public Register reflects the highest goals of transparency and by bringing the public interest and transparency lenses to Council and Committee work.

I offer a sincere measure of gratitude to our Registrar & CEO, Dr. Glenn Pettifer, whose knowledge of professional regulation and whose management capacity have moulded an effective and efficient staff.

As I leave office I take the opportunity to thank my fellow Council members, Committee members, and the profession at large for having served our mandate well.

It has been an honour and privilege to serve as President.

Dr. Ivan McFarlane

STRATEGY MAP

On June 23, 2017, Council adopted the College's Strategy Map 2017-2020. The 2017-2020 Strategy Map is the product of the Council's Strategic Planning day on December 10, 2016. This Strategy Map identifies the College's priorities and charts the course of its work over the period leading up to 2020.

In this Strategy Map, Council identified three priority areas:

Priority 1: Enhanced Communication and Stakeholder Engagement
Success in the work of the College can only occur when the College engages in effective, open communication with its stakeholders. Under this Priority, Council seeks to engage in promoting public awareness of the College's role in the safe delivery of Denturism care, modernize its member communications strategy, promote transparency of the College operations, and foster interprofessional collaboration.

Priority 2: Excellence in Governance
The profession and the College have the opportunity to engage in the governance of the profession of Denturism in a manner that reflects the commitment to excellence demonstrated by the profession. The profession is committed to this excellence and because of its relatively small size, the College can be nimble as it engages in the activities that support excellence in governance. Activities associated with this priority area will be aimed at promoting a culture of public confidence and transparency, improving Council and Committee member training, clarifying Council and Committee roles, and improvement in internal policy coordination and priority setting.

Priority 3: Enhanced Relations with Educational Institutions
The College recognizes the strong contribution by educators to the profession of Denturism. For the 2017-2020 Strategy Map, Council recognized opportunities to strengthen the relationship between the College and educational program administrators, encourage quality and consistency in academic program content, and explore the relationship between the existing Denturism competency profile and new registrant needs.

CDO STRATEGY MAP 2017–2020

MISSION

To regulate and govern the profession of Denturism in the public interest.

VISION

Leading our members to provide exemplary denturism care to Ontarians.

PROMOTING REGULATORY EXCELLENCE - ACTION PLAN FOR 2017–2020

Priority 1

Enhanced Communication and Stakeholder Engagement:

a. Promote public awareness of CDO role in safe delivery of denturism
   i. Public awareness campaign
b. Modernize member communications strategy
   i. Undertake communications needs survey
   ii. Attend Association conferences
   iii. Introduce peer circles
   iv. Enhance CDO webinars
c. Promote transparency of CDO operations
   i. Improve accessibility of website
   ii. Ensure public register reflects highest goals of transparency
   iii. Bring public interest and transparency lenses to Council and Committee work
d. Foster interprofessional collaboration
   i. Attend regular meetings of Ontario dental health regulators
   ii. Provide collaboration guidance to members through communications strategy

Priority 2

Excellence in Governance:

a. Promote culture of public interest and transparency
   i. Embed public interest in all College, Council and Committee decisions
b. Review and clarify Council and Committee roles
   i. Review through public interest & transparency lenses
   ii. Articulate Council and Committee competencies
c. Improve Council and Committee member training
   i. Leverage technology to enhance training and work of Council and Committees
   ii. Implement mentoring process for new Council members
   iii. Ensure agility of training that allows for response to changes in legislation and the broader regulatory landscape
   iv. Provide regular orientation for all Council members
d. Improve internal policy coordination and priority-setting
   i. Establish policy coordination and oversight process

Priority 3

Enhanced Relations with Educational Institutions:

a. Strengthen relationship between CDO and educational program administrators
   i. Coordinate regular meetings between CDO and Ontario educational program leadership
b. Explore whether denturism competency profile is synchronized to new registrant needs
   i. Supplement identified deficiencies through CDO continuing education/QA program requirements
c. Encourage quality and consistency in program content among educational programs
   i. Explore accreditation model options
   ii. Engage provincial counterparts in conversation exploring role of national denturism competency profile

GUIDING PRINCIPLES

Integrity, Honesty, Transparency, Accountability, Fairness, Inclusivity

COLLEGE COUNCIL

Who We Are

Officers

Dr. Ivan McFarlane, *Public Member – President & Chair*
Joey Della Marina, *Professional Member – Vice President*

Public Members

Kristine Bailey (from February 2019)
Mark Fenn (to February 2019)
Anita Kiriakou
Wangari Muriuki
Barbara Smith (to December 2018)
Hanno Weinberger

Professional Members

Jack Abergel
Abdelatif Azzouz (from June 2018)
Alexia Baker-Lanoue
Keith Collins
Robert C. Gaspar
Christopher Reis
Luc Tran (to June 2018)
Michael Vout, Jr.

What We Do

In Ontario, the self-regulation of health care professions is a partnership with the public. The operation of each regulatory college is overseen by a Council, which is like a board of directors. The Council of the College of Denturists of Ontario is made up of:

- Denturists elected by their peers (the Registrants of the College); and
- Public members appointed by the provincial government

This governing Council is chaired by the President, elected by the Council from among the public members. The Council sets out the strategic and policy direction for the College, while a staff team led by a Registrar (like a CEO) carries out the College's day-to-day work. The College has seven statutory committees that have their own regulatory responsibilities.

Council meets 3-4 times per year to discuss regulatory policy and make decisions in the public's best interest, as mandated in the *Regulated Health Professions Act, 1991 (RHPA)*.

COMMITTEE REPORTS

Statutory Committees

Executive Committee

Inquiries, Complaints and Reports Committee

Discipline Committee

Fitness to Practise Committee

Patient Relations Committee

Quality Assurance Committee – Panel A and Panel B

Registration Committee

Non-Statutory Committees

Qualifying Examination Committee

Qualifying Examination Appeals Committee

EXECUTIVE COMMITTEE

Who We Are

Chair
Dr. Ivan McFarlane, *Public Member*, *President*

Public Members
Wangari Muriuki

Professional Members
Joey Della Marina, *Vice President*
Alexia Baker-Lanoue (from June 2018)
Luc Tran (to June 2018)
Michael Vout, Jr.

What We Do

The Executive Committee facilitates the efficient and effective functioning of Council and other committees. It also makes decisions between Council meetings for matters that require immediate attention (but cannot make, amend, or revoke a regulation or by-law). The Executive Committee serves as the committee that prepares and presents suggested changes to the College By-laws to Council. The Executive Committee also functions as the Finance Committee, receiving interim financial reports and considering any financial matters that arise during the fiscal year.

Achievements

As part of its mandate, the Executive Committee provides routine, continuous oversight to the financial management of the College. The Committee considered and approved 21 Clinic Name requests. The work of the Executive Committee provides for consistent, timely College governance on matters that arise in between Council meetings.

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE

Who We Are

Chair
Barbara Smith, *Public Member*

Public Members
Kris Bailey (from March 2019)
Dr. Ivan McFarlane
Wangari Muriuki (until June 2018)

Professional Members
Alexia Baker-Lanoue
Joey Della Marina
Christopher Reis (from June 2018)
Michael Vout, Jr.

Non-Council Members of the Profession
Carrie Ballantyne (from June 2018)
Carmelo Cino
Eugene Cohen (until June 2018)
Norbert Gieger (until June 2018)
Emilio Leuzzi (from June 2018)

What We Do

When a concern about a Registered Denturist comes to the attention of the College, the Inquiries, Complaints and Reports Committee (ICRC) investigates the matter. This includes a wide range of issues related to a Registered Denturist's conduct or practice, such as:

- ignoring the basic rules of the profession;
- failing to maintain the standards of practice;
- providing inappropriate care;
- sexually abusing a patient; or
- having a physical or mental condition or disorder that interferes with the ability to practise.

Anyone can raise an issue to the College – that includes patients, their family members, Registered Denturists themselves, their colleagues or employers, and other health care professionals. By law, it is the College's duty to review all complaints about Registered Denturists who are registered to practise in

Ontario, and to give serious consideration to each matter. Members of the Inquires, Complaints and Reports Committee are trained and strive to review all complaints objectively.

Once their investigation is complete, the Inquiries, Complaints and Reports Committee has the authority to make one or more of the following decisions:

- **Take no further action.**
- **Offer guidance to the Registered Denturist in writing or in person.** This is done by the Committee when it feels that guidance will help the Registered Denturist to understand how to conduct himself or herself in the future.
- **Direct the Registered Denturist to complete education or remediation** to improve his or her practice.
- **Refer the matter** to either the Discipline Committee or to the Fitness to Practise Committee for a hearing.
- Take any other action not inconsistent with the *Regulated Health Professions Act, 1991 (RHPA)*.

Achievements

- In keeping with Priority 2 "Excellence in Governance" of the College's 2017-2020 Strategy Map which identifies a commitment to improving Council and Committee member training, in August 2018, ICRC members participated in a training and orientation session presented by Rebecca Durcan, the College's Legal Counsel. The training session included a presentation outlining the statutory framework for the ICRC focusing on ICRC process and current practices.

- The Committee met 20 times to review 53 cases (21 of them carried forward from 2017-2018). That included 40 complaints, 8 reports, and 1 incapacity inquiry. Below are the outcomes of the ICRC deliberations, based on 49 decisions. A decision on a particular matter may involve more than one outcome.

Took no further action	21
Issued reminders or advice to member	4
Required member to appear for an oral caution	6
Required member to complete a specified continuing education or remediation program (SCERP)	9
Members referred to a separate panel of the ICRC for a Health Inquiry	2
Referred to Discipline Committee	2
Undertaking	0

DISCIPLINE COMMITTEE

Who We Are

Chair
Hanno Weinberger, *Public Member*

Public Members
Kristine Bailey (from February 2019)
Mark Fenn (to February 2019)
Anita Kiriakou
Dr. Ivan McFarlane
Wangari Muriuki
Barbara Smith (to December 2018)

Professional Members
Jack Abergel
Abdelatif Azzouz (from June 2018)
Alexia Baker-Lanoue
Keith Collins
Joey Della Marina
Robert C. Gaspar
Christopher Reis
Luc Tran (until June 2018)
Michael Vout, Jr.

Non-Council Members of the Profession
Carrie Ballantyne
Noa Grad (from June 2018)
Emilio Leuzzi
Karla Mendez-Guzman (from June 2018)
Braden Neron (until June 2018)
Marija Popovic (until June 2018)
Garnett Pryce
Bruce Selinger
Robert Velensky (until June 2018)

What We Do

The Discipline Committee considers the most serious cases where a Registered Denturist may be incompetent or may have committed an act of professional misconduct.

Professional misconduct is a breach of the regulations that reflect the accepted ethical and professional standards for the profession. A Registered Denturist may be incompetent if the care provided displayed

a lack of knowledge, skill or judgment, demonstrating that either they are unfit to practise or their practice should be restricted.

Discipline of professionals is a critical aspect of maintaining the trust of the public in health profession self-regulation. The Discipline Committee holds hearings that are like court proceedings. Hearing panels include members of both the profession and the public.

If a panel of the Discipline Committee makes a finding against a Registered Denturist, it can:

- **Revoke** a Certificate of Registration;
- **Suspend** a Certificate of Registration;
- **Place terms, conditions and/or limitations** on a Certificate of Registration;
- **Require a Registered Denturist to appear** before the panel to be reprimanded; or
- **Require a Registered Denturist to pay** a fine and/or pay the College's legal, investigation and hearing costs, and other expenses.

At the end of the process, the panel issues written decision and reasons. The College publishes these on its website, and on the online listing of registrants, the Public Register. A Summary of the decision and a full-text version of the Discipline Panel's decision and reasons are available in the member's profile that can be accessed through the College's online **Public Register (www.denturists-cdo.com).**

Achievements

This year, the Discipline Committee did not hold any hearings.

FITNESS TO PRACTISE COMMITTEE

Who We Are

Chair
Michael Vout, Jr., *Professional Member*

Public Members
Kristine Bailey (from February 2019)
Mark Fenn (to February 2019)
Anita Kiriakou
Dr. Ivan McFarlane
Wangari Muriuki
Barbara Smith (to December 2018)
Hanno Weinberger

Professional Members
Jack Abergel
Abdelatif Azzouz
Alexia Baker-Lanoue
Keith Collins
Joey Della Marina
Robert C. Gaspar
Luc Tran (until June 2018)
Christopher Reis

Non-Council Members of the Profession
Carrie Ballantyne
Carmelo Cino (until June 2018)
Noa Grad (from June 2018)
Karla Mendez-Guzman (from June 2018)
Braden Neron (until June 2018)
Marija Popovic (until June 2018)
Bruce Selinger

What We Do

As with some members of the general population, sometimes a Registered Denturist might be suffering from a physical or mental condition, illness or ailment. If this renders them unable to practise safely or effectively, that's called "incapacity".

The College is mandated to address these situations in a manner that ensures that the care to the public is not compromised. These types of matters are addressed by the Fitness to Practise Committee. The Committee is responsible for holding hearings to determine incapacity. In these matters the burden of proof rests with the College.

If a Registered Denturist is found to be incapacitated, the Fitness to Practise panel may:

- **revoke** the Certificate of Registration;
- **suspend** the Certificate of Registration (generally until the Registered Denturist has demonstrated to the College that he or she has recovered); or
- **impose terms, conditions or limitations** on the Certificate of Registration for a set or indefinite period.

The panel may also specify criteria that must be satisfied before lifting a suspension, or removing terms, conditions or limitations. The public is entitled to know the results of all proceedings when a Registered Denturist is found to be incapacitated. This information is available on the College's online **Public Register (www.denturists-cdo.com).**

Achievements

There were no Fitness to Practise hearings this fiscal year.

PATIENT RELATIONS COMMITTEE

Who We Are

Chair
Alexia Baker-Lanoue, *Professional Member*

Public Members
Mark Fenn (to February 2019)
Anita Kiriakou (from February 2019)
Dr. Ivan McFarlane (to June 2018)
Hanno Weinberger (from June 2018)

Professional Members
Jack Abergel (to June 2018)
Keith Collins
Robert C. Gaspar
Christopher Reis

Non-Council Members of the Profession
Abdelatif Azzouz (to June 2018)
Carrie Ballantyne (to June 2018)
Norbert Gieger (from June 2018)
Elizabeth Gorham-Matthews

What We Do

The Committee oversees the patient relations program, including implementing measures for preventing or dealing with sexual abuse of patients. It administers the funding program for therapy and counselling for patients who have been sexually abused. The Patient Relations Committee also advises the Council on a program to enhance relations between Registered Denturists and their patients. The program includes education of the profession, Council and staff and the provision of information to the public.

Achievements

- Met 3 times during the year to consider the legislative framework surrounding the Patient Relations Committee and its mandated responsibilities related to program items, including funding for support for therapy and counselling for victims of sexual abuse by members of the College.

- Developed Terms of Reference which were approved by Council on December 14, 2018.
- Considered elements of a sexual abuse prevention plan including education for members, education for students, guidelines for the conduct of members, training for College staff, provision of information to the public, funding for therapy and counselling, and a process for the evaluation of the program's effectiveness.
- Directed staff to review and update information sheets and application forms which were made available for members of the public to apply for funding for therapy.
- Will continue to have an oversight role of applications for funding to ensure that patients are being served and the College is being responsive.

QUALITY ASSURANCE COMMITTEE

What We Do

As part of belonging to a College, Registered Denturists must maintain and enhance their knowledge, skill and judgment – all to keep providing appropriate high-quality care that the public expects. The Quality Assurance (QA) program is one way that the College gives Registered Denturists the tools and feedback to continually improve their competence. That adds to public protection.

Through the Quality Assurance Committee, the College promotes continuing competence among registrants. The robust QA program requires:

- All Registered Denturists to complete a self-assessment once each CPD cycle – this is a tool that assists practitioners in identifying areas in their practice that may require improvement; identifying specific learning needs; and developing a document that records those needs in a learning plan (goals and timelines);

- All Registered Denturists to pursue continuing professional development (at least 10 credits annually) and maintain a professional portfolio (an organizational tool that contains all information related to participation in QA); and

- Randomly-selected Registered Denturists to participate in a Peer & Practice Assessment, to ensure that the treatment environment demonstrates, ethically and physically, the highest regard for the patient's well-being.

PANEL A

Who We Are

Chair
Keith Collins, *Professional Member*

Public Members
Anita Kiriakou
Hanno Weinberger

Professional Members
Jack Abergel (until June 2018)
Abdelatif Azzouz

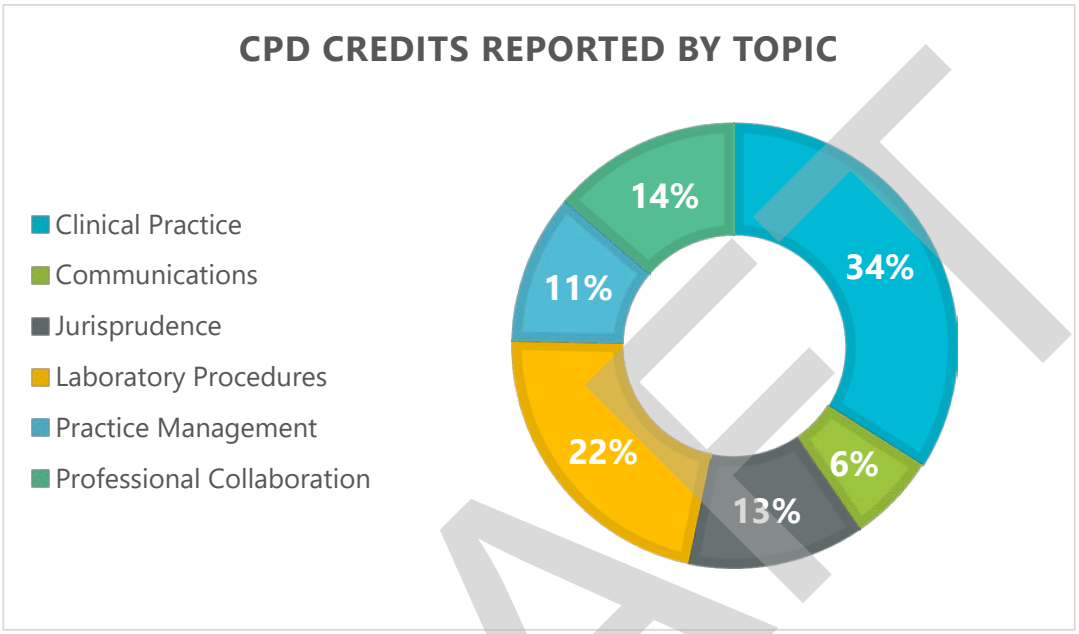
Non-Council Members of the Profession
Karla Mendez-Guzman (from June 2018)
Marija Popovic
Robert Velensky (until June 2018)

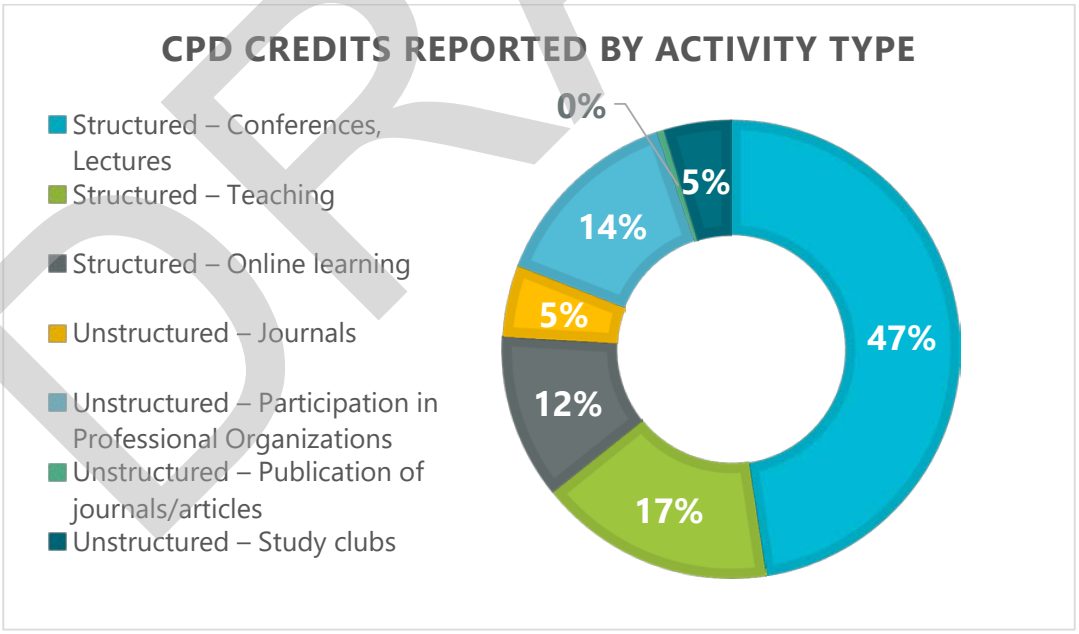
Achievements

- Met 5 times during the year to develop Quality Assurance Program components, monitor compliance with the Continuing Professional Development requirements, and review Peer & Practice Assessment reports. Of the 36 assessments, 17 were satisfactory, 11 required some remedial action and 3 participated in modified non-clinical assessments.
- Continued development of the new Self-Assessment Tool by completing the content and working with a third-party vendor to develop the online application.
- Launched the Peer Circles project, which included attending the 2018 Perfecting Your Practice conference hosted by the Denturist Association of Ontario.
- Implemented revisions to the Peer Assessor Eligibility and Appointments Policy.

30.3 hours The **average number of CPD hours** reported by Registered Denturists in 2018-2019

The **total number of CPD hours** reported by all Registered Denturists in 2018-2019 **20,891 hours**


CPD CREDITS REPORTED BY TOPIC
Clinical Practice
Communications
Jurisprudence
Laboratory Procedures
Practice Management
Professional Collaboration
34%
6%
13%
22%
11%
14%


CPD CREDITS REPORTED BY ACTIVITY TYPE
Structured – Conferences, Lectures
Structured – Teaching
Structured – Online learning
Unstructured – Journals
Unstructured – Participation in Professional Organizations
Unstructured – Publication of journals/articles
Unstructured – Study clubs
47%
17%
12%
5%
14%
0%
5%

PANEL B

Who We Are

Chair
Hanno Weinberger, *Public Member*

Public Members
Barbara Smith (until June 2018)

Professional Members
Robert C. Gaspar
Christopher Reis

Non-Council Members of the Profession
Carrie Ballantyne
Tom Bardgett (until June 2018)
Theodore Dalios (until June 2018)
Noa Grad (from June 2018)
Damien Hiorth (until June 2018)
Patrick McCabe (until June 2018)
Braden Neron

Achievements

- Met twice, with a mandate to recommend to Council new or revised Standards of Practice and guidelines associated with providing patient care. Standards describe the College's expectations for professional practice.

- The following Standards of Practice and Guides were developed:
    - Guide: Post-Insertion Patient Education and Continuity of Care
    - Standard of Practice: Professional Collaboration
    - Standard of Practice: Professional Boundaries, and
    - Code of Ethics.

- The following Standards of Practice were implemented:
    - Conflict of Interest, and
    - Advertising (Revised).

- The College offers webinars related to Standards of Practice. These webinars assist members of the profession with understanding the expectations articulated in the Standards. Webinars are available as live presentations or on-demand recorded presentations that Registered Denturists can access at their convenience. The following table summarizes the number of sessions, attendees and on-demand views of the webinars:

Standard	# of Sessions	# of Attendees	On Demand Views
Record Keeping	5	88	53
Informed Consent	6	66	49
Confidentiality & Privacy	8	100	94
Advertising	8	135	79
Conflict of Interest	8	148	55

PEER CIRCLES WORKING GROUP

The Peer Circle, an innovative continuing professional development tool, was developed in collaboration between the College of Denturists of Ontario and several members of the profession. Peer Circles was launched in November 2018 and has received widespread support and positive feedback from all participants.

As part of the development, members of the profession volunteered to either draft cases that were used in the Peer Circle discussions or act as facilitators of these discussions. The College acknowledges the hard work and dedication from the following members:

Facilitators

Carrie Ballantyne
Sanjiv Biala
Xin (Cindy) Chen
Paul Conrad
Naresh Garg
Adam Lima
David Mulzac
Braden Neron
Christine Reekie
Tessa Tsang
Robert Velensky

Consultant

Dr. Anthony Marini, Martek Assessments

REGISTRATION COMMITTEE

Who We Are

Chair
Elizabeth Gorham-Matthews, *Non-Council Member*

Public Members
Mark Fenn (until February 2019)
Anita Kiriakou
Wangari Muriuki

Professional Members
Jack Abergel (from June 2018)
Robert C. Gaspar
Luc Tran (until June 2018)

Non-Council Members of the Profession
Damien Hiorth (until June 2018)
Karla Mendez-Guzman (from June 2018)

What We Do

The College ensures that people using or applying to use the title of Denturist in Ontario are qualified. A big part of that is the registration process.

To be registered for the first time, applicants must demonstrate that they have met the strict criteria that are required to practise safely and competently. To continue to practise, all Registered Denturists must renew their registration annually.

The Registrar reviews all initial registration applications. If an applicant does not meet one or more of the registration requirements, or if the Registrar proposes to refuse the application, the matter is referred to the Registration Committee for consideration. Decisions of the Registration Committee can be appealed through the Health Professions Appeal and Review Board (HPARB).

To ensure that only academically qualified individuals attempt the Qualifying Examination, the Committee conducts academic assessments for out-of-province and internationally educated candidates to determine if their education is equivalent to a Diploma in Denturism from George Brown College in Ontario.

The Committee also monitors the number of practice hours a Registered Denturist completes, ensuring that the number of hours required to maintain competence are obtained.

During 2018-2019, the College had 48 new registrants, 20 members resigned their Certificate of Registration and 13 members were suspended for non-payment of registration fees. As of March 31, 2019, the College had 724 registrants.

The public can be confident that everyone registered to practise Denturism in Ontario is responsible for meeting the strict entry-to-practice requirements, Standards of Practice, quality assurance requirements and other criteria of the College.

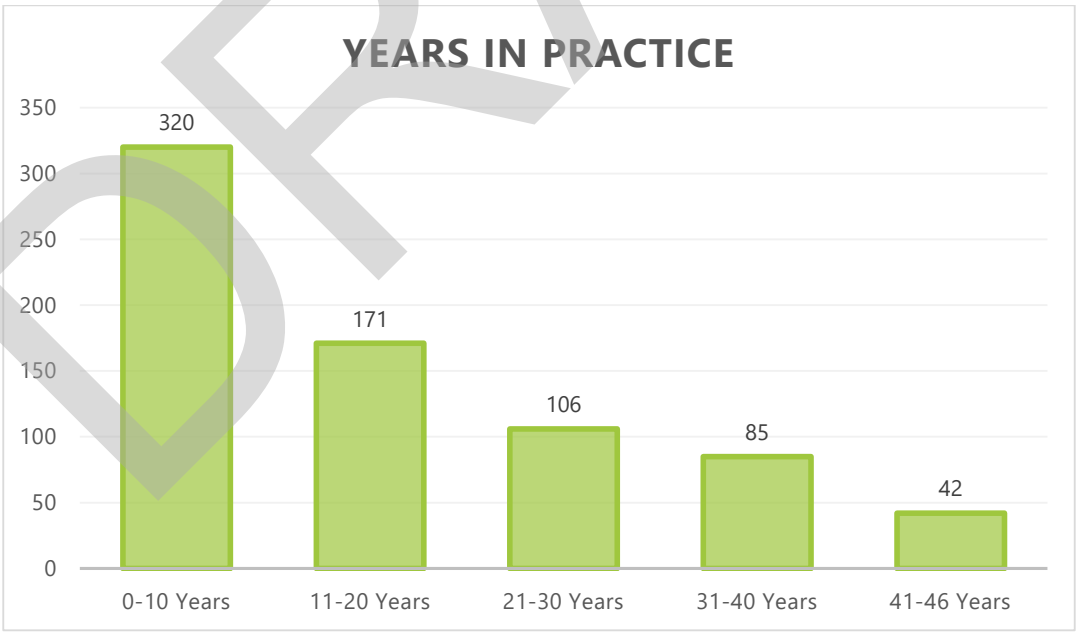
Achievements

- Met 8 times
- Conducted 8 academic assessments.
- Considered 3 applications for registration.
- Considered 2 practice hours matters.
- Considered 1 approval of terms, conditions and limitations for registration.
- Continued to work collaboratively with the Ministry of Health and Long-Term Care on revising the College's Registration Regulation.
- Participated in ongoing training and development regarding the application of fair access law and registration practices recommended by the Ontario Fairness Commissioner.
- Participated in the Ontario Fairness Commissioner's registration practices assessment.
- Piloted the College's newly developed Jurisprudence program. The purpose of this program is to give Registered Denturists a deeper understanding of the regulatory framework in which they practise.
- Launched the Jurisprudence program that consists of a manual and an accompanying online examination module.
- Implemented revisions to the following Registration policies:
    - Criminal Record and Judicial Matters Check Policy
    - Language Proficiency Requirements Policy, and
    - Clinical Supervision of Students, Examination Candidates, and Potential Examination Candidates Policy

48.3% The percentage of Registered Denturists who are **practice owners**

The percentage of Registered Denturists who practice in a **solo practice setting** **40.6%**


CDO MEMBERSHIP
740
720
700
680
660
640
620
600
580
560
624
660
673
678
698
724
2013-14
2014-15
2015-16
2016-17
2017-18
2018-19


YEARS IN PRACTICE
350
300
250
200
150
100
50
0
320
171
106
85
42
0-10 Years
11-20 Years
21-30 Years
31-40 Years
41-46 Years

QUALIFYING EXAMINATION COMMITTEE

Who We Are

Chair
Christine Reekie, *Non-Council Member*

Public Members
Mark Fenn (until June 2018)
Anita Kiriakou (from June 2018)

Professional Members
Joey Della Marina
Robert C. Gaspar (until June 2018)

Non-Council Members of the Profession
Abdelatif Azzouz
Karla Mendez-Guzman (from June 2018)

What We Do

The Qualifying Examination Committee (QEC) is responsible for making recommendations regarding the content and administration process of the Qualifying Examination.

The Qualifying Examination is grounded in the examination of professional judgment and provides for a comprehensive assessment of entry to practice skills.

Achievements

- The Committee met on several occasions and completed the item selection process ensuring that examination content is fair and relevant to the day to day practice of denturism. Following each administration of the Qualifying Examination, the Committee met to review the item analysis for each component.

- The QE working groups consisting of several practicing denturists continue to develop and refine examination materials and content for both the Multiple-Choice Question (MCQ) & Objective Structured Clinic Examination (OSCE) examinations. MCQ item writing workshops were held to write new questions for various competency areas identified in the examination blueprint. An OSCE working group met and developed several new interactive stations that will

be incorporated into the OSCE item bank.

- The Committee approved a policy revision schedule outlining the current QE policies with a recommended order of review based on their approval and revision dates. This is in line with the Council's Strategic Plan for 2017-2020, Priority 2 "Excellence in Governance" which includes improving internal policy coordination and priority-setting through establishing an oversight process.

QUALIFYING EXAMINATION APPEALS COMMITTEE

Who We Are

Chair
Michael Vout, Jr., *Professional Member* (from June 2018)

Public Members
Dr. Ivan McFarlane (to June 2018)
Hanno Weinberger (from June 2018)

Professional Members
Alexia Baker-Lanoue

Non-Council Members of the Profession
Carmelo Cino (to June 2018)
Noa Grad (from June 2018)
Emilio Leuzzi (to June 2018)

What We Do

The Committee is responsible for reviewing appeals of the results of the Qualifying Examination.

Achievements

- Received and adjudicated 2 appeals from the Summer 2018 administration of the Qualifying Examination.
- Received and adjudicated 1 appeal from the Winter 2019 administration of the Qualifying Examination.

QUALIFYING EXAMINATION WORKING GROUP AND OSCE ASSESSORS

The development and successful administration of the Qualifying Examination requires the commitment and expertise of many professional members. Their dedication to the continuous improvement of the Qualifying Examination reflects a strong sense of professionalism and responsibility to the process of professional self-regulation.

Working Groups continue to meet on a regular basis to develop and refine examination materials and content for both the Multiple-Choice Question (MCQ) and Objective Structured Clinic Examination (OSCE) components of the Qualifying Examination.

Professional Members

Sean Akkawi
Matthew Barclay-Culp
Douglas Beswick
Jeffrey Choi
Paul Conrad
James Durston
Marianne Dyczka
Annie Gallipoli
Julian Garber
Naresh Garg
Akram Ghassemiyan
Norbert Gieger
Sultana Hashimi
Esther Kang
Eric Kim
Ricardo Laboni
Brandon Lilliman
Adam Lima
Tudor Markovski
Anette McTaggart
Dean McTaggart
David Mulzac
Braden Neron
John Rafailov
Adita Shirzad
Chi-Sam Tran
Luc Tran
Sam Tran
Ben Vorano
Carlo Zanon

Chief Examiner

Robert Velensky (Summer 2018, Winter 2019)

Consultant

Dr. Anthony Marini, Martek Assessment

COLLEGE OF DENTURISTS OF ONTARIO

SUMMARY FINANCIAL STATEMENTS

MARCH 31, 2019

HILBORN LLP

HILBORN LLP

Report of the Independent Auditor on the Summary Financial Statements

To the Council of the College of Denturists of Ontario

Opinion

The summary financial statements, which comprise the summary statement of financial position as at March 31, 2019, and the summary statement of operations for the year then ended, and related note, are derived from the audited financial statements of the College of Denturists of Ontario (the "College") for the year ended March 31, 2019.

In our opinion, the accompanying summary financial statements are a fair summary of the audited financial statements, on the basis described in the note to the summary financial statements.

Summary Financial Statements

The summary financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations. Reading the summary financial statements and the auditor's report thereon, therefore, is not a substitute for reading the audited financial statements of the College and the auditor's report thereon.

The Audited Financial Statements and Our Report Thereon

We expressed an unmodified audit opinion on the audited financial statements in our report dated September 6, 2019.

Management's Responsibility for the Summary Financial Statements

Management is responsible for the preparation of the summary financial statements on the basis described in the note to the summary financial statements.

Auditor's Responsibility

Our responsibility is to express an opinion on whether the summary financial statements are a fair summary of the audited financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standard (CAS) 810, *Engagements to Report on Summary Financial Statements*.

Hilborn LLP

Toronto, Ontario
September 6, 2019

Chartered Professional Accountants
Licensed Public Accountants

401 Bay Street · Suite 3100 · P.O. Box 49 · Toronto · ON · CA · M5H 2Y4 · P416-364-1359 · F416-364-9503 · hilbornca.com

COLLEGE OF DENTURISTS OF ONTARIO

Summary Statement of Financial Position

March 31	2019 $	2018 $
ASSETS		
Current assets		
Cash	**2,487,731**	2,271,148
Prepaid expenses	**28,204**	17,788
	2,515,935	2,288,936
Capital assets	**76,621**	86,513
Intangible assets	**9,288**	1,829
	85,909	88,342
	2,601,844	2,377,278
LIABILITIES		
Current liabilities		
Accounts payable and accrued liabilities	**146,256**	175,176
Deferred registration fees	**319,847**	331,851
	466,103	507,027
Deferred lease incentives	**50,392**	58,791
	516,495	565,818
NET ASSETS		
Invested in capital and intangible assets	**54,229**	51,382
Internally restricted for therapy and counselling	**160,000**	160,000
Internally restricted for complaints and discipline	**360,000**	360,000
Unrestricted	**1,511,120**	1,240,078
	2,085,349	1,811,460
	2,601,844	2,377,278

COLLEGE OF DENTURISTS OF ONTARIO

Summary Statement of Operations

Year ended March 31	2019 $	2018 $
Revenues		
Registration fees	**1,412,010**	1,381,076
Examination fees	**253,600**	230,675
Administration fees	**18,708**	14,183
Investment income	**19,145**	15,430
	1,703,463	1,641,364
Expenses		
Salaries and benefits	**474,407**	481,328
Examinations	**315,362**	314,991
Council and committees	**17,466**	19,246
Professional fees	**150,462**	123,868
Quality assurance	**45,003**	55,137
Rent	**100,719**	101,687
Complaints and discipline	**134,869**	45,563
Office and general	**166,793**	154,885
Amortization of capital assets	**22,531**	22,831
Amortization of intangible assets	**1,962**	544
	1,429,574	1,320,080
Excess of revenues over expenses for year	**273,889**	321,284

COLLEGE OF DENTURISTS OF ONTARIO

Note to Summary Financial Statements

March 31, 2019

1. **Basis of presentation**

These summary financial statements have been prepared from the audited financial statements of the College of Denturists of Ontario (the "College") for the year ended March 31, 2019, on a basis that is consistent, in all material respects, with the audited financial statements of the College except that the statements of changes in net assets and cash flows and the information disclosed in the notes to the audited financial statements have not been presented.

Complete audited financial statements are available to members upon request from the College.

401 Bay Street · Suite 3100 · P.O. Box 49 · Toronto · ON · CA · M5H 2Y4 · P416-364-1359 · F416-364-9503 · hilbornca.com

BRIEFING NOTE

To: **Council**

From: **Dr. Glenn Pettifer, Registrar and CEO**

Date: **December 6, 2019**

Subject: **Infection Prevention and Control (IPAC) Guidelines**

Infection Prevention and Control (IPAC) requires the attention and participation of all oral health care workers involved in the delivery of denturism care and service. This commitment by Registered Denturists and all individuals working in the practice environment will help prevent the spread of infectious microorganisms among and between patients and care providers.

This document aims to consolidate recommendations for IPAC best practices and procedures published by the Government of Ontario, Public Health Ontario, the Provincial Infectious Disease Advisory Committee, the Canadian Standards Association, and the College of Dental Hygienists of Ontario. The draft guidelines will provide Registered Denturists with valuable resource tailored to denturism practice as they implement these IPAC best practices.

The draft guidelines have been reviewed by Program IPAC Specialists from Public Health Ontario, and incorporates comments from the profession, and the Quality Assurance Committee -Panel B.

At its November 1, 2019 meeting, the Quality Assurance Committee -Panel B adopted a motion to recommend the attached draft IPAC Guidelines to Council consideration.

College Staff continue to work on drafting two accompanying IPAC checklists that will summarize best practices and equipment/instrument reprocessing. The aim for the checklists is to provide Registered Denturists with a self-assessment tool to review their own practices as they pertain to IPAC.

COLLEGE OF
DENTURISTS
OF ONTARIO

DRAFT Guidelines: Infection Prevention and Control

Table of Contents

1. Introduction

The College of Denturists of Ontario is pleased to provide Registered Denturists with this guiding document that outlines best practices in the implementation of infection prevention and control (IPAC), it will serve as a basis for IPAC best practices, standards, and professional responsibilities within the context of the practice of Denturism.

These guidelines consolidate recommendations for IPAC published by Public Health Ontario (PHO), the Public Health Agency of Canada, the Provincial Infectious Disease Advisory Committee, the Canadian Standards Association, other health professions, regulatory bodies and associations.

The College of Denturists of Ontario recognizes that practice standards for infection prevention and control are continually evolving. This document presents the best practice at the time of publication and will be amended as new information becomes available.

1.1 Duty of Care

IPAC requires the attention and participation of all oral health care workers involved in the delivery of denturism care and service. This commitment by Registered Denturists and all individuals working in the practice environment will assist in the prevention of infection transmission among and between patients and care providers.

This duty of care can be met by:

- Ensuring that all legislative requirements are met
- Ensuring written policies and protocols related to infection prevention and control, workplace health and safety, hazardous waste management, and human rights obligations for the practice facility are in place
- Ensuring that equipment, supplies and technology that support best practices in infection prevention and control are available, fully operational, up-to-date and routinely monitored for efficacy.
- Establishing and maintaining preventative maintenance schedules and recordkeeping
- Ensuring that staff are adequately trained in infection prevention and control practices
- Ensuring that current scientifically accepted infection prevention and control practices are in place.

1.2 Duty of Compliance

Registered Denturists must always serve in the public interest. They have a legal responsibility to adhere to the requirements of current legislation and to use the information contained in this guideline and other information provided by Public Health Ontario to ensure that their own clinic IPAC practices or those IPAC practices in any clinic in which they work, meet the expectations and best practices described in these sources.

1.3 Role of Public Health Units (PHU)

In accordance with the *Infection Prevention and Control Practices Complaints Protocol, 2018*, Public Health Units (PHUs) are required to investigate complaints, referrals, or reportable diseases. This applies to all health care settings.

PHUs may investigate complaints at facilities during announced or unannounced inspections. Following an inspection, facilities are provided with recommendations or required remediations that are based on best practices and current legislation.

If an IPAC lapse is identified, a PHU may issue an order that could include closure of the facility or partial restrictions on specific services that a facility can provide. The PHU may also post the IPAC lapse in accordance with the public disclosure requirements of the Ontario Ministry of Health. When a complaint is received, the investigating PHU will work jointly with the CDO during the investigation.

1.4 Transmission of Microorganisms & Chain of Transmission

There are six components in the Chain of Transmission. Each of these six components need to be present for an infectious agent to spread and cause an infection. Knowledge of the components of this chain of transmission is essential in understanding the approaches to infection prevention and control.

Generally, in oral healthcare, there are three main modes of transmission of disease-causing microorganisms:

- Direct transmission (e.g., from hands contaminated by touching a contaminated surface, object or body part such as mouth, nose)
- Indirect transmission (e.g., from a contaminated object such as an improperly sterilized impression tray)
- Droplet transmission (e.g., from coughing or sneezing)

Elimination of any one of the six links through IPAC measures will break the chain, preventing transmission from occurring. This is an important piece of information that can be used when a Registered Denturist is faced with questions about novel infection prevention and control situations.

There are six components in the Chain of Transmission:

- **Infectious Agent** – the pathogen or germ that causes the disease

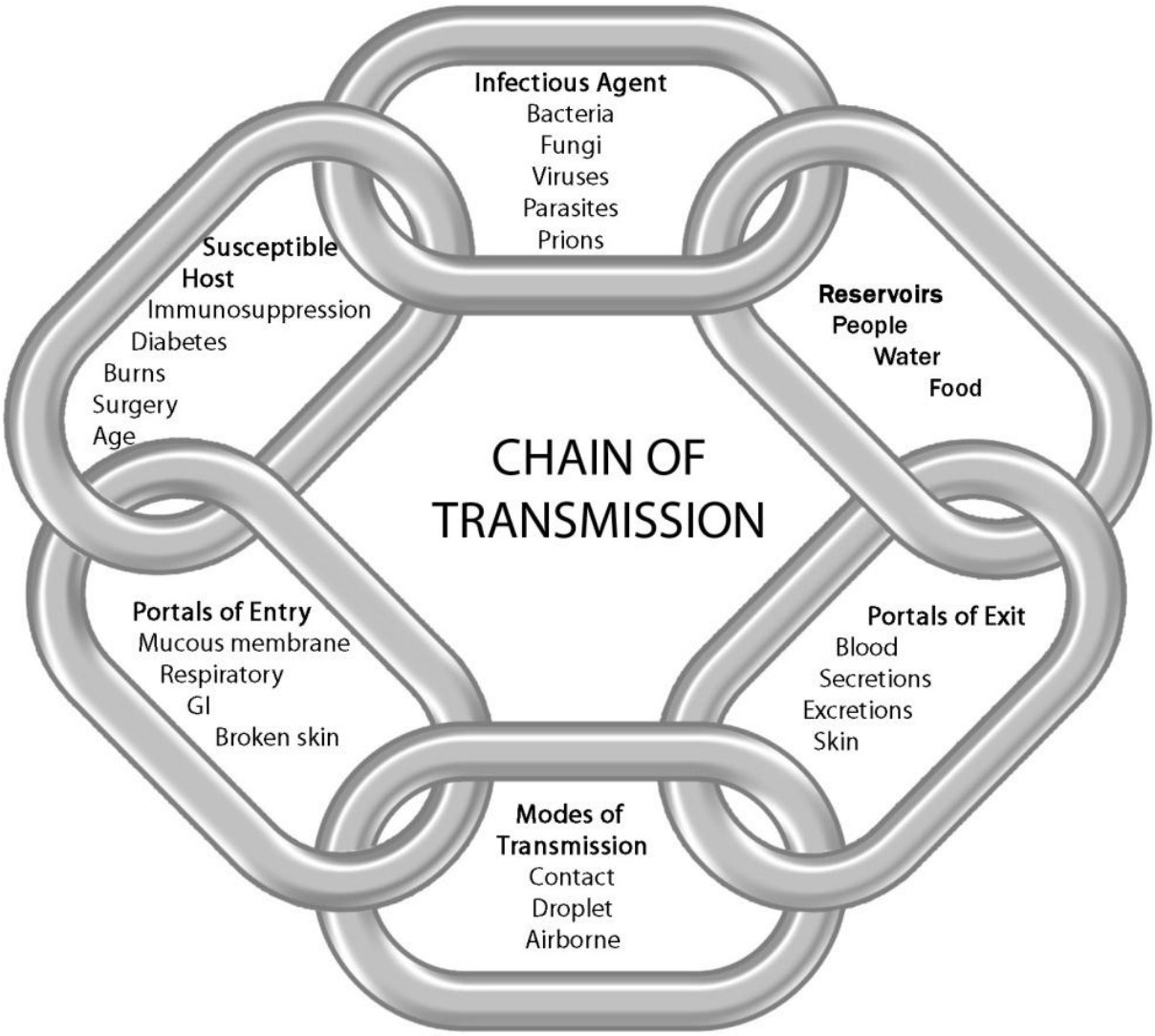
- **Reservoir** – places in the environment where the pathogen lives (people, animals, insects, medical/dental equipment, soil and water)

- **Portal of Exit** – the way the infectious agent leaves the reservoir (blood, secretions, excretions, skin)

- **Mode of Transmission** – the way the infectious agents are transferred (direct or indirect contact, droplet, airborne)

- **Portal of Entry** – the way an infectious agent can enter a new host (through broken skin, respiratory, mucous membranes, gastrointestinal tract)

- **Susceptible Host** – can be any individual at risk. Some individuals are more vulnerable to infection that others (individuals who are immunocompromised)



Source: The Chain of Transmission, Routine Practices and Additional Precautions In All Health Care Settings, 3rd Edition, November 2012, Public Health Ontario, PIDAC

2. Routine Practices & Additional Precautions

Routine Practices

The Public Health Agency of Canada uses the term "Routine Practices" to describe basic standards of IPAC that are required for all safe patient care. Routine Practices encompass the most important measures that all Registered Denturists should be familiar with, understand, and follow in their practices.

Routine Practices are based on the premise that all patients are potentially infectious, even when symptoms are not clinically evident. The same IPAC practices must be routinely applied by all Registered Denturists or their staff when in contact with blood, body fluids, secretions, mucous membranes and non-intact skin.

Most exposures to blood, body fluids, secretions, mucous membranes and non-intact skin can be avoided with the proper use of Personal Protective Equipment (PPE) such as gloves, eyewear, masks and outer protective clothing. Safe handling and disposal of sharps will help to prevent injuries related to the use and transport of sharp instruments.

The five principles in IPAC Routine Practices for Registered Denturists are:

- Personal Risk Assessment
- Hand Hygiene
- Personal Protective Equipment
- Environmental Controls
- Administrative Controls

Additional Precautions

Additional Precautions are used to describe measures or interventions (e.g. PPE, barrier equipment, accommodation, additional environmental controls) that are used in addition to Routine Practices to protect staff and patient and interrupt transmission of certain infectious agents.

Additional Precautions are implemented after a personal risk assessment is conducted based on the mode of transmission of the infection e.g. direct or indirect contact, airborne or droplet. Additional Precautions shall not be used to discriminate against patients based on the Human Rights Code.

Additional Precautions may include the following measures:

- Physical separation of the infected patient from others (e.g., a separate waiting area or room)
- Use of PPE (e.g., gowns, gloves, masks) based on the mode of transmission of the organism
- Patients are offered masks and alcohol-based hand rub (hand sanitizer) upon arrival

For examples of Additional Precautions to be used based on the mode of transmission of some infectious diseases, see **Appendix 2**.

It is up to the professional judgement of the Registered Denturist to determine if Additional Precautions are required, noting that they can always reschedule an appointment, even if during the visit it is determined that the patient is infectious.

2.1 Personal Risk Assessment

The first step in the effective use of Routine Practices is to perform a personal assessment of the risk of transmission. This should be done before each interaction with the patient in order to determine the interventions that are required to prevent the transmission of infection.

A Registered Denturist and/or their staff should conduct a personal risk assessment before or at every interaction with the patient, including:

- When booking and/or confirming appointments, a Denturist or their staff can confirm with the patient in advance for illnesses (e.g., cough, fever, vomiting, diarrhea) when they are booking or confirming appointments

- When the patient arrives for their appointment, the Denturist or their staff can pre-screen for any symptoms of communicable diseases or acute respiratory infections such as influenza, fever, cough, vomiting, diarrhea, or colds. Appointments must be rescheduled to prevent the spread of microorganisms

- If their dental condition is of an urgent nature, every effort must be made to separate the ill patient from others by seating them in a secluded space as soon as possible. In this way, the spread of microorganisms by contact or droplet transmission can be minimized. PPE must be selected and worn based on personal risk assessment

2.2 Hand Hygiene

Hand hygiene reduces potential pathogens on the hand and is considered **the single most critical measure for reducing the risk of transmitting organisms to patients and health care workers.** The term hand hygiene includes both handwashing with liquid soap and water, and hand rubbing with an alcohol-based hand rub.

Alcohol-Based Hand Rub (ABHR), is the preferred method for cleaning hands when hands are not visibly soiled. It has been shown to be more effective than washing hands with soap (even with antimicrobial soap). ABHR should contain between 70 – 90% alcohol. A minimum of 70% should be chosen.

Hand washing with soap and water must be performed when hands are visibly soiled with dirt, blood, and bodily fluids. ABHR should not be used immediately after hand washing.

Hand Hygiene must be performed:

Before:

- Initial contact with a patient or items in their environment, this should be done on entry into the clinical room
- Performing an aseptic procedure
- Putting on personal protective equipment
- Preparing or handling patient care items
- Eating or drinking

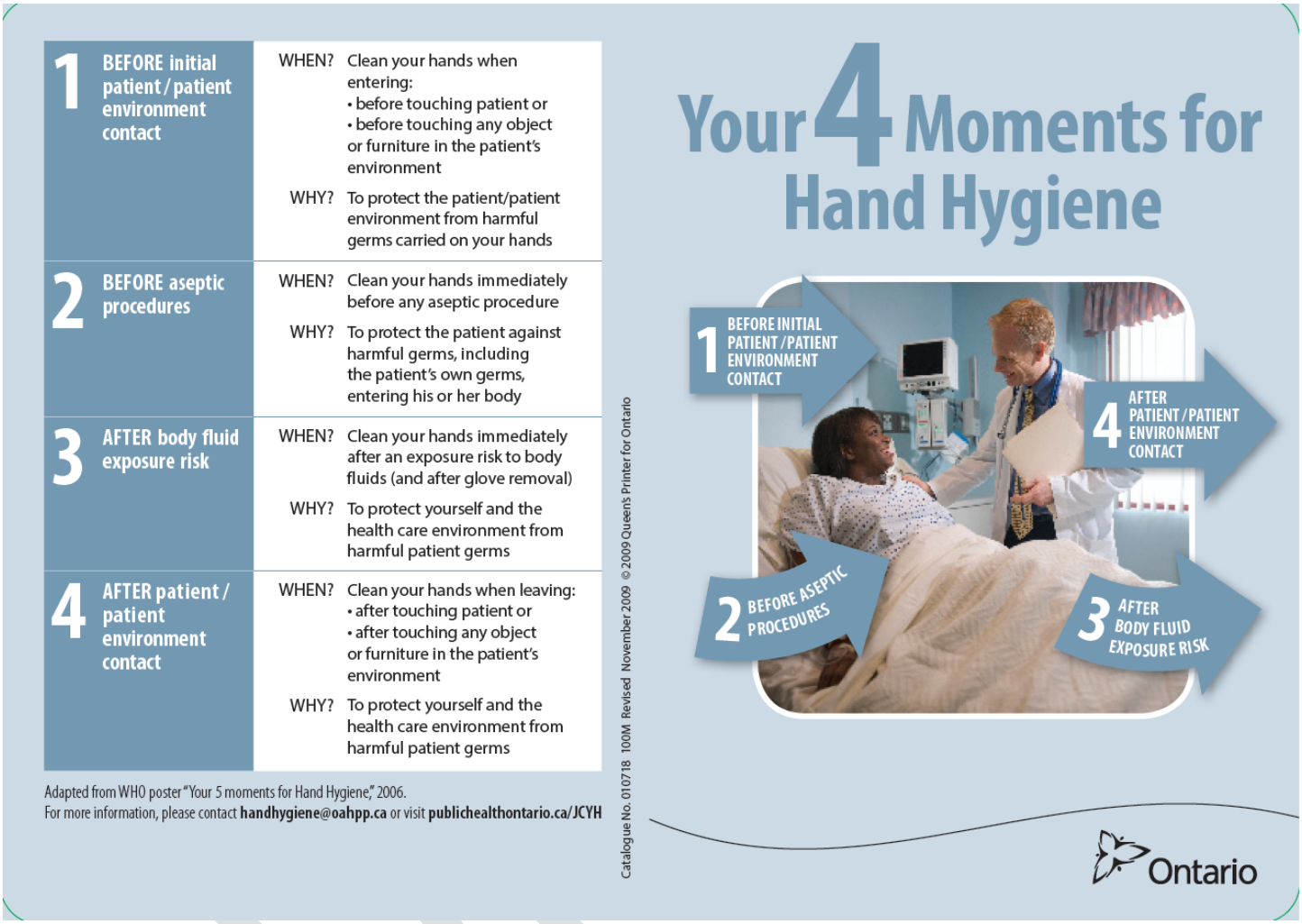
After:

- Contact with blood, body fluids, and secretions of a patient, even if gloves are worn
- Removing PPE such as gloves
- Moving between extra oral and intra oral procedures
- Contact with a patient or items in their immediate surroundings, even if patient has not been touched
- Hands are visibly soiled
- Handling waste
- Cleaning contaminated and visibly soiled equipment (e.g. dental instruments and/or environmental surfaces)
- Personal bodily functions
- Whenever in doubt

Public Health Ontario has simplified the essential indications for hand hygiene into four moments. The four moments makes it easier to understand the moments where the risk of transmission of microorganisms via the hands is highest.

2.2.1 Your Four Moments for Hand Hygiene

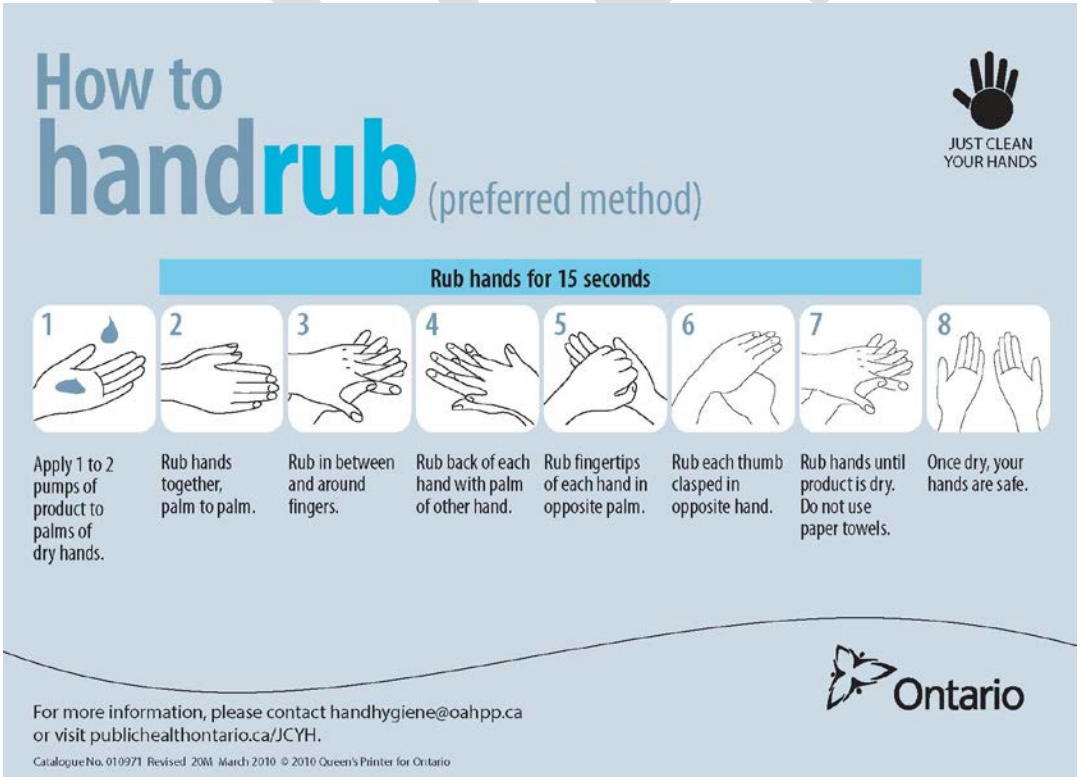
The following figure depicts the points in an activity at which hand hygiene is performed. There may be several hand hygiene moments in a single care sequence or activity.



Source: Just Clean your Hands Program - Your 4 Moments Pocket Card, Public Health Ontario, November 2009

2.2.2 Effective Hand Hygiene Techniques

The following two figures illustrate how to perform hand hygiene using soap and water, and hand rubbing using an alcohol-based hand rub.



Source: Just Clean your Hands Program, Public Health Ontario, March 2010

2.3 Personal Protective Equipment

Personal Protective Equipment (PPE) refers to equipment that is designed to protect the wearer from exposure to potentially infectious agents. It serves as a barrier from splashing, spraying or splatter of saliva, blood, or other body fluids. PPE for a Registered Denturist may include gloves, masks, protective eyewear, and outer protective clothing (e.g., gowns, lab coats, scrubs) and is selected based on personal risk assessment.

Gloves

- Perform hand hygiene before putting on gloves and immediately after removing gloves. Wearing gloves does not replace the need for hand hygiene. Use new properly fitting single-use gloves for each patient
- Wear new single-use protective gloves whenever the hands might be contaminated with blood, saliva or other bodily fluid, or will be in contact with contaminated instruments, devices or surfaces
- Do not wash single-use gloves as this may damage glove integrity
- Replace gloves as soon as possible if they become soiled or damaged
- Wear puncture-resistant, heavy-duty utility gloves when handling or manually cleaning contaminated sharp instruments
- Wear appropriate gloves when handling heated objects

Masks

- Wear a surgical mask that covers both your nose and mouth during patient-care activities and/or during all procedures likely to generate splashes or sprays of blood or contaminated fluids
- Avoid touching the front of the mask
- Do not hang around neck or chin, fold or store in pockets
- Masks lost efficiency over time and must be changed when they become contaminated
- Change your mask with each patient or when they become wet or visibly contaminated
- Remove gloves, masks and protective eyewear and perform hand hygiene before moving from a contaminated zone to a clean zone in your practice setting
- Follow the manufacturer's instructions to ensure the most appropriate fit and optimum protection

Protective Eyewear

- Use the protective eyewear that is fit for purpose and with complete coverage over and around the eyes, including solid (not vented) side shields. Protective eyewear should be comfortable and not interfere with your vision
- Wear protective eyewear when exposure to blood or other potentially infectious material is possible and during fabrication process when eye injury is possible
- A face shield is recommended if side shields are not used
- Protective eyewear may be disposable or reusable
- Clean and disinfect reusable protective eyewear after each use

Outer Protective Clothing

- Use of outer protective clothing such as gowns, laboratory coats, or scrubs are based on a personal risk assessment

- Care taken to use different outer protective clothing for patient-care activities versus for fabrication processes
- Outer protective clothing is worn for procedures (e.g., instrument cleaning) that are likely to result in splashes or sprays of blood or other body fluids
- All outer protective clothing should be made of synthetic material so that contaminants are not easily absorbed into the material
- Change outer protective clothing as soon as possible when visibly soiled or wet, or when exposed to contaminated aerosols for prolonged periods of time
- Footwear worn in the patient treatment areas and reprocessing areas needs to have enclosed toes and heels
- Outer protective clothing should not be worn outside of the clinic office or worn at home
- Place disposable outer protective clothing in the general laboratory waste after use
- Staff shall not share PPE

2.4 Environmental Controls

2.4.1 Sharps – Handling and Avoiding Injury

Sharps are devices capable of causing a cut or puncture wound, they may include disposable blades, burs, needles, laboratory utility knives, syringes with needles, scalpel blades, scalers, and other sharp instruments. They should be kept out of the reach of patients and should always be safely stored and disposed of.

Some strategies to avoid injury by sharps include:

- Maintaining good intact skin; intact skin is the first line of defense as a barrier to disease transmission
- Using occlusive dressings to protect non-intact skin
- Use an intermediary tray instead of passing sharp instruments between staff members, for example, scalpels or utility knives
- Dispose single-use sharps at point-of-use in a puncture resistant secured container immediately after use
- Transporting sharps by using a puncture-resistant secured container when disposal at point of use is not possible
- Wearing heavy-duty utility gloves and PPE when cleaning instruments.

2.4.2 Blood and Body Fluid Exposure Management

Registered Denturists may be exposed to blood, saliva and other body fluids via punctures, lacerations or by splashing onto their non-intact skin, mucosa of the eyes, nose or mouths. As such it is important for Registered Denturists to have an exposure management protocol in their practices.

The following processes should be included in the standard operating procedures of a denturism practice:

- Immediate first aid procedures

- Prompt referral of injured persons to his/her family physician, an infectious disease specialist or hospital emergency department for counselling, baseline blood tests and, if deemed necessary, post exposure prophylaxis (preventative treatment).
- Document the incident:
    - Include the name and vaccination status of persons exposed
    - Date and time of the exposure
    - Nature of the exposure including what oral health procedure was being performed
    - Name and health status of the source person if known, including any known blood-borne infections

2.4.3 Sending and Receiving Items

Dental prostheses, impressions, orthodontic appliances, and other prosthodontic materials (e.g., occlusal rims, temporary prostheses, or bite registrations) are potential sources for cross-contamination and should be handled in a manner that prevents transmission of infectious agents.

It is routine practice to treat all incoming items as contaminated and to perform cleaning and disinfection procedures if there has been no communication prior that it has been properly disinfected with low-level disinfectant, or there are any lingering doubts or confusion.

Routine Practices may include:

- Creating a dedicated receiving, cleaning, disinfection area in the practice to minimize the spread of contamination
- Conducting a personal risk assessment to determine which PPE should be used
- Clean and disinfect any received items (e.g. impression materials, bite registration) thoroughly and carefully to remove any blood, saliva or bodily fluids
- Dispose of all single-use shipping materials such as plastic bags that have touched contaminated received items
- Using a low-level disinfectant that has a Drug Identification Number (DIN) from Health Canada. Ensure it is safe for use with minimal toxic or irritating effects
- When sending items out, all items should be properly cleaned and disinfected (if necessary)

2.5 Administrative Controls

2.5.1 Education and Training

Denturists, like all health care professionals, receive training on IPAC best practices and protocols through their formal education, workplace training, and ongoing continuing professional development. It is important that all staff receive office-specific training in IPAC as part of their orientation, and whenever new procedures, equipment, or processes are introduced.

Regular education (orientation and continuing education) to include the following:

- The risks associated with infectious diseases, including acute respiratory infection and gastroenteritis
- The importance of appropriate immunization

- Hand hygiene, including the use of alcohol-based hand rubs and hand washing
- Principles and components of Routine Practices as well as additional transmission-based precautions (Additional Precautions)
- Assessment of the risk of infection transmission and the appropriate use of PPE, including safe application, removal and disposal
- Reprocessing of reusable medical equipment
- Appropriate cleaning and/or disinfection of surfaces or items in the health care environment

This guideline should be provided to all staff members as a key reference document. An Office Manual for a denture practice can be created from this guideline along with resources from Public Health Ontario, and various manufacturer's manuals for equipment and instruments.

Regular education and support should always be provided in all practices and workplaces to help staff consistently implement appropriate infection prevention and control practices. There should be process to record and report attendance of staff at education/training sessions.

2.5.2 Immunization

Immunizations are an important component of infection prevention and control. They minimize the potential risk for contracting an infectious disease from a patient and from transferring an infectious disease to patients and other staff.

All Registered Denturists should be aware of their personal immunization status and ensure their vaccines are up to date. It is highly recommended by Public Health Ontario that all health care professionals be immunized against:

- Hepatitis B
- Diphtheria
- Rubella
- Polio
- Influenza
- Mumps
- Tetanus
- Measles
- Pertussis
- Varicella

2.5.3 Illness and Work Restrictions

Hand hygiene is the single most important measure in protecting patients and staff from the transmission of microorganisms. However, even with the best of efforts, Registered Denturists and their staff may become ill.

All practices should create a healthy workplace policy that fosters a positive work environment and culture where employees feel secure and supported in making health lifestyle choices. Such provisions may include quarantining themselves at home when they fall ill.

Registered Denturists and their staff who have any of the following should not see patients:

- Influenza or a common cold
- Severe respiratory illness with fever
- Vomiting and diarrhea
- Acute conjunctivitis (e.g., pink eye)
- Dermatitis

2.5.4 The Occupational Health and Safety Act & Workplace Hazardous Materials Information System

In Ontario, employers have the responsibility to meet the requirements of the Occupational Health and Safety Act (OHSA) which includes the Workplace Hazardous Materials Information System (WHMIS).

Depending on the workplace setting, a Registered Denturist may have different roles and responsibilities under the OHSA. They may be classified as an employer, a supervisor or a worker under the Act. In many cases, Registered Denturists may be a combination of roles.

- A Denturist is an employer if they employ one or more workers or contracts for the services of one or more workers
- A Denturist is a supervisor if they have charge of the workplace or authority over any worker
- A Denturist is a worker if they perform work or supply services for monetary compensation

See **Appendix 1** for a detailed breakdown of duties for employers, supervisors and/or workers.

WHMIS is Canada's national workplace hazard communication standard that is exemplified in Ontario Regulation 860 of the OHSA.

The three key elements to WHMIS are:

- Cautionary labelling of containers of hazardous substances, called "controlled products", e.g., disinfectants
- Provision of safety data sheets (SDS) for all hazardous substances, which shall be renewed every three years
- Worker education programs.

2.5.5 Human Rights

The Ontario Human Rights Code (the Code) provides for equal rights and opportunities, and freedom from discrimination. The Code prohibits discrimination based on any of the following:

- Race
- Ancestry
- Place of origin
- Colour
- Ethnic origin
- Citizenship
- Creed
- Sex
- Sexual orientation
- Gender identity
- Gender expression
- Age
- Marital status
- Family status
- Disability

The Code recognizes persons living with certain illnesses, along with AIDS or HIV. Registered Denturists and their staff are prohibited from discriminating against such patients. This includes using extraordinary and/or unnecessary IPAC measures that are not recommended as per best practices. Registered Denturists may employ Additional Precautions based on the risks associated with certain procedures provided they are used for all patients undergoing the same procedures.

3. Reprocessing: Cleaning, Disinfection, and Sterilization of Reusable Equipment/Instruments

Reprocessing refers to the steps that are performed to ensure that a contaminated reusable equipment/instrument is made safe for reuse from one patient to another patient. It requires specialized equipment, dedicated space, qualified staff and regular quality control monitoring.

Newly purchased non-sterile semi-critical and critical medical equipment/instruments shall first be inspected and decontaminated according to their intended use prior to being put into circulation. Refer to the table below for the level of reprocessing required based on the intended use of the equipment/instrument.

3.1 Classification of Items

All reusable dental equipment/instruments are categorized as critical, semi-critical or non-critical based on its use, and each category requires a different level of reprocessing. The majority of semi-critical equipment/instruments used in denturism are available in heat tolerant or disposable alternatives.

Category	Use	Minimum Level of Reprocessing	Examples
Critical	Enters sterile tissues, including the vascular system (veins & arteries)	Cleaning followed by Sterilization	Surgical items e.g., implant tools, periodontal probes
Semi-critical	Contact with mucous membranes or non-intact skin but does not penetrate them	Cleaning followed by Sterilization	Mouth mirrors, reusable impression trays, facebow intraoral fork, fox plane, implant abutment wrenches and screwdrivers, wire bending pliers, suction tips, handpieces, burrs, and any tool used in the mouth
Noncritical	Contact with only intact skin (healthy skin with no breaks, cuts or scrapes) and not mucous membranes	Cleaning followed by Low-Level Disinfection	External portion of a facebow, cameras, mixing spatulas, laboratory knives, rubber mixing bowls, Boley gauges, shade guides, curing lights, radiograph head/cone, and blood pressure cuffs

3.2 Single-Use Items

Single-use equipment/instruments that are labeled by the manufacturer as single-use must be disposed of properly after each use.

3.3 Reprocessing Area

In a clinical practice setting, all equipment/instrument cleaning, disinfecting, and sterilizing should occur in a designated reprocessing area in order to more easily control quality and ensure safety. Registered

Denturists should establish a reprocessing area that has the following:

- One-way workflow from dirty to clean with the following distinct areas:
    - Receiving, decontamination, cleaning, and drying
    - Preparation and packaging
    - Sterilization
    - Storage
- Adequate space for the cleaning process and storage of necessary equipment and supplies
- Distinct separation from areas where clean/disinfected/sterile equipment/devices are handled or stored
- Easy access to hand hygiene facilities (i.e., hand washing sink or alcohol-based hand rub in lieu of a separate hand washing sink)
- Surfaces that can be easily cleaned and disinfected
- Slip-proof flooring that can withstand wet mopping and hospital-grade cleaning and disinfecting products
- Environmental controls in accordance with requirements for reprocessing areas (e.g., temperature, ventilation, humidity)
- Restricted access from other areas in the setting
- Policies or procedures in place to prohibit eating/drinking, storage of food, smoking, application of cosmetics or lip balms, and handling of contact lenses in place

3.4 Transportation and Handling of Contaminated Equipment/Instruments

Soiled dental instruments, dentures, and other medical equipment must be handled to avoid risk of exposure, contaminating contact surfaces, and injury to personnel. Best practices include:

- Use of closed carts or covered containers designed to prevent the spill of liquids, with easily cleanable surfaces, shall be used for handling and transporting soiled medical equipment/devices, including dentures
- Transport of soiled equipment/instruments by direct routes that avoid high-traffic, clean/sterile storage areas, and patient care areas
- Cleaning of containers or carts used to transport soiled medical equipment/instruments after each use
- Disposal of sharps in aa puncture-resistant sharps container at point-of-use, prior to transportation

3.5 Pre-Cleaning and Cleaning

Cleaning is the removal of visible contamination and gross debris from instruments. It is always required before disinfection and/or sterilization. If blood, saliva, and other contamination are not removed immediately and are allowed to dry on the instruments, these materials can shield microorganisms and potentially compromise the disinfection or sterilization process. As such, gross soil (e.g., saliva, blood) shall be removed immediately at point-of-use.

Cleaning can be performed manually or with the use of automated cleaning equipment such as ultrasonic cleaners or washer-disinfectors. Ensure equipment/instruments are in the open/unlocked position as per manufacturer's instructions.

3.5.1 Manual Cleaning

- Cleaning is achieved by manually scrubbing the instruments with a surfactant, detergent, or an enzymatic cleaner and must be done while immersed in water to minimize splashing
- The brush used for scrubbing instruments must be inspected for damage frequently and rinsed throughout the day
- All brushes must be disposed or disinfected at the end of each day
- Instruments must be rinsed after cleaning to remove any disinfectant, or surfactant residue
- Instruments must be dried with a lint-free cloth or designated automatic dryer
- Instruments must be visually inspected to ensure all organic and inorganic materials have been removed and integrity of the instruments has not been altered

3.5.2 Ultrasonic Cleaner

Ultrasonic cleaners work by subjecting instruments to high frequency, high-energy sound waves, thereby loosening and dislodging dirt. They are strongly recommended for any semi-critical or critical instruments that have joints, crevices, lumens or other areas that are difficult to clean.

- Follow the manufacturer's instructions for operation, maintenance and quality assurance of the ultrasonic cleaner to ensure that it works properly
- Remove gross debris from instruments prior to placement in an ultrasonic cleaner
- Completely immerse the instruments, in the unlocked open position if applicable, in the washing solution
- Rinse instruments with water after cleaning (with minimal splashing) to remove chemical or detergent residue
- Dry instruments after rinsing with a lint-free cloth or designated automatic dyer
- Inspect instruments visually to ensure all materials or contamination has been removed and the integrity of the instrument has not been altered

3.5.3 Washer-Disinfectors

Washer-disinfectors are generally computer-controlled units for cleaning, disinfecting, and drying solid and hollow surgical and dental equipment. Note that critical and semi-critical instruments must be sterilized.

- Follow the manufacturer’s instructions for the operation, maintenance and quality assurance of the washer-disinfector to ensure that it works properly
- Washer-disinfectors must meet the requirements of the Canada Standards Association
- Washer-disinfectors may be used for low-level disinfection, but not high-level disinfection
- Avoid stacking or overloading instruments in the washer-disinfectors, and disassemble devices as per the equipment/instrument’s manufacturer’s instructions
- Maintain and clean the washer-disinfectors regularly to prevent formation of biofilms that could contaminate processed instruments
- Dry instruments with a lint-free cloth or designated automatic dyer

- Inspect instruments visually to ensure all materials or contamination have been removed and the integrity of the instrument has not been altered

3.5.4 Drying

Drying is an important step that prevents the dilution of chemical disinfectants which can in turn render them ineffective in preventing microbial growth. After cleaning, instruments must be rinsed with water to remove detergent residue, dried and visually inspected to ensure all debris has been removed.

- Follow the manufacturer's instructions for drying of the instruments
- Dry instruments by using a drying cabinet, air-dry, or dry by hand using a lint-free towel
- Dry stainless-steel instruments immediately after rinsing to prevent spotting
- Inspect the instruments for any malfunction or damage after drying

3.6 Disinfection

Disinfection is the inactivation of disease-producing microorganisms, it does not destroy bacterial spores. Disinfection of reusable instruments falls into two major categories, low-level disinfection and high-level disinfection.

3.6.1 Low Level Disinfection

Low level disinfection eliminates vegetative 'live' bacteria, some fungi and enveloped viruses. It is used for the disinfection of some environmental surfaces and the reprocessing of noncritical equipment/instruments that only had contact with intact skin (healthy skin with no breaks, cuts or scrapes) and **not** mucous membranes.

Impressions, prosthesis and appliances that are removed from a patient's mouth should be cleaned and disinfected using a low-level disinfectant as soon as possible after removal. Wet impressions or appliances should be placed in secured plastic leak-proof bag prior to transport.

Choose a disinfectant that:

- Has a Drug Identification Number (DIN) from Health Canada
- Has efficacy for the intended use
- Is compatible with the instrument being disinfected
- Is safe for use with minimal toxic and irritating effects for staff

Follow the manufacturer's instructions regarding:

- The use of disinfectants (e.g., amount, dilution, contact time, safe use, shelf life, storage and disposal).
- The method for monitoring the disinfectant's concentration.
- The instructions for rinsing the disinfectant (e.g., water quality, volume, time) after disinfection.

3.6.2 High Level Disinfection & Cold Soaking

High-level disinfection (HLD) is used for the disinfection of semi-critical equipment/instruments. They may include 2% glutaraldehyde, 6% hydrogen peroxide, 0.2% peracetic acid, 2-7% enhanced action

formulation hydrogen peroxide and 0.55% ortho-phthalaldehyde. HLD is performed **after** the equipment/instrument is thoroughly cleaned, rinsed and excess water is removed.
The use of cold-soaking as a **sterilization method** is associated with a number of challenges: 1) difficulty in properly tracking immersion time, 2) unnecessary exposure to corrosive chemicals that may pose health risks to patients, Denturists, and clinic staff, 3) the need for direct ventilation in the reprocessing area, 4) disposal requirements for used disinfectants, 5) a lack of reliable monitoring mechanisms (physical, chemical or biological indicators) to ensure sterilization has occurred and 6) processing requires the rinsing of soaked instruments with sterile water to remove potentially irritating HLD chemicals and direct packaging into a sterile package following rinsing.

Because of these challenges, the use of HLD for sterilization through cold soaking **does not reflect current best practices** for the sterilization of dental equipment and instruments. Public Health Ontario notes that dynamic air removal steam sterilization, such as autoclaving, is the preferred method of contamination for heat-resistant equipment and instruments and the College strongly discourages the use of cold-soaking as a method of sterilization.

3.7 Sterilization

Sterilization is a process by which all disease-producing microorganisms including spores are eliminated. All critical medical instruments must be sterilized by steam under pressure (autoclaving), or by dry heat. Sterilization is the preferred method for reprocessing semi-critical medical instruments.

All sterilization must be performed by using medical sterilization equipment registered with Health Canada. Sterilization times, temperatures and other operating parameters recommended by the manufacturers of the equipment used, as well as instructions for the correct use and placement of packages and chemical or biological indicators, must be followed.

Instrument packages must be allowed to dry inside the sterilizing chamber before handling to avoid wicking of moisture and possible contamination with bacteria from hands.

3.7.1 Preparing and Packaging of Reusable Items

Equipment and instruments that are to be sterilized require wrapping prior to sterilization. Equipment and instruments shall be wrapped/packaged in a manner that will allow adequate air removal, steam penetration and evacuation on all surfaces (e.g., no over-filling, instruments are in the open position). The most common packaging material for the clinical office are plastic/peel pouches. They are easy to use, often with features such as self-sealing closures, chemical indicator strips, and they come in a variety of sizes that can accept single or small groups of instruments.

Each package must be labelled with:

- Date reprocessed
- Sterilizer used
- Cycle or load number
- Reprocessor's initials

Instruments should be evenly distributed in a single layer within the package or container, unless the container is designed by the manufacturer for more than one layer. Hinged instruments must be

reprocessed in the open and unlocked position. Equipment/instruments shall be disassembled as per the manufacturer's instructions.
A packaged instrument must not be placed within another package, unless this is supported by the sterilizer and the manufacturer of the internal packaging has designed and validated its product for this use.

Labels, chemical indicator tapes, and handwritten or printed inks must be compatible with the packaging system and colour-fast, so as not to degrade, run, leach, fade or become illegible with exposure to the sterilization process. If a labelling sticker is used, it shall be placed in an area that does not block the breathable area of the package.

3.7.2 Monitoring of Sterilization Process

The sterilization process shall be monitored to ensure the integrity and effectiveness of the process. Performance monitoring includes a combination of physical, chemical and biological indicators:

Physical Indicators

- Physical Indicators (cycle time, temperature, and pressure) must be checked, verified, recorded and signed for each sterilizer cycle by the person sterilizing the instruments
- Newer sterilizers can display, printout, or provide results digitally. A combination of indicators must be used as a display readout is insufficient when used alone

Chemical Indicators

- Chemical indicators (internal and external) use sensitive chemicals to indicate chemical or physical changes have occurred. It does not indicate sterility, it only indicates the package has been processed through a sterilization cycle. An internal and external indicator must be placed with each package
- External indicators (Type 1) - indicate that the package has been directly exposed to steam for a minimum amount of time, it helps distinguish between processed and unprocessed packages. **Each package must have an external Type 1 indicator**
- Internal indicators (minimum Type 4) - indicates one or more chemical or physical change has occurred. Must be placed inside each package in the area least accessible to steam penetration as per the autoclave manufacturer's instructions. **Each package must have, at a minimum, an internal Type 4 indicator**
- See **Appendix 3** for the different types of chemical indicators

Biological Indicators

- A Biological Indicator (BI) is a test system containing viable microorganisms that provide a defined resistance to a specified sterilization process. They are generally contained within a Process Challenge Device (PCD). Once sterilized, a BI is incubated to see if the microorganism will grow, which indicates a failure of the sterilizer
- **A BI is used to test the sterilizer each day the sterilizer is in use as well as tested for each type of cycle that is used that day**

- BI testing can be conducted only once per day that the sterilizer is in use, even though multiple batches are run throughout the day – usually the BI test is completed on the last load of the day
- Items in the processed loads should be quarantined until the results of the BI test are available (most are 24 hours for steam sterilization)
- If a failed BI is found, the contents of the autoclave batch shall be reprocessed before use and autoclave inspection and servicing shall be required
- Contingency plans including policies on recall and procedures must be in place in the event of reprocessing failures

3.7.3 Conducting Sterilizer Testing and Process Challenge Devices (PCDs)

Process challenge devices (PCD) are test devices used to provide a challenge to the sterilization process that is equal to or greater than the challenge posed by the most difficult item that is routinely processed. Put another way, PCDs are used to verify that the sterilizer has effectively sterilized all items in that cycle and that the sterilizer is working as intended.

Three most commonly encountered PCDs in the denturism practice are:

- Bowie-Dick, air removal PCD test pack
- Biological indicator PCD test pack
- Chemical indicator PCD test pack

Bowie-Dick, air removal PCD test pack

The Bowie-Dick test is only required for *pre-vacuum sterilizers* as it indicates sufficient air has been removed from the sterilizer for steam penetration and contact with instrument surfaces. The Bowie-Dick test pack must be performed in an empty sterilizer at the beginning of each day the pre-vacuum sterilizer is used. If the Bowie-Dick test fails, the sterilizer must be removed from service until it has been inspected, repaired and successfully re-challenged multiple times. Follow the manufacturer's guidelines on where to place test pack within the sterilizer.

Biological indicator PCD test pack and BI interpretation

A Biological indicator (BI) PCD test pack is performed daily and included with the last load of the day. They are placed in the chamber along with a full load of packages. All sterilized loads completed throughout the day must be quarantined until the BI PCD test pack successfully passes. When using a BI test pack, a Type 5 Chemical Indicator (CI) strip should be included as well.

Once the sterilization cycle has completed, the BI is prepared and incubated for the recommended time as indicated by the manufacturer's guidelines. A control BI, from the same lot as the test indicator that has not been processed through the sterilizer must also be prepared and incubated with the test BI. The control BI will indicate positive results for bacterial growth while the sterilized BI indicates negative results. If the Type 5 CI also indicates a pass and all physical parameters have been met (time, temperature, and pressure), the reprocessed instruments may be released for use.

In the event of a failed BI test, ensure the following are carried out:

- Remove the sterilizer from service
  Review all the records pertaining to physical and chemical indicators since the last negative BI
- Review procedures to determine if it was an operator error or mechanical error i.e. overloading, inadequate package separation, incorrect or excessive packaging material
- If the reason for the failure is identifiable, correct procedural problems, repeat BI test immediately using the same cycle that produced the failure. While waiting for repeat test results, the sterilizer must remain out of service. If repeat BI test is successful, the sterilizer may be placed back into service. Packages from the failed load are to be reprocessed
- If the repeat BI test is unsuccessful or the cause of the initial failure is not known, the sterilizer must remain out of service until it has been inspected, repaired and successfully re-challenged with the BI test in 3 consecutive full chamber sterilization cycles. Previous items from the suspect load must be recalled and reprocessed

Chemical indicator PCD test pack

A Type 5 CI in a PCD must always be used if the reprocessed instruments are going to be released prior to knowing the result of the BI test. If the sterilizer does not have a printer/USB or recording device, then a Type 5 CI must be placed in every package of the load to demonstrate that correct sterilizing conditions were achieved in the cycle.

A successful CI PCD test pack will indicate the critical indicators that the CI is measuring have been met (e.g., time, temperature, and pressure) and that instruments may be released upon successful daily BI test results. Although instruments can be released based on the results of the Type 5 CI in a PCD, best practice is to quarantine the load until results of the BI are available.

A log must be kept documenting the date, time of sterilization, sterilizer number, sterilizer cycle, and location of the PCD within the cycle. The results of all sterilization monitoring tests must be recorded and retained.

In the event of a failed CI test:

- Remove the sterilizer from service
- Review all the records of physical and chemical indicators since the last negative CI. Review procedures to determine if it was an operator error or mechanical error
- If the failure is confined to one load and can be immediately corrected, correct the problem and reprocess the load.
- If it was failed in only one package, reprocess the package. If the failure was found in multiple packages, the entire load must be reprocessed.
- If the failure cannot be immediately corrected, recall and reprocess all items back to the last successful load (Physical, CI, and BI parameters met)
- Sterilizer must remain out of service until it has been inspected, repaired and successfully re-challenged with BI test in 3 consecutive full chamber sterilization cycles.

3.7.4 Sterilization Record Keeping

A log of test results during sterilization must be maintained and reviewed. Information to be recorded includes:

- load control label (sterilizer number, load number, and date of sterilization)
- chart/printout of physical parameters of the sterilization cycle
- load contents
- person responsible for the sterilization cycle
- chemical indicator (CI) monitoring results
- biological indicator (BI) monitoring results

Other logs such as efficacy testing and maintenance of sterilizers, ultrasonic cleaners, and washer/disinfectors must be maintained as per manufacturer's instructions for use.

4. Cleaning of Environmental Surfaces and Management of Waste

The prevention of cross-contamination or the spread of microorganisms from one source to another is of primary concern in the practice of denturism. When evaluating the environment, Registered Denturists should consider ways to minimize the transfer of microorganisms from soiled hands, soiled instruments or soiled environmental surfaces. Cleaning and low-level disinfection of environmental surfaces will help achieve this.

There are two categories of cleaning for clinical practice settings:

- Public environmental surfaces - reception areas, consultation rooms, and offices
- Clinical environmental surfaces - patient treatment areas and reprocessing rooms

4.1 Public Environmental Surfaces

Public environmental surfaces refer to areas open to the public such as reception areas with chairs, toys, countertops, consultation rooms and business offices that patients may touch or encounter.

To minimize the risk to patients and staff, lab coats or PPE must be removed upon exiting the laboratory area and/or the treatment rooms before entering public spaces. Public areas should be cleaned daily, or more frequently, if soiled.

While floors and walls have a limited risk of disease transmission, these surfaces require periodic cleaning. Mop heads and buckets must be cleaned thoroughly between uses and allowed to dry completely. Mops used in clinical areas should not be used in public areas. Carpeted areas and upholstered furnishings are discouraged. Areas where carpets have not yet been removed should be vacuumed daily using a HEPA filtered vacuum.

In the event public environmental surfaces become soiled with blood or body fluids, the surfaces must be cleaned and disinfected.

4.2 Clinical Environmental Surfaces

Clinical environmental surfaces refer to areas of patient treatment/care as well as instrument reprocessing areas.

Treatment rooms should not be carpeted, upholstered or contain wood furnishings as they are difficult to clean and disinfect. When choosing finishes and furnishings for the clinical practice setting, seamless, slip-resistant, non-porous and easy to clean materials should be considered. Sinks and garbage bins ideally should operate hands free.

High-touch surfaces include:

- Dental chair & switches
- Chairside computer keyboards, monitors and mouse
- Sink and faucet handles
- Telephones and pens
- Overhead light handle and switches
- Drawer and door handles
- Countertops

Clinical surfaces including the high-touch surfaces must be cleaned of gross debris and then disinfected with a low-level disinfectant. Treatment areas must be free of clutter and unnecessary supplies and equipment on counter tops in order to minimize contamination with spatter, droplets or sprays and facilitate effective disinfection. Appropriate PPE must be worn while disinfecting surfaces to prevent occupational exposure to infectious microorganisms and chemicals.

4.3 Management of Waste

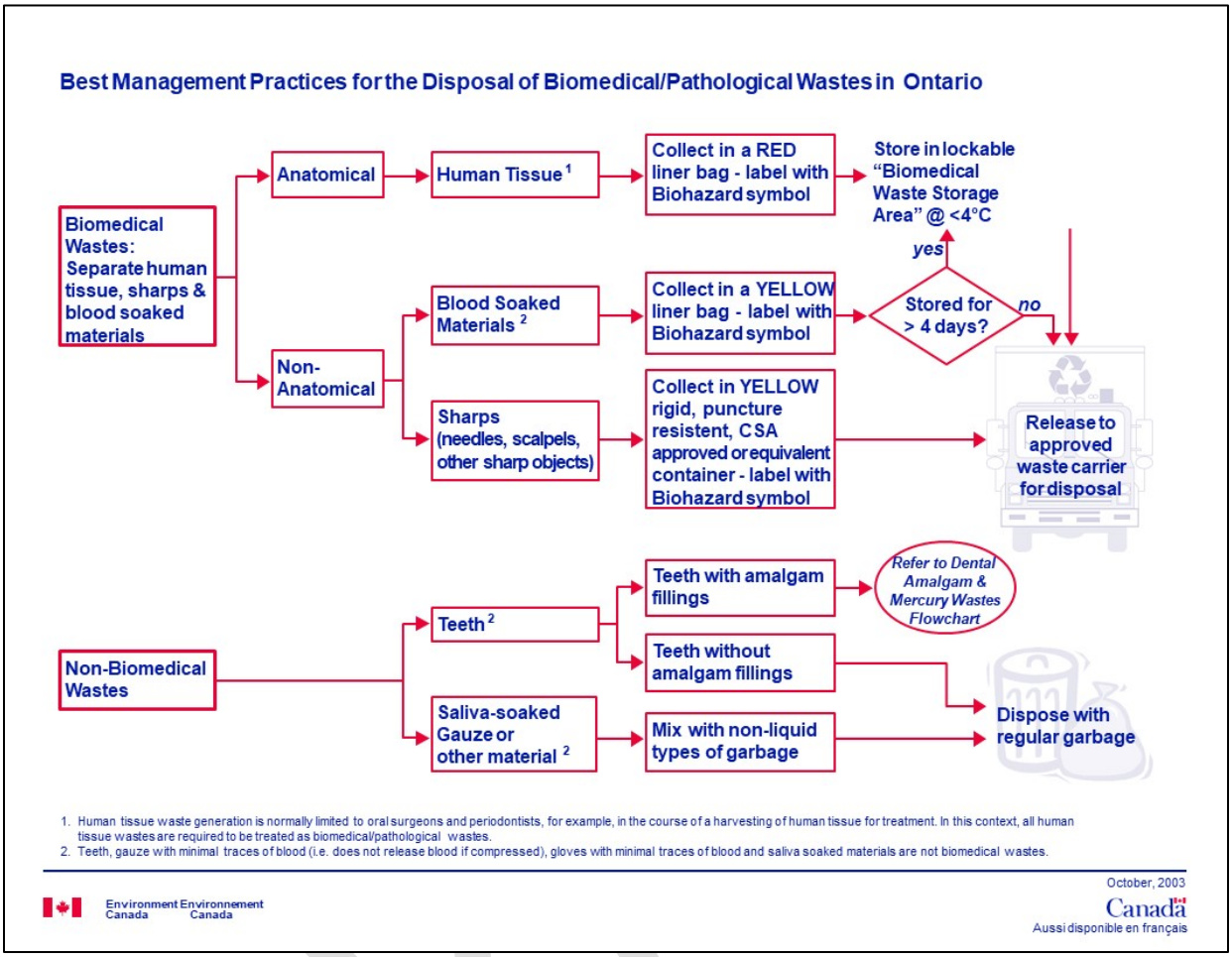
Waste must be separated into biomedical waste (hazardous waste) and general office waste. General office waste may be disposed of by your regular municipal waste collection service. Biomedical waste must be disposed of in an appropriate manner to prevent the transmission of possible infections from contaminated waste.

4.3.1 Biomedical waste

Biomedical waste is classified as hazardous waste and must not be disposed with regular office waste. It must be handled safely to protect human health and the environment. In general, all biomedical waste must be:

- Stored in colour-coded containers that are marked with the universal biohazard symbol
- Released to an approved biomedical waste carrier for disposal
- For further information, visit the Government of Ontario's online guidelines for the management of biomedical waste.

The figure below depicts best practices for the disposal of various biomedical/pathological waste.



Source: Dental Wastes Best Management Practices for the Dental Community, Environment Canada, April 2005.

Blood and Body Fluid Soaked Items

Considerations for cleaning up a blood or body fluid spill:

- Wipe up any blood or body fluid spills immediately using disposable towels, dispose into regular waste if they do not release liquid or semi-liquid blood when compressed/squeezed
- Blood soaked gauze, cotton rolls, examination gloves, and disposable towels are considered general office waste if it also does not release liquid or semi-liquid blood when squeezed
- If the soiled materials are so wet that blood can be squeezed out of them, they must be placed in a leak proof liner bag labelled with the universal biohazard symbol. Containers should be labelled yellow
- If blood-soaked materials are to remain on site for more than four days, they must be stored in a refrigerated storage area marked "Biomedical Waste Storage Area" displaying the universal biohazard symbol. Refrigeration should be at or below 4^0C
- Disinfect the entire area with hospital-grade disinfectant, wipe up the area again with disposable towels and discard into regular waste
- Blood-soaked materials must be released to an approved biomedical waste carrier for disposal

4.3.2 General Office waste

General office waste is no different than residential waste. The majority of soiled items generated in a denture clinic do not require any special disposal methods other than careful containment and removal, with the exception of biomedical waste. Some general recommendations for office waste include:

- Ensure all garbage containers are waterproof and have tight-fitting lids, preferably operated by a foot pedal. Open wastebaskets are unadvised
- Use plastic bags to line the garbage containers. The use of double bagging is not necessary, unless the integrity of the bag is jeopardized, or the outside is visibly soiled
- Do not overfill garbage containers
- Do not place sharp, hard or heavy objects into plastic bags that could cause them to burst
- Do not place biomedical waste or sharps with general office waste

4.3.3 Sharps Disposal

The following are best practices regarding the disposal of sharps:

- Dispose of a single use sharp immediately after use
- Sharps must be disposed of in a YELLOW puncture-resistant, leak-proof container specifically designed for their management and labelled with the universal biohazard symbol
- Use rigid walled, leak- and puncture-resistant yellow containers for disposal of sharps. The closure should be secure
- Containers must not be filled beyond their designated capacity
- Must be released to an approved biomedical waste carrier for disposal
- For reusable sharps, carry them in a lidded puncture-resistant container, cassette or covered tray from the point of origin to the reprocessing area.
- Place appropriate sharps (biohazard) containers as close as possible to the area where the items are used

Most healthcare professionals, including Registered Denturists, source a private company to assist with the appropriate disposal of sharps and biomedical waste. Such companies may also provide clinics with appropriate containers to store disposed sharps in between pick-ups.

Appendix 1 – Duties of Employers, Supervisors, and Workers under the Occupational Health and Safety Act

The following information was reproduced with permission from the Infection Prevention and Control for Clinical Office Practice, April 2015, Public Health Ontario.

Duties of Employers

- Make sure workers know about hazards and dangers by providing information, instruction and supervision on how to work safely.
- Appoint a "competent person" as defined by the OHSA to be a supervisor.
- Make sure supervisors know what is required to protect workers' health and safety on the job.
- Create workplace health and safety policies and procedures where more than 5 workers are regularly employed. If you regularly employ 5 or less workers, you do not have to put policies in writing unless ordered by a Ministry of Labour inspector.
- Make sure everyone follows the workplace health and safety policies and procedures.
- Make sure workers wear and use the correct PPE.
- Maintain equipment, material and protective devices in good condition.
- Comply with applicable legislation and reporting requirements.
- Do everything reasonable under the circumstances to protect workers from being hurt or getting a work-related illness.

Duties of Supervisors

- Inform workers about hazards and dangers and respond to their concerns.
- Show workers how to work safely, and make sure they follow the law and workplace health and safety policies and procedures.
- Make sure workers wear and use the right PPE.
- Do everything reasonable under the circumstances to protect workers from being hurt or getting a work-related illness.

Duties of Workers

- Comply with the OHSA and its regulations and the workplace's health and safety policies and procedures.
- Work and act in a way that won't hurt themselves or anyone else.
- Report any hazards or injuries to the supervisor/employer.
- Wear and use the PPE required by the employer.

Additional requirements under the Occupational Health and Safety Act include:

- A joint health and safety committee shall be implemented in any workplace that regularly employs 20 or more workers.
- A health and safety representative is required at a workplace where six or more workers are regularly employed, and where there is no joint committee. The representative shall be chosen by the workers.
- No matter how small the workplace, it shall be inspected at least once a month.

Monthly Inspection Checklist

Visit all areas of the workplace, looking for hazards that need correction, such as:

- are sharps containers overfilled?
- is PPE (gloves, masks, gowns) available and accessible?
- is PPE in good condition?
- are chemical disinfectants/sterilants labelled and stored properly?
- are food preparation areas clean and dedicated for that purpose?
- is there adequate ventilation if liquid disinfectants are used?
- is storage shelving in good condition?
- is there adequate liquid soap available at hand washing sinks?
- is there alcohol-based hand rub at point-of-care?
- is the protocol for disposal of hazardous waste being followed?
- is the waste collection area clean and tidy, with waste covered?
- are blood/body fluid spills cleaned by trained staff as they occur?

Appendix 2 - Additional Precautions Based on Mode of Transmission for

Some Infectious Diseases

The following is reproduced with permission from Infection Prevention and Control for Clinical Office Practice, April 2015, Public Health Ontario

CONTACT PRECAUTIONS	DROPLET PRECAUTIONS	AIRBORNE PRECAUTIONS
For patients with: • Antibiotic-resistant organisms (e.g., MRSA infection) • Acute vomiting and/or diarrhea • Uncontained drainage • Conjunctivitis	For patients with: • Pertussis • Mumps • Rubella • Meningitis, etiology unknown and meningococcal Droplet + Contact Precautions for patients with: • Acute Respiratory Infection (e.g., croup, RSV, common cold, influenza, bronchiolitis, pneumonia, acute exacerbation of asthma)	For patients with: • Pulmonary tuberculosis • Measles • Chickenpox
▼	▼	▼
Patient Identification and Management • Identify at triage • Separate symptomatic patients from other patients in waiting room or triage into a single room	Patient Identification and Management • Identify at triage • Surgical mask for patient • Triage into single room • Respiratory etiquette • Post alert at entrance to room, if available	Patient Identification and Management • Identify at triage • Surgical mask for patient • Triage into single room with door (closed) – open window in room, if applicable • Place alert at entrance to room, if available
▼	▼	▼
Health Care Worker's Response • Hand hygiene • Gloves for any contact • Gown, if soiling is likely • Clean and disinfect equipment and surfaces that the patient contacted with a low-level disinfectant after patient leaves	Health Care Worker's Response • Hand hygiene • Surgical face mask and eye protection for any contact • Clean and disinfect equipment and surfaces that the patient contacted with a low-level disinfectant after patient leaves	Health Care Worker's Response • Hand hygiene • N95 respirator if patient has suspected or confirmed pulmonary tuberculosis • Respirator not required for chickenpox/measles if HCW is immune. Only immune staff to provide care

Appendix 3 – International Types of Steam Chemical Indicators

The following is reproduced with permission from the Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices In All Health Care Settings, 3rd edition, May 2013, Public Health Ontario.

Type	Definition	Use	Examples
Type I: Process Indicators	Indicators that differentiates processed from non-processed items	• Used with individual units (e.g., packs, containers) to indicate that the item has been directly exposed to the sterilization process • Usually applied to the outside of packages • Respond to one or more critical process variables	• Indicator tapes • Indicator labels • Load cards
Type II: Indicator for Use in Specific Tests	Indicator for use in specific test procedures as defined in sterilizer/sterilization standards (e.g., air-detection, steam penetration)	• Used for equipment control to evaluate the sterilizer performance	• Bowie-Dick test
Type III: Single Variable Indicator	Indicator that reacts to a single critical variable in the sterilization process to indicate when a specified value has been reached (e.g., temperature at a specific location in the chamber)	• May be used for monitoring process control but not as useful as type IV or type V indicators • May be used for exposure control monitoring (e.g., temperature at a specific location in the chamber)	• Temperature tubes
Type IV: Multi-variable Indicator	Indicator that reacts to two or more critical variables in the sterilization cycle under the conditions specified by the manufacturer	• May be used for process control	• Paper strips
Type V: Integrating Indicator	Indicator that reacts to all critical variables in the sterilization process (time, temperature, presence of steam) and has stated values that correlate to a BI at three time/temperature relationships	• Responds to critical variables in the same way that a BI responds • Equivalent to, or exceeds, the performance requirements of BIs • Used for process control • May be used as an additional monitoring tool to release loads that do not contain implants	
Type VI: Emulating Indicator	Indicator that reacts to all critical variables (time, temperature, presence of steam) for a specified sterilization cycle (e.g., 10 min., 18 min., 40 min.)	• Used as internal CI for process control • A different Type VI emulating indicator is required for each sterilization cycle time and temperature used • Cannot be used as an additional monitoring tool to release loads that do not contain implants	

Modernizing the provincial health profession regulatory framework: A paper for consultation

Steering Committee on Modernization of Health Professional Regulation

November 2019

BRITISH COLUMBIA

Contents

Introduction

The purpose of this consultation paper is to seek feedback from British Columbians and health-sector stakeholders that will assist the Steering Committee on Modernization of Health Professional Regulation to refine their proposal on how to modernize the regulatory framework for health professions in British Columbia.

Regulation of health professionals[1] is part of the foundation of safe health care and ensures that trust in health professionals is maintained. The public must be comfortable seeking care from health professionals and have confidence that these professionals will deliver safe, effective, ethical care. Regulation is one of the key mechanisms that assures patients that the care they receive is provided by qualified, capable and competent professionals.

On March 8, 2018, the Honourable Adrian Dix, Minister of Health appointed Harry Cayton, a leading expert in the field of professional regulation, to undertake an inquiry into the College of Dental Surgeons of British Columbia. The inquiry examined concerns about the College of Dental Surgeons' governance and operations, as well as reviewing the *Health Professions Act* and the model of health profession regulation in B.C.

On April 11, 2019, *An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* (the Cayton report) was released to the public. The report contains two parts:

- Part One focuses on the inquiry into the College of Dental Surgeons[2]; and,
- Part Two suggests approaches to modernize B.C.'s overall health profession regulatory framework.

In response to the suggestions outlined in Part Two of the Cayton report, the minister established and chairs the Steering Committee on Modernization of Health Professional Regulation. Committee members include Norm Letnick, health critic for the official Opposition, and Sonia Furstenau, health critic and house leader for the BC Green Party caucus. The steering committee was established to provide advice on an approach to modernize the regulatory framework for health professions. The authority to modernize the regulatory framework rests with the cabinet and the Legislative Assembly.

In developing this consultation paper, the steering committee has considered research, expert guidance, evidence from other jurisdictions and feedback gathered from an initial phase of public consultation.

[1] Terms defined in Appendix A first appear in **bold font.**

[2] The recommendations contained in Part One of the Cayton report related to the College of Dental Surgeons were accepted by the Minister of Health in April 2019. The minister directed the college to implement the recommendations. Information on the college's progress toward implementation of the recommendations is available online.

Scope of consultation

To modernize B.C.'s health profession regulatory framework, the steering committee is seeking feedback from stakeholders and the public. This consultation paper proposes wide ranging changes, including to current structures and the creation of new structures to strengthen the province's framework for health profession regulation.

In considering how to modernize health profession regulation, the steering committee is guided by three objectives:

1. Improve patient safety and public protection.
2. Improve efficiency and effectiveness of the regulatory framework.
3. Increase public confidence through transparency and accountability.

The Ministry of Health's most recent service plan explains that "underpinning the work of all ministries are two shared commitments: reconciliation with Indigenous peoples and consideration of how diverse groups of British Columbians may experience our policies, programs and initiatives."[3] In addition to the consultation outlined below, the steering committee supports implementation of the *Declaration on the Rights of Indigenous Peoples Act* and commits to honouring the United Nations Declaration on the Rights of Indigenous Peoples.

The steering committee supports cultural safety, diversity and accessibility of the regulatory system as foundational to increasing public trust and ensuring public protection for all British Columbians. Based on engagement completed to date, improvements to cultural safety have been most frequently linked to changes to the complaints and discipline process, ensuring leadership including board membership reflects the diversity of the people and communities that make up B.C., and creation of standards that promote cultural competence of health professionals and regulatory organizations.

Ways to participate

Members of the public, community groups and health-sector stakeholders are invited to submit feedback on the proposals outlined in this consultation paper.

Feedback is accepted from Nov. 27, 2019 to Jan. 10, 2020 via:

- Online survey here.
- Written submissions may be provided by email to PROREGADMIN@gov.bc.ca using the subject line 'Feedback – Regulating health professionals.' An email confirming receipt of the submission will be sent, but personalised responses will not be provided.

This engagement opportunity is at the level of *consult* on the spectrum of engagement.

[3] Ministry of Health 2019/2020-2021/22 Service Plan, p.1.

Background

In B.C., health profession **regulatory colleges** are responsible for ensuring that regulated health professionals provide services in a safe, competent, and ethical manner. Regulatory colleges hold a register of professionals, set standards of practice, set and maintain standards of education and training, and investigate complaints and discipline **registrants**. Regulatory colleges' role in setting and enforcing standards of competence and conduct for the professions they regulate influences patients' and families' interactions with health professionals. Regulatory colleges also protect certain titles - like doctor, nurse, traditional Chinese medicine practitioner, and dentist - that help the public to recognize qualified professionals who have demonstrated the requirements to practice safely.

There are 20 regulatory colleges established under B.C.'s *Health Professions Act*. This legislation provides a common regulatory framework for 25 health professions.[4] There have been criticisms that the current model of regulation, set out in the *Health Professions Act*:

- has enabled cultures that can sometimes promote the interests of professions over the interests of the public;
- is not keeping up with the changing health service delivery environment, particularly in relation to interprofessional team-based care;
- is not meeting changing patient and family expectations regarding transparency and accountability; and
- is inefficient.

Further to this, there has been growing concern regarding the performance of some regulatory colleges in carrying out their mandate to protect the public from harm.

Cayton report findings

The Cayton report finds that the provincial regulatory framework for health professionals fails to support regulatory colleges in fulfilling their mandate, stating that the *Health Professions Act* "is no longer adequate for modern regulation."[5] Deficiencies with the current regulatory model are highlighted, including issues related to the governance of regulatory colleges, a complex complaints and discipline process, and lack of transparency of regulatory colleges.

There is also concern that the current model of regulation has allowed for promotion of the interests of the profession over the interests of the public. The report identifies a lack of public trust in regulators and a lack of "relentless focus on the safety of patients"[6] as inadequacies of the current model. These themes are closely aligned with previous findings from a 2003 report conducted by the ombudsperson on self-governance in health professions in B.C.[7]

[4] See Appendix B – *List of regulatory colleges and regulated professions in British Columbia.*
[5] Cayton report, p. 70.
[6] Cayton report, p. 85.
[7] Office of the Ombudsman of British Columbia. *Acting in the public interest? Self Governance in the Health Professions: The Ombudsman's Perspective*. 2003.

The Cayton report makes suggestions for improvements related to regulatory college governance, reduction in the number of regulatory colleges, oversight of regulatory colleges, and transparency of the complaints and discipline process.

Results from initial public consultation

Following the release of the Cayton report and the minister's establishment of the steering committee, one of the committee's first steps was to seek input from the public and stakeholders regarding their views on health profession regulation and the suggestions contained in the report. The initial consultation was held for one month, ending June 14, 2019. Through this consultation, the steering committee heard from British Columbians and health-sector stakeholders about the aspects of health profession regulatory modernization that are important to them.

The steering committee reviewed and considered all submissions and published an overview of themes on the Ministry of Health's Professional Regulation website.[8] Over 300 written submissions were received from a broad cross section of respondents, including: 190 members of the public; 50 health practitioners; 25 professional associations; 18 regulators; and 30 other health-sector stakeholders, including unions.

The submissions were broadly supportive of modernizing health profession regulation in B.C. Improved transparency and accountability throughout the system of health profession regulation were common themes. The need for greater oversight was also frequently expressed.

Members of the public who made complaints to regulatory colleges shared concerns about the current process for complaints and discipline. The importance of profession-specific clinical knowledge in health profession regulation was expressed. Other feedback themes included the need for consistent approaches to regulation across professions, cultural safety within the complaints and discipline process, and performance monitoring of regulators. Members of the public and health-sector stakeholders expressed support for continued engagement and consultation as potential changes progress.

Input from the initial public consultation assisted the steering committee to identify and prioritize the following elements of regulatory modernization that are important to British Columbians and health-sector stakeholders:

- Ensuring regulatory colleges are putting the public interest and patient safety ahead of the professional interest.
- Improving effectiveness of regulatory college boards and ensuring boards are composed of members appointed based on merit and competence.
- Reducing the number of regulatory colleges to improve efficiency and effectiveness.
- Creating a body to oversee regulatory colleges to improve public confidence and patient safety.
- Simplifying and increasing transparency in the complaints and disciplinary process.

[8] Initial consultation themes summary, 2019.

Modernization proposals

The steering committee is seeking input on the proposed changes outlined in the following sections of this consultation paper.

1. Improved governance

In its simplest form, governance is how groups organize themselves to make decisions. It refers to the structures, policies and processes put in place to make decisions. Regulatory colleges are governed by boards of directors that provide strategic leadership, decision making and stewardship, among other responsibilities.

In 2003, the ombudsperson reported on self-governance in health professions in B.C., citing concerns that "the professions do not appear to have fully accepted or understood what it means to act in the public interest."[9] Concerns have persisted and the Cayton report highlights that for many regulatory colleges, "their governance is insufficiently independent, lacking a competency framework, a way of managing skill mix or clear accountability to the public they serve."[10]

Regulatory college boards must provide effective leadership to ensure regulatory colleges fulfill their legally defined mandate. To achieve this, boards need to be composed of individuals with the right balance of skills and experience, who are focused on public safety. Ensuring boards are composed of individuals whose motivation is consistent with legislative requirements is critical to ensuring the protection of public safety.

Competency-based board appointments and balanced board membership

Each regulatory college board is made up of public board members (who are *not* registrants of the college) and health professional board members (who *are* registrants of the college). Public board members make up between one third and one half of each college's board (a legislated requirement). They are appointed by the Minister of Health and ensure that the public's perspective is considered in strategic leadership and decision making. Registrant board members make up the rest. They are elected by registrants within their professions and provide a profession-specific perspective.

The majority of regulatory college board members are elected by health professionals who are registered with the regulatory college overseen by the board. The ombudsperson's 2003 report highlighted concerns that these elections have led to a "strong sense of accountability [among colleges] to the profession,"[11] and ultimately have led to a diminished "sense of direct accountability to the public."[12]

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[9] Office of the Ombudsman of British Columbia. *Acting in the public interest? Self Governance in the Health Professions: The Ombudsman's Perspective*. May 2003, p. 3.
[10] Cayton report, p. 85.
[11] Office of the Ombudsman of British Columbia. *Acting in the public interest? Self Governance in the Health Professions: The Ombudsman's Perspective*. May 2003, p. 10.
[12] Office of the Ombudsman of British Columbia. *Acting in the public interest? Self Governance in the Health Professions: The Ombudsman's Perspective*. May 2003, p. 11.

The election of registrant board members has continued to promote the misconception that these board members are accountable to those who have elected them, rather than accountable to protect British Columbians. To address this issue, the Cayton report proposes the elimination of elected board members in favour of "fully appointed boards combining health professionals and members of the public in equal parts."[13]

Striving for balanced numbers of public and registrant board members will ensure that the perspective of the public is well represented. Ideally, a balanced board will include about half public and half registrant board members.[14] Increased public representation will also ensure that boards are more diverse and reflective of the public they serve. Using a **competency-based process to appoint board members** ensures boards have the right mix of skills and experience to govern effectively.

Feedback from the initial public consultation supported having regulatory college boards with an equal number of professional and public members, as well as the appointment of both public and professional members of boards based on merit, skills and experiences. Stakeholders also noted that ensuring cultural diversity of board members, as well as other leadership positions, is important to fostering cultural safety at all levels of organizations.

It is proposed that regulatory college boards have equal numbers of registrant and public members.

It is proposed that all board members (registrant and public) be recommended for appointment through a competency-based process, which considers diversity, is independently overseen, and is based on clearly specified criteria and competencies. The Minister of Health would appoint all board members based on the recommendations of the competency-based process.

Questions:
Q1a. *Do you support an equal number (50/50) of public and professional board members?*
Q1b. *Are there any possible challenges to the proposed approach, and if so, how can they be addressed?*

Size of boards

The Cayton report suggests regulatory college boards be reduced in size. In the initial public consultation, there was support for smaller boards. Evidence shows the most effective size for a board is between eight and 12 members.[15] Larger boards can lead to communication and co-ordination problems, causing effectiveness and performance to suffer.[16] A reduction in board size will help ensure boards provide effective strategic decision making and oversight.

To improve functioning and effectiveness, it is proposed that regulatory college boards move to a more consistent and smaller size.

Questions:
Q1c. *Do you support reducing the size of boards?*
Q1d. *Are there any possible challenges to reducing board size, and if so, how can they be addressed?*

[13] Cayton report, p. 74.
[14] It is envisioned registrant members would make up one half of college boards and public members would make up one half of college boards. The number of registrant members or public members could not exceed the number of the other type by more than one.
[15] Professional Standards Authority. *Board size and effectiveness: advice to the Department of Health regarding health profession regulators*, September 2011.
[16] Professional Standards Authority. *Board size and effectiveness: advice to the Department of Health regarding health profession regulators*, September 2011.

Board member compensation

Regulatory colleges rely on fees collected from registrants to fund their operations, including compensation of board members. The amount regulatory colleges currently pay their board members varies significantly from board to board. Registrant board members are sometimes paid at a higher rate than public board members creating inconsistency within the same board.

The Cayton report notes, "if a higher performance is to be expected of board and committee members, they should be adequately rewarded. Board and committee members, both professional and public should be paid for the time they give and the expertise they provide."[17]

It is proposed that board and committee members be fairly and consistently compensated (within and between colleges) and move away from volunteerism.

Questions:
Q1e. *Do you support fair and consistent compensation for board and committee members?*
Q1f. *What are the benefits of this approach?*
Q1g. *What are challenges and how can they be addressed?*

2. Improved efficiency and effectiveness through a reduction in the number of regulatory colleges

To improve performance, efficiency and effectiveness of the regulatory framework, the Cayton report recommends a transition to fewer regulatory colleges. In the initial public consultation, increased efficiency and cost-savings were identified by many respondents as a key reason to support amalgamation. Some submissions from regulatory colleges indicated that smaller regulatory colleges are struggling to meet their mandate due to resource challenges. In some cases, these resource constraints significantly hamper the regulatory college's ability to protect the public from harm.

Of the 20 regulatory colleges under the *Health Professions Act*, there is significant variation in size and financial resources available to fulfil their legislated mandate. The smallest regulatory college, the College of Podiatric Surgeons of B.C., has just over 85 registrants and an annual revenue of about $330,000.[18] The largest regulatory college, the B.C. College of Nursing Professionals, has more than 59,000 registrants and an annual revenue exceeding $25 million.[19]

Amalgamation may also have benefits for registrants in the long term. Registrants of the College of Podiatric Surgeons pay the highest registration fees of regulated health professions, while registrants of the College of Nursing Professionals pay among the lowest.

[17] Cayton report, p.75.
[18] College of Podiatric Surgeons 2018 Annual Report.
[19] BC College of Nursing Professionals 2018 Annual Report.

Larger regulatory colleges are not only more efficient but are likely to be more effective. In clinical practice, experience and repetition of tasks improves performance.[20] The same is true for activities of regulation; writing clear standards, checking registrations, investigating complaints and making decisions on disciplinary matters are all performed more efficiently and effectively by colleges with extensive experience doing them. Adequate financial resources allow regulators to provide registrants with up-to-date clinical standards and guidance, and access to high-quality practice support resources.

B.C. is moving toward interdisciplinary teams of health-care professionals to better meet the health-care needs of patients and families. As health-care delivery shifts from solo professionals to team-based care, the regulatory framework must also evolve. Maintaining a focus on regulating single professions in isolation does not position regulatory colleges to respond to the increasing complexities of modern team-based care. A reduction in the number of regulators will support more consistent standards across professions, enabling integrated care for patients and empowering professionals to better understand the scope of their role within a team.

Fewer regulatory colleges will also make it easier for patients and families to determine who they should contact regarding concerns about the care received by a health professional. For example, as a result of the amalgamation of the three nursing regulatory colleges, there is now a single point of contact for concerns about the professional practice or behaviour of any nurse.

Reduction in the number of regulatory colleges – from 20 to five

To increase public protection, and improve efficiency and effectiveness of regulation, a reduction in the number of regulatory colleges from 20 to five is proposed.

Maintain the College of Physicians and Surgeons of B.C., the College of Pharmacists of B.C. and the B.C. College of Nursing Professionals. The College of Physicians and Surgeons, the College of Pharmacists and the College of Nursing Professionals are of sufficient size and have a sufficient registrant base to continue as standalone regulatory colleges. As a result of previous amalgamations, the College of Nursing Professionals has over 59,000 registrants and is the largest regulatory college in the province.

The College of Physicians and Surgeons, and the College of Pharmacists are large regulatory colleges, and also have unique jurisdiction and responsibilities. The College of Pharmacists has jurisdiction over the Drug Schedules Regulation and the operation of pharmacies in the province. The College of Physicians and Surgeons has jurisdiction over laboratory and diagnostic facilities and non-hospital medical and surgical facilities. These unique program responsibilities add to the need for these regulatory colleges to continue.

[20] Benner, P. (1982) From Novice to expert. American Journal of Nursing, 82(3), p. 402-407.

Creation of an oral health regulatory college. It is proposed that the four oral health regulatory colleges amalgamate to form a single oral health regulatory college. The four oral health regulators include: College of Dental Surgeons of B.C., College of Denturists of B.C., College of Dental Hygienists of B.C., and College of Dental Technicians of B.C. Certified dental assistants would shift from certified non-registrants of the College of Dental Surgeons to registrants of the oral health regulatory college. This would create a large regulatory college with ample resources and expertise in regulation of oral heath professions. This would also simplify system navigation for patients and families with questions or concerns related to oral health professions.

Creation of the College of Health and Care Professions of B.C. A new multi-profession regulatory college, which for the purposes of this paper will be referred to as the College of Health and Care Professions, will be created. The College of Health and Care Professions will be similar to the Health and Care Professions Council in the United Kingdom, which effectively regulates a broad range of professions.[21] The new College of Health and Care Professions will bring together the remaining regulatory colleges. Dissolution of the remaining regulatory colleges will address current resource challenges, improve regulatory effectiveness and create new economies of scale.

Options for remaining regulatory colleges. Regulatory colleges, apart from the oral health colleges, the College of Physicians and Surgeons, the College of Pharmacists and the College of Nursing Professionals will join the College of Health and Care Professions. As an alternative to joining the new College of Health and Care Professions, some regulatory colleges may consider approaching the College of Physicians and Surgeons, the College of Pharmacists, or the College of Nursing Professionals regarding a possible merger.

Mergers between a regulatory college and the College of Physicians and Surgeons, the College of Pharmacists or the College of Nursing Professionals must be supported by rationale for the merger and be approved by the boards of directors of both regulatory colleges. Following approval, board chairs of both regulatory colleges would be required to write to the Minister of Health indicating their mutual support for a merger and outlining rationale for the merger. Cabinet is responsible for making the final decision on whether colleges may merge.

The boards of directors of the College of Nursing Professionals and the College of Midwives have jointly submitted a letter to the minister outlining their support and rationale for an amalgamation. Similarly, the boards of the College of Physicians and Surgeons and the College of Podiatric Surgeons have submitted a letter to the minister outlining their interest in merging. The steering committee is supportive of these proposals.

[21] Health & Care Professions Council.

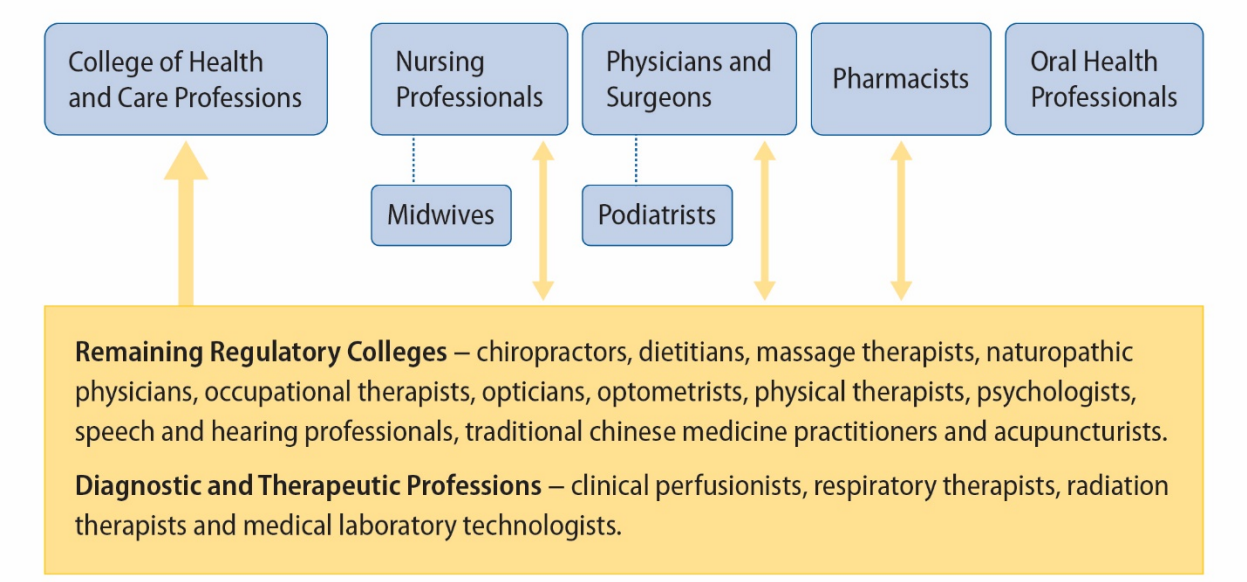
Diagnostic and therapeutic professions. Prior to the release of the Cayton report, cabinet approved creation of a diagnostic and therapeutic professions regulatory college to oversee respiratory therapists, radiation therapists, clinical perfusionists and medical laboratory technologists. If the College of Physicians and Surgeons, the College of Pharmacists, or the College of Nursing Professionals' board has confirmed a willingness to regulate one or more of these professions, the board should write to the minister to confirm its intention. Following receipt of the letter, ministry representatives will work with representatives of the diagnostic and therapeutic professions to determine if there is rationale to support regulation by a regulatory college other than the College of Health and Care Professions.

While a reduction in the number of regulatory colleges is proposed, the intention of this change is not to reduce the number of regulated health professions. All currently regulated health professions will continue to be regulated. A reduction in the number of regulatory colleges does not create a barrier to regulation of new professions. Instead, the process will be streamlined through removal of the costly and time-consuming requirement to set up a new regulatory college each time a new profession is regulated. As set out on page 14, the new oversight body will make recommendations to the minister and cabinet regarding regulation of new professions.

Given the current commitment to a reduction in the number of regulatory colleges, it is proposed that any new health professions be regulated by an existing regulatory college or the new College of Health and Care Professions.

Questions:
Q2a. *Are you supportive of the proposed approach to reduce the number of regulatory colleges from 20 to five?*
Q2b. *Please share your concerns with this approach, as well as your suggestions to address challenges.*
Q2c. *Are you supportive of a moratorium on the creation of new regulatory colleges?*

Figure 1. Proposed arrangement of regulatory colleges



Legislative change to support amalgamations

In November 2017, the *Health Professions Act* was amended to add provisions allowing for the amalgamation of regulatory colleges (Part 2.01). These provisions were used in September 2018 to successfully amalgamate the three former nursing colleges into a single regulatory college.

Submissions from the initial consultation noted that the current legislative provisions may not be suitable in all merger situations due to concerns about the disruption resulting from the amalgamation process. For example, the requirement to dismiss regulatory college boards was cited as an issue in potential mergers of small and large regulatory colleges, where it is intended that the large college continue to function without disruption and absorb the smaller college, leaving its board and bylaws in place.

The creation of broader legislated merger provisions to minimize disruption resulting from future amalgamations is proposed.

Question Q2d: *Do you have suggestions for ways to minimise the disruption caused by a merger of regulatory colleges that can be addressed through broader legislative provisions?*

Subcommittees to ensure clinical expertise

Stakeholders expressed concern that access to profession-specific clinical expertise could be lost in a transition to fewer regulators. For example, profession-specific clinical expertise is needed in the development of clinical standards of professional practice. The continued reliance on profession-specific knowledge and expertise is acknowledged as an important element of any future system. Sub-committees will be created to ensure that regulatory colleges continue to have access to profession-specific expertise and that understanding of professional context is maintained for effective regulation.

There would be a clear separation between professional sub-committees - responsible to establish clinical standards for professions - and the board which is responsible for governance. Regulatory college board members would be unable to serve as members of sub-committees.

It is proposed that sub-committees will be created within multi-profession regulatory colleges to address matters requiring profession-specific clinical expertise.

Question Q2e: *The importance of and continued reliance on profession-specific clinical expertise is acknowledged as an important element of effective regulation; for example, in the development of professional standards. Where is profession-specific experience required to ensure effective regulation?*

3. Strengthening the oversight of regulatory colleges

It is becoming common for governments to establish independent bodies to 'regulate the regulators' as part of a transparent regulatory system. To restore public trust in natural resource decision making, the government passed the *Professional Governance Act* (2018), which establishes the Office of the Superintendent of Professional Governance as an authority on professional governance matters in the natural resource sector.[22] The Cayton report suggests a new independent body be created to oversee health regulatory colleges (the **oversight body**).

In previous public consultation, submissions were broadly supportive of the creation of an oversight body, with particular interest in increasing accountability and consistency of regulatory colleges. At present, it is difficult for the public to find objective information on how health profession regulatory colleges are performing. An oversight body would increase accountability and transparency by defining performance standards for regulatory colleges, measuring performance against those standards, and publicly reporting on regulatory performance and opportunities for improvement. The steering committee supports a process that includes all parties in the appointment of the head of the oversight body.

Creation of a new oversight body with the following responsibilities is proposed:

1. **Routine audits of regulatory colleges based on clear performance standards.**
2. **Public reporting on common performance standards.** All regulatory colleges would be required to provide the oversight body with common performance data. Regular, consistent reporting would allow the public, policymakers and legislators to acknowledge good performance and determine where improvement may be required.
3. **Conducting systemic reviews and investigations.** The oversight body would conduct investigations into regulatory college performance and undertake systemic reviews on its own or at the request of the minister and would have the authority to make recommendations (e.g., the replacement of a regulatory college board with a public administrator). The minister could direct a regulatory college to implement the oversight body's recommendations.
4. **Review of registration and complaint investigation decisions.** The Health Professions Review Board would become an arm of the oversight body and continue to carry out independent reviews of registration and complaint investigation decisions made by regulatory colleges. Its role would not be expanded at this time as the creation of an oversight body would result in significant improvements to accountability and transparency of the overall provincial regulatory environment.
5. **Publishing guidance on regulatory policy and practice.** The oversight body would be responsible for analyzing performance data and publishing guidance in support of improvements across the regulatory system, with the aim of protecting patients from harm and improving overall quality of care.

[22] Government of British Columbia. Qualified professional legislation to restore public trust in natural-resource decision-making. News release. Oct. 22, 2018.

6. **Identify core elements of shared standards of ethics and conduct across professions.** The oversight body would work with regulatory colleges to facilitate a collaborative process to support alignment of common elements of standards of ethics and conduct across professions. Regulatory colleges would continue to have the authority to add to their standards of ethics and conduct; however, there will be an expectation that certain core elements, as established by the oversight body, are present in the standards of all regulatory colleges. Patients could expect increased consistency in standards of conduct, while allowing for some differences based on the care provided by the profession.

7. **Establishing a range of standards of professional practice.** Regulatory colleges would continue to have the authority to create standards of professional practice and responsibility for the content of those standards; however, the oversight body could require regulatory colleges to create or update certain standards of professional practice. This would increase consistency of standards across health professions, while respecting profession-specific clinical expertise. The oversight body would monitor emerging practice issues to keep the range of standards of professional practice up-to-date.

8. **Development of model bylaws and oversight of the process for bylaw amendments.** Working with regulatory colleges, the oversight body would develop a common set of model bylaws to support consistency, particularly in matters related to governance. To simplify the process for bylaw amendments, the posting and filing periods for bylaws that align with the model bylaws would be shortened or removed.

   Responsibility for the review and filing of bylaws would shift from ministry staff to the oversight body. The minister and oversight body would have the authority to disallow certain bylaws.

9. **Overseeing a board member appointment process.** The boards of directors of regulatory colleges would be appointed through a transparent, competency-based appointment process – developed and managed by the oversight body. This process would involve the regulatory colleges in identifying the desired competencies, diversity and experience required. The head of the oversight body would make a recommendation to the minister on board appointments.

   The oversight body would use the same process to facilitate appointments to the discipline panel (discussed starting on page 16 of this paper).

10. **Recommending health occupations that should be regulated under the *Health Professions Act.***

    New professions – The oversight body would recommend to the minister which, if any, unregulated occupations should become regulated. This recommendation would be based on the level of risk the occupation's activities have on public health, considering both the likelihood of harm and its severity should harm occur. The oversight body would also recommend how to address the risk of harm posed by an occupation, including whether another form of oversight might be more appropriate. If the minister accepts a recommendation for regulation under the *Health Professions Act* it would go to cabinet for final decision.

    Existing professions not regulated under the Health Professions Act – Not all regulated health professions fall under the umbrella of the *Health Professions Act*. For example, emergency medical assistants are regulated by a government-appointed licensing board under the *Emergency Health*

Services Act. Some social workers are overseen by a regulatory college under the *Social Workers Act,* while other social workers are overseen by their employer, the Ministry of Children and Family Development. In the future, the oversight body could assess and recommend whether the public interest could be better served if certain existing professions were to be regulated under the *Health Professions Act* and, if so, by which regulator.

The steering committee has noted that there is opportunity to consider improvements to how emergency medical assistants, social workers and counselling therapists are regulated. The oversight body may wish to prioritize review of these groups.

11. **Holding a list (single register) of all regulated health professionals.** The oversight body would be responsible for creating an online list of all regulated health professionals that is publicly-accessible and easy to search. Responsibility for inputting data would rest with regulatory colleges.
12. **Oversight of systemic progress on timeliness of the complaint process.** The oversight body would monitor regulatory colleges' systemic progress on meeting time limits; and provide guidance on complaints' resolution best practices, including guidance related to timeliness. Concerns about timeliness of individual complaints would continue to be reviewed by the Health Professions Review Board.
13. **Collection of fees.** The oversight body would be given the authority to collect fees from regulatory colleges in the future. It is envisioned that initial funding for the oversight body will be provided by government.

Questions:
Q3a. *Do you support the creation of an oversight body?*
Q3b*. Do you agree with the functions listed above*?
Q3c. *Do you have any concerns and if so, what are they?*

Increased accountability to the Legislative Assembly

The *Health Professions Act* requires regulatory colleges submit an annual report to the Minister of Health. To increase transparency and accountability of the regulatory framework to the Legislative Assembly, the minister will be required to table the annual reports of regulatory colleges and the oversight body in the Legislative Assembly.

It is proposed that annual reports of regulatory colleges and the oversight body be provided to the Legislative Assembly by the Minister of Health.

Questions:
Q3d. *Do you support increased accountability by requiring regulatory colleges' annual reports to be filed with the Legislative Assembly?*
Q3e. *Should annual reports of the oversight body also be filed with the Legislative Assembly?*

4. Complaints and adjudication

The Cayton report brings to light challenges with the current complaints investigation and discipline process set out in the *Health Professions Act* and undertaken by regulatory colleges. The report finds this process "needs significant revision to make it more efficient and effective, transparent and fair."[23] In particular, the report notes there is a need to create a clearer separation between the investigation and discipline stages of the complaints process.

The need for transparency and fairness in the complaints and discipline process were common themes from earlier public consultation. Members of the public who made complaints to regulatory colleges reported finding the process to be cumbersome and commented on delays and unsatisfactory resolutions. Health professionals and associations also highlighted the need for a timely and fair process. Regulatory colleges and health-sector stakeholders spoke to the necessity for professional clinical expertise in investigations and discipline.

Simplifying the complaints and discipline process is proposed in order to provide a clear focus on patient safety, public protection and strengthening public trust in regulation.

Proposed changes would include:

- Establishing a new disciplinary process that would create clear separation between the investigation and discipline stages of complaints. Regulatory colleges would continue to investigate complaints; however, disciplinary decisions would be made by a separate independent process.
- Increasing transparency by requiring that actions resulting from accepted complaints be made public.
- Removing the ability of professionals to negotiate agreements late in the process.

New independent discipline process

The Cayton report finds a lack of separation between the investigation of complaints and the disciplinary decision-making stage of the process, noting "separation of investigation from **adjudication** is a common principle of law which currently does not apply under the [*Health Professions Act*]."[24]

The report recommends that a new adjudication body be established, separate from regulatory colleges, to make disciplinary decisions regarding regulated health professionals.[25] Most prior public consultation submissions supported an adjudication body.

A new discipline process would be created, in which disciplinary decisions would be made by discipline panels independent of regulatory colleges. This new process would further separate the investigation stage of complaints (undertaken by regulatory colleges) from the discipline stage and provide consistency across regulated health professions. The use of a panel approach supported by the oversight body would be more efficient than creation of a new body.

[23] Cayton report, p.77.
[24] Cayton report, p.87.
[25] Cayton report, p.86-87.

The oversight body would support establishment of a pool of qualified discipline panel members. The Minister of Health would appoint an executive panel lead who would select a specific panel for each discipline hearing depending on the competencies required to decide the matter. Regulatory college board members and senior-level staff within related health professional associations would be ineligible for panel membership.

A panel for each discipline hearing would include at least one health professional with clinical competence in the same health profession as the registrant facing the complaint and at least one public member (non-health professional). Three-member panels are envisioned; however, panels would be larger in complex complaints. Single-member panels would make decisions on simple matters (e.g., a registrant's failure to respond to a regulatory college in a timely way regarding a complaint).

A new disciplinary process is proposed in which independent discipline panels would make decisions regarding regulated health professionals.

Questions:
Q4a. *Do you support the creation of a new disciplinary process which would be independent from regulatory colleges?*
Q4b. *What are the benefits of such an approach?*
Q4c. *What are possible challenges and ways to address these?*

Regulatory college roles in the complaints process

The Cayton report makes a range of recommendations related to the role of regulatory colleges in complaint matters; especially related to the role of inquiry committees. The report recommends regulatory colleges continue to be responsible for investigation of complaints against registrants.[26] During consultation, stakeholders expressed the need to clearly delineate the functions of regulatory college inquiry committees in relation to adjudicative functions of a potential new external disciplinary body.

To improve public trust in the complaints process and ensure that public safety is at the forefront of complaints investigations, regulatory colleges would need to demonstrate their use of a fair and open process to appoint inquiry committee members. Regulatory colleges would need to ensure that inquiry committee membership considers competence, merit and diversity. Also, inquiry committee members would be required to undertake regular training and appraisal. Regulatory college boards would not be involved in complaints and discipline,[27] and persons in senior positions within related health professional associations would be ineligible for inquiry committee and discipline panel membership.

[26] Cayton report, p.86.
[27] Cayton Report, p.87 and p.75.

Regulatory college inquiry committees would continue to have many of their current functions, including to investigate complaints, dismiss vexatious complaints, send caution or advice letters, and to resolve matters consensually via agreements with registrants. Additionally, inquiry committees would have wider discretion to dispose of complaints, in line with the Cayton report's recommendation. Once inquiry committee investigations are complete, committees would refer matters to a discipline panel, where appropriate.

Regulatory colleges and their inquiry committees would continue to be responsible for the investigation of complaints. This will assure professional expertise in the investigation of complaints.

Questions:
Q4d. *Do you support regulatory colleges continuing to investigate complaints regarding health professionals?*
Q4e. *Do you support improvements to the composition of inquiry committees?*

Transparency

The Cayton report finds that "the *Health Professions Act* builds secrecy into the complaints process" and in doing so, protects registrants' privacy but not the public.[28] It reflects that "it should be recognised as a fundamental right of a patient to know about their healthcare provider's competence and conduct."[29] Of significant concern is that when a registrant resolves a complaint by making an agreement with their regulatory college, in some cases public notification can be negotiated and the matter can be kept private. The report recommends that "all or any **sanctions** imposed in relation to complaints" be accessible to the public (via the single online register of professionals).[30] The need for increased transparency in the complaints and discipline process was a frequent theme of feedback during public consultation, specifically the need to disclose information regarding findings of complaints against professionals.

It is proposed that actions taken to resolve accepted[31] complaints about health professionals be made public.

All actions resulting from agreements between registrants and regulatory colleges would become public (e.g., agreements that registrants complete additional training). These actions would be listed under the health professional's name in the single online register and on the regulatory college's website. Public notification would be limited in some circumstances related to practitioner's ill health.[32]

Questions:
Q4f. *Do you support publishing actions taken to resolve accepted complaints about health professionals?*
Q4g. *Do you support all actions resulting from agreements between registrants and regulatory colleges being public?*

[28] Cayton report, p. 82.
[29] Cayton report, p. 82-83.
[30] Cayton report, p.86.
[31] Accepted complaints are those that are not dismissed, and where some action is being taken as a result of the complaint.
[32] *Health Professions Act*. Section 39.3 (4) to (6).

Enable regulatory colleges to make public comments about known complaints

At times, a complaint under investigation may become known to the public through the media or other means. However, regulatory colleges may not provide public information due to interpretation of privacy provisions in the *Health Professions Act*. This may be perceived as a lack of transparency or inaction.

To increase transparency and public confidence, it is proposed that regulatory colleges be allowed to provide limited public comment if a complaint becomes known to the public, modeled after similar public notification rules of the Law Society of British Columbia.[33] This would allow regulatory colleges to disclose: the existence of a complaint, subject matter, status and any interim undertakings.[34]

It is proposed that regulatory colleges be able to make limited public comments if a complaint under investigation becomes known to the public.

Questions:
Q4h. *Do you support allowing regulatory colleges to make limited public comments about a complaint under investigation if the complaint becomes known to the public?*
Q4i. *What are the benefits of such an approach?*
Q4j. *What are the challenges, and how can these be addressed?*

Ensuring past conduct is considered

The *Health Professions Act* appears to give regulatory colleges discretion on whether past conduct will be considered when current complaints are reviewed. The Cayton report highlights concerns regarding this discretion. The report notes that "a history of upheld complaints is clearly relevant to sanction, particularly if remediation has previously been prescribed but has failed to improve performance."[35]

In order to better protect patients from harm, it is proposed that complaint and discipline decisions must take into consideration the professional's past history.

Questions:
Q4k. *Do you support requiring that regulatory colleges and disciplinary panels consider a registrant's past history of complaints and discipline when making decisions on a current complaint?*
Q4l. *What are the benefits of such an approach?*
Q4m. *What are the challenges and how can they be addressed?*

Time limits and timeliness

Timely investigations and conclusions of complaint matters are important to ensuring public safety and confidence in the regulation of health professionals. Regulatory colleges, health professionals, health-sector employers, and public safety agencies may influence timeliness.

[33] Law Society of BC Rules 2015, updated July 2019, 3-3(2).
[34] This is modeled on the Law Society of BC Rules 2015, 3-3(2).
[35] Cayton Report, p.80-81.

The *Health Professions Act* currently sets time limits for how long inquiry committees have to complete complaint investigations (by disposing of complaints), allows the suspension of investigations if they are delayed, and gives certain powers to the Health Professions Review Board to investigate and respond.[36] The Cayton Report notes that "statutory time limits take no account of reality (complexity of cases, actions by the registrant, actions by lawyers, circumstances outside the college's control, resources available) and there are other better ways of improving timelines" and recommends removing the statutory time limit for how long inquiry committees have to complete investigations/dispose of matters.[37]

Time limits would be set for stages of the investigation process to encourage timeliness and transparency, instead of a statutory time limit for the overall length of time that investigations must be completed in. Time limits for stages in the investigation process would strengthen the requirements on registrants to co-operate with investigations. Time limits for points in the investigation process would be specified, and may include:

- A set number of days in which registrants are required to respond to a complaint.
- A set number of days in which regulators must respond to and update the complainant.
- Time limits for negotiations between registrants and inquiry committees, which may include limiting how long registrants have to make proposals to the inquiry committee once a citation has been issued for a disciplinary panel hearing. This would help to resolve complaints more quickly and could reduce costs.

The Health Professions Review Board would continue to be responsible for reviewing concerns of complainants when regulatory colleges do not meet time limits in the investigation process. The oversight body would be responsible for monitoring regulatory colleges' systemic progress on meeting time limits and for encouraging improvements.

It is proposed that time limits be set for stages of the investigation process, instead of a statutory time limit for the length of time that investigations must be completed in.

Responses to sexual abuse and sexual misconduct

The *Health Professions Act* leaves discretion with regulatory colleges in how they address sexual abuse and misconduct. Alberta and Ontario have taken specific measures to address sexual abuse by health professionals, these include mandatory cancellation of practice for sexual abuse, and requiring regulatory colleges to fund counselling for victims. Many other provinces do not have such measures.

The steering committee is seeking feedback to help establish consistency across regulatory colleges in relation to how they address sexual abuse and sexual misconduct.

Question Q4n: *What measures should be considered in relation to establishing consistency across regulatory colleges regarding how they address sexual abuse and sexual misconduct?*

[36] *Health Professions Act*. Section 50.55.
[37] Cayton Report, p.83.

5. Information sharing to improve patient safety and public trust

In matters of multi-profession complaints (i.e., a complaint regarding care from a team of health professionals) and patient safety matters, information sharing is needed in order to protect the public. Regulatory colleges, along with all parts of the health profession regulatory system, must work together to improve patient safety and secure public trust in health professionals.[38]

During public engagement, regulatory colleges noted that legislative barriers to information sharing made it difficult to work with other health system stakeholders. Information sharing between regulatory colleges, health authorities and other agencies is affected by multiple pieces of legislation. It was suggested that statutory changes are required to allow effective communication among regulatory colleges and with other agencies. It was also suggested that regulatory colleges should be responsible for co-ordinating team-based care complaints, so that patients only have to connect with one regulator.

It is proposed that health profession regulatory colleges be enabled to share information (between each other and with other agencies) where necessary for public safety and protection.

Questions:
Q5a. *What are the benefits of enabling regulatory colleges to more easily share information?*
Q5b*. What are the challenges of this approach and how can they be addressed?*
Q5c*.What organizations should regulatory colleges be able to share information with in order to protect the public from future harm, or address past harms?*

Next steps

Feedback from British Columbians and health-sector stakeholders will assist the steering committee to finalize recommendations for modernization of health profession regulation. Following the public consultation period, a summary of feedback received will be shared.

[38] *Regulation rethought: Proposals for reform*. Professional Standards Authority. October 2016. Page 4.

Appendix A: Glossary of Terms

Adjudication: To make a formal judgement or decision on a disputed matter.

Audit or audits: In the context of this paper, an audit is a routine assessment, conducted by the oversight body, of the performance of regulatory colleges.

Competency-based appointment process: A process by which individuals are assigned to a position of responsibility based on demonstrated competency, experience and skill.

Oversight body: In the context of this paper, a dedicated body responsible for promoting regulatory best practices and holding regulators to account through rigorous reporting and review mechanisms.

Registrant or registrants: Refers to a health professional(s) registered with a regulatory college under the *Health Professions Act.*

Regulation: Regulation is a means to control an activity, process or behaviour, usually by means of rules made by government or other authority.

Regulatory college: In B.C., regulated health professionals are governed under the *Health Professions Act*. The act establishes regulatory colleges that are responsible for ensuring that regulated health professionals provide health services in a safe, professional and ethical manner. A regulatory college's legal obligation is to protect the public through the regulation of their registrants.

They do this by:

- Determining registration requirements;
- Setting standards of practice;
- Recognizing education programs;
- Maintaining a register that everyone can search;
- Protecting certain titles; and,
- Addressing complaints about their registrants.

Review/investigation: In the context of this paper, a review or investigation is an in-depth examination of a regulatory college (or groups of regulatory colleges), conducted by the oversight body for a specific purpose.

Sanction: Penalties or other means of enforcement used to provide incentives for obedience with the law, or with rules and regulations.

Appendix B: List of regulatory colleges and regulated professions in British Columbia

Regulatory College	Reporting Year	Practising Registrants	Total Registrants (all categories, including non-practising)
College of Chiropractors of B.C.	2017/18[39]	1,215	1,252
College of Dental Hygienists of B.C.	2018/19		4,012
College of Dental Surgeons of B.C.	2018/19	Dentists: 3,725 Certified Dental Assistants: 6,138 Dental therapists: 7	**Total:** 10,432 Dentists: 3,851 Certified Dental Assistants: 6,574 Dental therapists: 7
College of Dental Technicians of B.C.	2018/19	Dental Technicians: 386	**Total:** 995 Dental Technicians: 393 Dental Technician Assistants: 559 Student: 43
College of Denturists of B.C.	2018/19	260	268
College of Dietitians of B.C.	2018/19	1,284	1,318
College of Massage Therapists of B.C.	2017/18	4,564	4,759
College of Midwives of B.C.	2018/19	293	379
College of Naturopathic Physicians of B.C.	2018	597	705
B.C. College of Nursing Professionals	2018	Registered nurse: 39,921 Nurse practitioner: 525 Licensed practical nurse: 13,168 Registered psychiatric nurse: 2,913 Graduate & employed students: 688	**Total:** 59,493 Registered nurse: 41,636 Nurse practitioner: 552 Licensed practical nurse: 13,477 Registered psychiatric nurse: 3,139 Graduate & employed students: 689
College of Occupational Therapists of B.C.	2017/18	2,469	2,575
College of Opticians of B.C.	2018/19	981	1011

[39] Annual reporting cycles differ between regulatory colleges (i.e., fiscal year reporting vs. calendar year reporting). Information in this document was obtained from the latest published annual reports from each college.

Regulatory College	Reporting Year	Practising Registrants	Total Registrants (all categories, including non-practising)
College of Optometrists of B.C.	2018	811	815
College of Pharmacists of B.C.	2018/19	Pharmacists: 6,272 Pharmacy technicians: 1,576	**Total:** 8,772 Pharmacists: 6,321 Pharmacy technicians: 1,583 Student: 868
College of Physical Therapists of B.C.	2018	4,192	4,436
College of Physicians and Surgeons of B.C.	2018/19	12,960	13,724
College of Podiatric Surgeons of B.C.	2018	78	85
College of Psychologists of B.C.	2018	1,255	1,331
College of Speech and Hearing Professionals of B.C.	2018		**Total:** 1,864 Audiologists: 43 Hearing instrument practitioners: 265 Speech language pathologists: 1,300 Multi-profession registrants: 256
College of Traditional Chinese Medicine Practitioners and Acupuncturists of B.C.	2018/19	2,267	2,361

BRIEFING NOTE

To: **Council**

From: **Quality Assurance Committee - Panel B**

Date: **December 6, 2019**

Subject: **Standard of Practice: Record Keeping – Revisions**

The original Standard of Practice: Record Keeping was drafted and approved in 2015 and implemented on January 1, 2017.

Since then, the format the Standards of Practice has been modified to provide members of the profession with a more accessible format. Increasing the accessibility of information in the Standards assists members of the profession with understanding the expectations articulated in the Standards and, consequently, the incorporation of the expectations into the clinical practice of Registered Denturists. Council will be familiar with this newer format.

Since the Standard of Practice: Record Keeping existed in the old, much lengthier format, the Quality Assurance Committee – Panel B considered a revision of this Standard to bring its format in line with the format of Standards that have been developed (and approved) in the new format. This revised format is presented today for Council's consideration. The information in the old Standard and the accompanying Guide has been incorporated into the new Standard and the accompanying Guide and FAQs. The FAQs were developed to reduce the length of the current Guide.

Options:

After review of the relevant documents, Council may:

1. Adopt the proposed amendments to the revised Standard of Practice: Record Keeping and approve the draft for stakeholder consultation.
2. Modify the proposed amendments, adopt the modified amendments and then post the Standard for stakeholder consultation.
3. Return the draft documents to Quality Assurance – Panel B with comments and a request for further revision. This revision would be returned to Council for consideration.
4. Other

COLLEGE OF DENTURISTS OF ONTARIO

STANDARDS OF PRACTICE: RECORD KEEPING

Standards of Practice are a validated set of expectations that contribute to public protection. The Standards define the expectations for the profession, communicate to the public the Denturists' accountability and guide the Denturist's practice. The College or other bodies may use the Standards of Practice in determining whether appropriate standards and professional responsibilities have been met. In the event of any inconsistency between this Standard and any legislation that governs the profession, the legislation prevails.

Introduction

Documentation and maintaining records is a key component of a Denturist's practice. Documentation whether paper, electronic or digital is used to provide evidence of service, monitor treatment plans, support recall of information, and identify who did what, and when.

This Standard of Practice explains the regulatory expectations for documentation and record keeping. It takes into account applicable legislation and regulations that impact denturism practice. To help Denturists understand their legal and professional obligations, the content is presented as a set of standard statements which describe a broad practice principle. Each standard statement is followed by a corresponding performance indicator that explains how a Denturist would meet the standard when documenting and maintaining records.

Purpose of Record Keeping

The patient record should provide a clear understanding of the patient goals, plan of care, services provided, cost of services, evaluation and outcomes. Information captured in the record can be used for many purposes: 1) to determine the care and services provided; 2) to evaluate professional practice as part of quality assurance requirements; 3) for Denturists to reflect on their practice; and 4) to provide evidence in a court of law or College tribunal.

The physical patient record is owned and held by the Denturist (known as the custodian and/or agent) but information contained in the record is owned by the patient. Therefore Denturists are highly accountable to ensure information is accurate, secure and kept from unauthorized access. Denturists also have an obligation to know the patient's rights with regards to accessing records in accordance with applicable laws.

Failing to keep records as outlined in the Standard, falsifying a record, signing or issuing a document that the Denturist knows is false or misleading, collecting, using, and disclosing information without patient consent and failing to make arrangements for the timely transfer of a patient's record when required all constitute professional misconduct under the *Denturists Act, 1991* and may result in College proceedings.

Glossary

Agent	Any person who is authorized by a health-information custodian to perform services or activities on the custodian's behalf.
Confidentiality	A set of rules or a promise that limits access to or places restrictions on certain types of information. Patient confidentiality is based on the principle that information should not be revealed to any third party without the patient's consent.
Attestation (to attest)	The process of assigning responsibility and authority for an activity, usually by applying a signature.
Record	A record may include the patient's medical record, an appointment book, video recordings, photographs, dentures, rough notes that might not be

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	kept with the record, invoices, billable receipts, consent forms, release forms, patient education materials and information sheets, a master signature list, a laboratory script, and any other documentation relevant to the patient's treatment and/or interaction with the Denturist and others.
Custodian (health information custodian)	A person or organization with custody or control of personal health information as a result of or in connection with performing the person's or organization's power or duties.
Information	Information includes both personal non-health (e.g. phone number, email address, address, birth date) and personal health information.
Encryption	Coding that protects access to electronic data. Encryption is the most effective way to achieve data security. To read an encrypted file, the individual must have access to a security key or password that removes the encryption.
Lock Box	The term adopted by the health-care community to refer to the situation when a patient shares information but asks that it be kept out of the patient record. Individuals may also provide instructions to health-information custodians not to use or disclose their personal information for health-care purposes. The health information custodian is required to respect the request of the individual and ensure that no unauthorized collection, use or disclosure of the information occurs. The custodian records such expressed instructions or limitations on the consent to collect, use or disclose personal health information. When a lock box has been triggered the Denturist can advise any third party that personal health information has been lock boxed. The specifics of the lock boxed information must remain confidential and not be disclosed to a third party.
Security	The degree of protection from loss, damage, disclosure, or misuse.
Substitute Decision-Maker (SDM)	A person described in the *Health Care Consent Act, Substitute Decision-Maker Act* or *Personal Health Information Protection Act* as a person who is authorized under these acts to consent on behalf of the individual.
Unique Identifier	An identifier includes the date of birth, the patient's name, or the unique alpha-numeric code assigned to a record to ensure that information belonging to a patient exists in only one patient profile.

The Standard

Standard Statement	**Performance Indicators**
Documentation is accurate, clear, concise, and presents a comprehensive picture of provided services.	1. Maintains records in an organized, logical and systematic fashion to support ease of retrieval of information.
	2. Ensures documentation is legible and written in either English or French.
	3. Ensures the patient health record contains the following: a. the patient's name, address and date of birth; b. dental and relevant medical history; c. name of emergency contact person and contact information; d. name of the primary-care physician and any referring health professional; e. medication and supplement use; f. information obtained during the examination performed by the Denturist; g. clinical findings and professional opinions of the Denturist; h. when a Denturists either refers a patient or accept a referral the records include the reason for the referral, and name of the professional accepting or referring; i. information about advice provided and patient education

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Standard Statement	Performance Indicators
	that occurred; j. the date and nature of all patient's interactions, including patient services related to any repairs and/or adjustments made; k. information about any procedure that was commenced but not completed and the reason for the non-completion; l. documentation of a refund and the reason for the refund; m. a unique identifier on every part (or page) of the patient record; n. a copy of the external laboratory design prescription; o. a notation documenting the informed consent process according to the Standards for Consent; and p. a copy of the signed consent form, if obtained.
	4. Clearly notes the unique identifier and date on all multi-media data (e.g. pictures of the patient, images of teeth /oral cavity, dentures, email messages, video tapes).
	5. Maintains a master signature list if initials are used to attest the records.
	6. Documents in a timely manner and completes documentation during or soon after the services or event.
	7. Corrects and initials errors while ensuring the original information is visible or retrievable.
	8. If the only service a member provides is a repair of dentures that the member did not fabricate, the record for the repair need only contain: a. the patient's name, address, birth date and contact information; b. the date and nature of the repair; c. the name of the treating Denturist(s); d. advice given to the patient; e. clinical findings and professional opinions; f. a notation of the assessment if conducted; and g. a notation documenting the informed consent process according to the Standards for Consent.
	9. Patient requests for a change in the record can be made in writing or requested orally. a. The Denturist makes changes to the record if he/she agrees the information is incomplete or inaccurate, within thirty days from the receipt of request. b. The Denturist documents the request and the rationale for the change. c. The Denturist is not obligated to make changes to records he/she believes are accurate or complete. This is particularly true when the entry contains an evaluative component or an expression of the professional opinion. d. In the event a change is not made, the Denturist attaches a statement of disagreement reflecting the correction requested. e. The Denturist gives notice of every correction made and every statement of disagreement attached to the patient record to every person and organization to which the record was disclosed during the 12 months preceding the date the correction was requested.

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Standard Statement	Performance Indicator
Records maintained in electronic form meet the Standard of Practice, regulations and legislation.	10. Ensures individual patient records are easily retrievable.
	11. Takes reasonable steps to ensure that records maintained in electronic form are secure from loss, tampering, interference or unauthorized use or access.
	12. Confirms the system maintains an audit trail that, at a minimum, records the date and time of each entry of each patient, shows any changes in the record, and preserves the original content when a record is changed, updated or corrected.
	13. Ensures regular off-site back-up and/or automatic back-up for file recovery to protect records from loss or damage.
	14. If documents are scanned and maintained in an electronic form, the original paper copy may be securely destroyed.

Standard Statement	Performance Indicators
Records are collected, maintained, shared and disclosed in a secure and confidential manner in accordance with applicable legislation and regulations.	15. Denturists who act as the custodian: a) ensure physical security of all records and personal information (including staff human resource files); b) put in place security systems on electronic devices (e.g. passwords, user IDs, encryption, firewall and virus scans); c) display the privacy and confidentiality policy and ensure it is visible to the public; d) train staff on security and confidentiality policies; e) act as or appoint a privacy officer; f) regularly audit the practice for compliance with security policies and confidentiality agreements; and g) notify patients whose personal health information has been compromised (stolen, lost, or accessed by an unauthorized person).
	16. Take reasonable steps to transfer patient records before resigning as a member or selling practice in accordance with the Standards for Professional Communications.
	Denturist:
	17. Collects and stores only necessary information that pertains to the services provided.
	18. Obtains and documents patients' informed consent prior to the collection, use, storage and release of information, digital images and impressions, according to the Standards for Confidentiality and Privacy.
	19. Retains patient records for a period of seven (7) years, either in paper or electronic form, from the date of the last entry.
	20. Maintains draft notes as a component of the patient record until such time as the notes are transcribed into the record and ensures all data is captured in the record before destruction of the notes.
	21. Ensures the maintenance of multi-media data (pictures of the patient, images of patient's teeth or oral cavity, patient's dentures, email messages, or other digital images or recordings) comply with the same collection, retention, use and disclosure legislation and standards as paper notes.
	22. Maintains a daily appointment record which sets out the name of each patient seen by the Denturist.
	23. Shares information and/or allows access to the patient record only for the purpose of providing services or assisting in the provision of care; for the purpose of seeking legal counsel or insurer advice being sought by the member or required by the member's policy of insurance; as ordered by a subpoena; or to

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Standard Statement	Performance Indicators
	comply with the *Regulated Health Professions* Act, (e.g. release patient records for the purpose of College Quality Assurance program or College investigation).
	24. Facilitates the right of patients and/or substitute decision-makers to access, inspect, and/or obtain a copy of the patient record, unless the Denturist reasonably believes there is serious risk of harm to the care of the patient or serious physical or emotional harm to the patient or another person.
	25. Provides a report or certificate relating to an examination or treatment performed by the Denturist within thirty days of a request from the patient or his or her substitute decision-maker.
	26. Provides patient records to the patient within a reasonable time on request, though a reasonable fee for the copying of a patient record may be collected first. (Denturists may refuse to release the record until such fees are paid, unless there is risk of harm to the patient if the information is not released.)
	27. Takes measures to ensure all information is kept secure and access is limited to authorized personnel only. (e.g. password protect documents, use of encryption, log off computer, lock filing cabinets, computer back-up).
	28. Respects patient requests to withhold information in the record (See glossary "Lock Box").
	29. Notifies the patient of a breach of security via unauthorized access, loss or theft of information.
	30. Obtains patient's informed consent before communicating by email and/or sending information electronically, explaining the potential risk of another person's access to information.
	31. Ensures the intended recipient of a facsimile is named on the document and places a confidentiality statement on the bottom of the facsimile.
	32. Takes reasonable steps to ensure security of information when transporting patient records or information (e.g. moving from one office to another, bringing patient files home).

Standard Statement	Performance Indicators
Records eligible for destruction are destroyed in a secure and confidential manner.	33. Ensures all information is permanently destroyed or erased in an irreversible manner making sure the record cannot be reconstructed in any way.
	34. Maintains a copy of the destruction date and the names of the individuals whose records were destroyed.
	35. Seeks consultation on the secure destruction of multi-media and computer files from a field expert.

Standard Statement	Performance Indicators
Financial records are kept as part of the patient record or linked by the unique identifier.	36. Maintains an account of all charges for services, which accurately reflects services provided.
	37. Issues an invoice which Includes the following: a) the Denturist's company name, address and phone

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	number; b) the patient's/recipient's name and address; c) the cost of the item/services; d) the date and method of payment received; e) balance due or owing; and f) if applicable, the fees charged by commercial laboratory.
	38. Issues a receipt for all payments received and a credit receipt for all refunds.
	39. Ensures a process is in place to provide upon request, an itemized account of fees charged for professional services, using terminology understood by the public.

Standard Statement	**Performance Indicators**
All services to, maintenance for and inspection of equipment and/or instruments are tracked.	40. Maintains an up-to-date record of service to and maintenance for equipment and/or instruments (e.g. safety datasheets, autoclave testing).
	41. Maintains equipment records for a minimum of seven (7) years from the date of the last entry, even if the equipment has been discarded.

Standard Statement	**Performance Indicators**
Takes reasonable steps when closing the clinic and/or resigning registration to ensure patients have access to their records.	42. Makes appropriate arrangements with the patient for the transfer of the patient's records when the member ceases practice, or when the patient requests the transfer.
	43. Makes reasonable efforts to notify patients before transferring records to a new custodian, or as soon as possible thereafter.
	44. Makes reasonable efforts to inform patients of the intent to close the clinic and/or resign, and provides information on how to access and /or obtain a copy of the record.

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References

Regulated Health Professions Act, S.O. 1991

Denturism Act, 1991 Ontario Regulation 854/93 Professional Misconduct Regulations
http://www.ontario.ca/laws/regulation/930854

Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A
http://www.ontario.ca/laws/statute/04p03

Your Health Information: Your Access and Correction Rights, Information and Privacy Commission of Ontario; 2005
https://www.ipc.on.ca/images/Resources/fact-02-e.pdf

Safeguarding Personal Health Information Fact Sheet #01, Information and Privacy Commission of Ontario; 2005
https://www.ipc.on.ca/images/Resources/fact-01-e.pdf

Secure Destruction of Personal Information, Information and Privacy Commission of Ontario; 2005
https://www.ipc.on.ca/images/resources/up-fact_10_e.pdf

Disclosure of Information Permitted in Emergency or other Urgent Circumstances, Information and Privacy Commission of Ontario; 2005
https://www.ipc.on.ca/images/Resources/fact-07-e.pdf

Lock Box Fact Sheet, Information and Privacy Commission of Ontario; 2005
https://www.ipc.on.ca/images/Resources/fact-08-e.pdf

A Guide to Personal Health Information Protection Act, Information and Privacy Commission of Ontario; 2004
https://www.ipc.on.ca/images/resources/hguide-e.pdf

Frequently Asked Questions: Personal Health Information Act, Information and Privacy Commission of Ontario; 2005
https://www.ipc.on.ca/images/Resources/hfaq-e.pdf

Electronic Records: Maximizing Best Practice, Information and Privacy Commission of Ontario; 1997
https://www.ipc.on.ca/images/Resources/elecrec.pdf

Council Approval Date	March 4, 2016
Effective Date	January 1, 2017

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COLLEGE OF DENTURISTS OF ONTARIO

Standard of Practice: Record Keeping

Preamble

Documentation and the maintenance of patient records is a key component of a Registered Denturist's practice. Documentation in all mediums is used to provide evidence of service, monitor treatment plans, support the recall of information, and identify who did what, and when.

The patient record should provide a clear understanding of the patient goals, plan of care, services provided, cost of services, evaluation and outcomes. Information captured in the record can be used for many purposes: 1) to determine the plan of care and recall the services provided; 2) to evaluate professional practice as part of quality assurance requirements; 3) to reflect on practice; and 4) to provide evidence in a court of law or College tribunal.

The physical patient record is owned and held by the Registered Denturist (known as the custodian and/or agent). The information contained in the record is owned by the patient. Registered Denturists must ensure that the information is accurate, complete, secure and protected against unauthorized access. Registered Denturists have an obligation to be knowledgeable of the laws that apply to a patient's rights regarding access of their patient record.

Failing to meet the expectations expressed in this Standard, falsifying a record, signing or issuing a document that the Registered Denturist knows is false or misleading, collecting, using, or disclosing information without patient consent or failing to make arrangements for the timely transfer of a patient's record when required can constitute professional misconduct (*Denturism Act, 1991*).

This Standard of Practice: Record Keeping identifies the expectations of the College for documentation and record keeping by Registered Denturists. It incorporates applicable legislation and regulations.

The Standard

A denturist meets the Standard of Practice: Record Keeping when they:

1. Identify as either a Health Information Custodian or Agent with respect to their patient records and understand and assume the responsibilities and obligations of the identified role, in accordance with applicable legislation and regulations.

2. Ensure documentation is legible and written in, at a minimum, either English or French.

3. Maintain a daily appointment record which sets out the name of each patient scheduled and seen.

4. Assign a unique identifier to each individual patient record.

5. Document accurately, clearly and concisely, and present a comprehensive picture the services provided.

6. Respect patient requests to withhold information that is recorded in the record (i.e. “lockbox”).

7. Amend/correct documentation, if they agree the information is incomplete or inaccurate, within thirty days from the receipt of request from the patient or their substitute decision maker.

8. Ensure patients have access to their records when a clinic is being closed, sold or transferred to another health care practitioner.

9. Provide an examination or treatment report within thirty days from receipt of the request from the patient or their substitute decision maker.

10. Link financial records to the patient record through the assigned unique identifier.

11. Maintain electronic records in accordance with applicable legislation and regulations.

12. Collect, use, disclose and maintain records in a secure and confidential manner, in accordance with applicable legislation and regulations.

13. Document all equipment or instrument service, maintenance, and/or inspection.

14. Retain patient and equipment records in paper or electronic form, for a period of seven years, from the date of the last entry.

15. Destroy eligible records in a secure and confidential manner and maintain a copy of the destruction date along with the names for the records that were destroyed.

Legislative References

Regulated Health Professions Act, S.O. 1991

Ontario Regulation 854/93 Professional Misconduct Regulation
http://www.ontario.ca/laws/regulation/930854

Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A
http://www.ontario.ca/laws/statute/04p03

Related Standards of Practice

Standard of Practice: Confidentiality & Privacy

Council Approval Date	March 4, 2016
Effective Date	January 1, 2017
Revision Approval Date	

Guide to the Standard of Practice: Record Keeping

The College's Standard of Practice: Record Keeping explains the regulatory expectations for documentation and record keeping. This Guide to the Standard offers further information regarding record keeping legislation and regulations that impact denturism practice and how to apply the Standard in practice. The Guide includes frequently asked questions and Practice Scenarios that illustrate elements of the record keeping process.

Retention

Why is the retention period 7 years for patient records?

Through the mandatory 60 day consultation process, the profession validated that a retention period of 7 years is sufficient for patient records.

Can records be kept for longer than 7 years?

Yes, records can be kept for longer than 7 years.

If a patient has not been to a clinic for 2 years and the file is transferred to another denturist (say, in the sale of the clinic), does the new denturist have to keep the record for another full 7 years? Or just the remaining 5?

The denturist would have to keep the record for a total of 7 years from the date of the last visit. Therefore, in this example, the denturist would keep the record for the remaining 5 years.

If I find out that one of my patients is deceased, do I still have to keep their record for 7 years?

Yes. The estate trustee of the deceased patient may request access to the personal health information.

How long do I have to keep the record of destruction for patient files that have been securely destroyed?

The record of destruction should be kept indefinitely. If the practice is transferred to another practitioner, the record of destruction should also be transferred.

For which equipment do I have to maintain records?

The denturist must maintain records for all equipment utilized in the practice (including technological and laboratory equipment).

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What is the time frame for maintaining financial records?

Financial information that is part of the patient record, such as invoices and receipts, should be kept for the duration that the patient record is active.

Denturists should seek advice from Canada Revenue Agency and accounting or legal professionals to determine the retention requirements for other financial records such as tax returns and audits.

Should denturists keep the models or any other physical items related to a patient record?

Denturists can keep the models and other physical items related to the patient record. If storage space is a concern, denturists may consider documenting the materials (i.e. through notation and photographs) and keep that documentation in the patient record.

If a document is scanned into a patient file, can the paper copy be destroyed or does it have to be kept for 7 years as well?

Once a physical document is scanned into a patient file and marked with the unique identifier, it can be securely destroyed.

What happens in the event that a denturist dies and no one purchases the practice? What happens with the files?

Upon the death of a custodian, the estate trustee or the person who assumed responsibility for the administration of the estate becomes the custodian, until custody and control passes to another person who is legally authorized to hold the records. A custodian may divest itself of responsibility for the record by transferring them to an archive.

Reference: https://www.ipc.on.ca/wp-content/uploads/Resources/phipa-faq.pdf

What happens in the event that a clinic is being closed and not sold or transferred to another registered practitioner?

A custodian remains the custodian in respect to a record of personal health information until complete custody and control of the record passes to another person who is legally authorized to hold it. Therefore, the denturist who is the custodian of the records must remain as such until the period of retention has passed for all patients and the records can be securely destroyed.

Reference: https://www.ipc.on.ca/wp-content/uploads/Resources/phipa-faq.pdf

Can I store records in my home or in a storage unit?

Yes. However, it is very important to keep in mind that wherever you are storing records must be secure. In other words, only authorized individuals should have access to the patient records, regardless of where the documentation is stored.

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Does the commercial laboratory fee need to be given to the patient or kept in the patient's file?

The commercial laboratory fee information should be provided to the patient and kept in the patient record.

Why can't a Date of Birth (DOB) serve as a unique identifier?

The DOB can serve as part of a unique identifier. However, it is not uncommon for patients to have the same name and possibly the same birth date. To avoid confusion and reduce the risk of error, it is recommended that the denturist select another way to uniquely identify patient records.

Would the master signature list require a signing at each appointment?

The master signature list is a tool designed to specify the names of the individuals that accessed and/or amended the patient record. This list should be kept in the denturist practice and made available upon request if a patient record is needed for review. If someone new has amended or accessed a record, their name and initials should be added to the master list.

Can I make up my own patient charts? Or do I have to use the chart created from one of the associations?

The College does not require that denturists use templates from any organization, including the associations. It is important to remember that the responsibility of adhering to the Standard of Practice for Record Keeping is the onus of the denturist. Therefore, denturists must ensure that any template they use is in accordance with the Standard.

Clarify what is required for the following performance indicator "must contain information about advice provided and patient education given."

A denturist who provides advice or patient education should note the conversation in the patient record and can include, but is not limited to, the following information: the date, the advice/education provided, the reason for providing the information, and any questions that the patient asked.

How do I acknowledge in the record that the patient understood my advice?

A denturist should note that the patient indicated their understanding of the information being provided to them. When the level of risk warrants it, the denturist should obtain written informed consent through the informed consent process. See the Standard of Practice: Informed Consent and the Guide to the Standard of Practice: Informed Consent for more information.

If someone discloses a lock-box item, does it actually have to be written into the file somewhere? Like on a separate piece of paper?

If a patient discloses a lock box item, the denturist should create a written account of the conversation so that the information can be recalled if/when necessary. However, this document (physical or electronic) should be kept separate from the patient record. The unique identifier should be present so that the documentation can be matched up with the correct patient.

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The notation in the patient record should indicate that information was shared but not disclosed in the record, at the patient's request.

Can I record patient visits on video? Is that sufficient for record keeping?

Denturists who operate video and/or surveillance equipment in their offices must ensure that visitors are aware that they are being recorded through the posting of noticeable signs, particularly in public areas, such as waiting rooms and operatories. Patient appointments may be recorded upon receipt of informed consent by the patient. Patient records should be transcribed after each appointment, either in hardcopy or electronically.

Do I have to transfer my old patient charts to a new chart form?

If you start to use a new chart template or form, you may consider transferring existing patient information to the new form to ensure that all of the required information is now being captured. Alternatively, you can start a new chart for an existing patient using the new template and include the old version of the chart as an appendix to the record.

Does the College recommend any specific software for patient record keeping?

No. The College does not provide recommendations for software or hardware systems. It is suggested that denturists speak to their colleagues and membership associations to inquire about various options, prices and features.

Patient-Related

If the patient refuses to provide any information about his or her medical history, should I treat this patient?

Denturists must be able to assess the patient's suitability for various treatment options. Refusing to provide information about medical history could put the patient at risk of harm. If there is something in the medical history that the patient does not want disclosed on the record, the denturist can make note that a disclosure was made but cannot be shared (the information was "lock boxed").

If the patient still refuses to provide this information, the denturist can refuse treatment.

If we are given fraudulent or incorrect info from patient, can we be accountable?

Denturists can include a disclaimer on their intake forms that requires patients to provide true, honest and accurate information and that assessment and treatment will be delivered based on the information that the patient provides. Denturists who receive fraudulent or incorrect information from a patient or on behalf of a patient should immediately note this in the patient record and consult a legal professional for further advice.

What are my mandatory reporting obligations to report any type of abuse to authorities when the patient has shared information they do not wish to be disclosed (i.e. "lock boxed").

If the patient is under the age of 18, the Child and Family Services Act (CFSA) could apply and permit the denturist to report to the police. However, that will only be triggered if the abuser is the child's parent.

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If the CFSA does not apply, the denturist must comply with the Personal Health Information Protection Act (PHIPA).

If the denturist believes that the disclosure to the police or parents is necessary to eliminate or reduce a significant risk of serious bodily harm to the patient, then he/she will not be breaching PHIPA. This is in light of s. 40(1) of PHIPA which states the following:

> 40. (1) A health information custodian may disclose personal health information about an individual 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. 2004, c. 3, Sched. A, s. 40 (1).

We strongly suggest that the denturist consult with a lawyer to see if he/she has the requisite belief in order to justify the disclosure.

If the patient has capacity (as set out in the Health Care Consent Act) he/she is authorized to provide instructions as to who can and cannot access their personal health information (PHI).

The "lock box" provision normally speaks to sharing PHI with other health care providers. For example, a health care provider is permitted to share PHI with health care providers who are within the circle of care. Express consent is not required for this disclosure. However, the "lock box" provision allows the patient to withhold or withdraw consent or may prohibit or place conditions on the disclosure.

According to PHIPA, once a patient says the PHI is to go in the lock box, it must remain there unless:

- The patient changes their mind and advises the denturist; and/or
- The denturist believes on reasonable and probable 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 denturist should still record the information provided to them by the patient. If using paper files, the information can be kept separately and securely away from the main chart with clear indications that part of the record has been removed under the lock-box provision.

The denturist may wish to ask the patient if he/she is still intent on keeping this information confidential. If they change their mind, this would permit the denturist to disclose the information. The denturist will likely want to provide the patient with resources so that he/she can obtain help.

How do I inform my patients if I am leaving or selling my practice? Can I inform them via an ad in the newspaper? I have seen thousands of patients and sending out a mailing would be costly and time consuming.

Denturists may consider sending an electronic communication such as an email message to patients who have provided an email address. Those without email addresses can be sent paper letters. Denturists can also place notices in newspapers to advise their patients if the clinic is being sold or transferred, is closing or is moving locations.

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If someone purchases a clinic and then is asked by the College to submit a file, should the patient be informed of the file being sent to the College?

If the College is requesting a patient record for an investigation, the denturist must release the record to the College. Denturists should advise patients that their record may be disclosed to the College, as part of their privacy policy and form.

The Personal Health Information Protection Act, 2004 (PHIPA) allows for disclosures related to that Act or others, such as the Regulated Health Professions Act, 1991 (RHPA). For more information, please review the Standard of Practice: Confidentiality & Privacy and the Guide to the Standard of Practice: Confidentiality & Privacy for more information.

What do I do if a patient record goes missing?

If personal health information has been stolen or lost or if it has been used or disclosed without authority (this includes the unauthorized viewing of health records):

- The health information custodian must notify the individual about whom the information relates at the first reasonable opportunity. The notice has to inform the individual that he or she is entitled to make a complaint to the Information and Privacy Commissioner of Ontario.
- As of October 1, 2017, health information custodians will also have to notify the Information and Privacy Commissioner directly of certain privacy breaches.
- An agent that handled the information must notify the responsible health information custodian at the first reasonable opportunity.

Health information custodians have additional reporting obligations to regulatory Colleges (which include the Colleges under the Regulated Health Professions Act, 1991 and the Ontario College of Social Workers and Social Service Workers) if the custodian takes disciplinary action against a member of a College for the unauthorized collection, use, disclosure, retention or disposal of personal health information.

For more information, please review the Standard of Practice: Confidentiality & Privacy and the Guide to the Standard of Practice: Confidentiality & Privacy for more information.

Multi-Disciplinary Practice:

Can we use the same record as other health care practitioners in the office? Or do we have to keep separate records?

Several professions acknowledge that in multi-disciplinary practices, it makes sense to have one record. This is likely more efficient and ensures that all members of the patient's team are aware of the care provided. Each regulated health professional will want to ensure that they comply with their respective college requirements when making such entries. Ideally, the organization who operates the multi-disciplinary practice will take all such requirements into account when stipulating how employees are to document in the record. The Personal Health Information Protection Act (PHIPA) and College standards must be complied with irrespective of the employer requirements. It is important to remember that each individual amending the record must be able to be identified (i.e. through a master signature/initial list).

With respect to billing and appointments, the same principle would apply. As long as the patient knows who provided the treatment on the common invoice, the College will likely be satisfied. The only caveat is if the denturist is practising through a professional corporation. IF that is the case, and the professional corporation is providing the invoice, no other regulated health professionals can bill from that denturist corporation.

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There are certain colleges who mandate that dually registered members (i.e. members who are registered in more than one regulated health college) must maintain separate records and issue separate receipts for each separate profession. The College of Denturists of Ontario is not one of them.

Who do the charts belong to if a denturist works for a dentist office as an associate?

Health professionals have different levels of responsibility depending on whether they are the health information custodian or an agent. If you are a regulated health professional or you operate a group practice, and you have custody and control of personal health information in connection with your duties, then you are a health information custodian for purposes of the Personal Health Information Protection Act (PHIPA).

However, even if you fall under the definition of a health information custodian, if you work for or on behalf of another custodian (such as another regulated health professional, a group practice or a hospital), then you are considered to be an agent of that health information custodian.

A health information custodian is ultimately responsible for the personal health information in his or her custody or control, but may permit an agent to collect, use, disclose, retain or dispose of the information if certain requirements are met.

For more information, please review the Standard of Practice: Confidentiality & Privacy and the Guide to the Standard of Practice: Confidentiality & Privacy for more information.

Practice Scenarios

Record Keeping No. 1

John, a denturist, owns a denture clinic. Carl, another denturist, is an associate of this clinic and therefore an agent of the records. Carl has been working in John's clinic for a number of years but has decided to open his own. Carl never signed a non-competition agreement. Can Carl notify the patients that he treats at John's clinic about his departure?

John is the custodian of the records and Carl is an agent. Carl and John need to have a professional conversation regarding how this change will be communicated to the patients. The denturists need to evaluate how the patients will be best served and work out the business details secondary to that. If the patients provide consent to release their information to Carl, and John agrees, copies of the records could be transferred to Carl's clinic.

Record Keeping No. 2

Debbie, a denturist, has been practising for 45 years in the same clinic, and has built up a busy and successful practice. She decides she is ready for retirement but wonders what she is supposed to do with her patient records. Does she have to retain them herself? Ordinarily she would have to retain patient records for seven years from the last interaction with the patient. But in this case Debbie may be selling her practice to another practitioner to take over the business and patients. If this is the case, she does not have to retain the records herself, but needs to notify the patients of the transfer of their patient records. This can be done through a combination of telling patients on their next visit, sending out letters and placing a notice in the local newspaper. All three of these strategies should be followed unless every patient has been reached in person and by letter.

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Guide to the Standard of Practice: Record Keeping

The College's Standard of Practice: Record Keeping explains the regulatory expectations for documentation and record keeping. It is important for Registered Denturists to maintain records in an organized, logical and systematic fashion to support ease of retrieval of information.

This Guide to the Standard offers further information regarding record keeping legislation and regulations that impact denturism practice and how to apply the Standard in practice. The Guide includes frequently asked questions and Practice Scenarios that illustrate elements of the record keeping process.

Retention

Records Eligible for Destruction:

The record of destruction should be kept indefinitely. If the practice is transferred to another practitioner, the record of destruction should also be transferred.

When destroying eligible patient records, Registered Denturists need to ensure that all information is permanently destroyed or erased in an irreversible manner and make sure the record cannot be reconstructed in any way.

If the Registered Denturists has electronic records, they should seek consultation on the secure destruction of multi-media and computer files from a field expert.

Closing, Leaving, or Selling a Practice:

Denturists must notify patients if they are closing, leaving or selling a practice. They should consider sending an electronic communication such as an email message to patients who have provided an email address. Those without email addresses can be sent paper letters. Denturists can also place notices in newspapers to advise their patients if the clinic is being sold or transferred, is closing or is moving locations.

A custodian remains the custodian in respect to a record of personal health information until complete custody and control of the record passes to another person who is legally authorized to hold it. Therefore, the denturist who is the custodian of the records must remain as such until the period of retention has passed for all patients and the records can be securely destroyed.

Reference: https://www.ipc.on.ca/wp-content/uploads/Resources/phipa-faq.pdf

Upon the death of a custodian, the estate trustee or the person who assumed responsibility for the administration of the estate becomes the custodian, until custody and control passes to another person who is legally authorized to hold the records. A custodian may divest itself of responsibility for the record by transferring them to an archive.

Reference: https://www.ipc.on.ca/wp-content/uploads/Resources/phipa-faq.pdf

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Review the Guide to Closing, Leaving or Selling a Practice for more information.

Charting

Basic Charting Information:

The patient record should contain:

a) the patient's name, address and date of birth;
b) dental and relevant medical history;
c) name of emergency contact person and contact information;
d) name of the primary-care physician and any referring health professional;
e) medication and supplement use;
f) information obtained during the examination performed;
g) clinical findings and professional opinions;
h) reasons for referring a patient or the patient accepting a referral, and the name of the professional accepting or referring;
i) information about advice provided and patient education that occurred;
j) the date and nature of all patient's interactions, including patient services related to any repairs and/or adjustments made;
k) information about any procedure that was commenced but not completed and the reason for the non-completion;
l) documentation of a refund and the reason for the refund;
m) a unique identifier on every part (or page) of the patient record;
n) a copy of the external laboratory design prescription;
o) a notation documenting the informed consent process according to the Standard of Practice: Informed Consent;
p) a notation documenting the consent to collect, use and disclose patient information in accordance with the clinic's privacy policy and according to the Standard of Practice: Confidentiality & Privacy; and
q) copies of the signed consent forms.

Records for Denture Repairs:

If the only service provided is a repair of dentures that the Registered Denturist did not themselves fabricate, the record for the repair need only contain:

a) the patient's name, address, birth date and contact information;
b) the date and nature of the repair;
c) the name of the treating Denturist(s);
d) advice given to the patient;
e) clinical findings and professional opinions;
f) a notation of the assessment if conducted;
g) a notation documenting the informed consent process according to the Standard of Practice: Informed Consent.
h) a notation documenting the consent to collect, use and disclose patient information in accordance with the clinic's privacy policy and according to the Standard of Practice: Confidentiality & Privacy; and
i) copies of the signed consent forms.

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Financial Records:

Registered Denturists must maintain an account of all charges for services, which accurately reflects services provided and the amounts paid for the services.

Registered Denturists also must issue an invoice which Includes the following information:

a) the Denturist's company name, address and phone number;
b) the patient's/recipient's name and address;
c) the cost of the item/services;
d) the date and method of payment received;
e) balance due or owing; and if applicable
f) the fees charged by commercial laboratory.

If a payment is received or a refund is issued, documentation must be provided to the patient with a copy kept in or linked to the patient record.

If a patient requests an itemized account of fees charged for professional services, the Registered Denturist must provide them with that information, using terminology that they would understand.

Electronic Records:

Registered Denturists that keep electronic patient records should keep the following in mind:

a) Ensure individual patient records are easily retrievable.
b) Take reasonable steps to ensure that records maintained in electronic form are secure from loss, tampering, interference or unauthorized use or access.
c) Confirm the system maintains an audit trail that, at a minimum, records the date and time of each entry of each patient, shows any changes in the record, and preserves the original content when a record is changed, updated or corrected.
d) Ensure regular off-site back-up and/or automatic back-up for file recovery to protect records from loss or damage.
e) Securely destroy paper documents once they are scanned and maintained in electronic form.

Registered Denturists should maintain draft notes as a component of the patient record until such time as the notes are transcribed into the record and ensures all data is captured in the record before destruction of the notes. Once a physical document is scanned into a patient file and marked with the unique identifier, it can be securely destroyed.

The College does not provide recommendations for software or hardware systems. It is suggested that denturists speak to their colleagues and membership associations to inquire about various options, prices and features.

Correcting Errors:

Patient requests for a change in the record can be made in writing or requested verbally.

The Registered Denturist must document the request and the rationale for the change. It is important remember that a Registered Denturist is not obligated to make changes to records they believe are

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accurate or complete. This is particularly true when the entry contains an evaluative component or an expression of the professional opinion.

In the event a change is not made, the Registered Denturist must attach a statement of disagreement reflecting the correction requested. The Registered Denturist must also give notice of every correction made and every statement of disagreement attached to the patient record to every person and organization to which the record was disclosed during the 12 months preceding the date the correction was requested.

When correcting a patient record, Registered Denturists should initial the error(s) while ensuring the original information is visible or retrievable.

Patient-Related

Disclosure of Patient Records

Registered Denturists must facilitate the right of patients and/or substitute decision-makers to access, inspect, and/or obtain a copy of the patient record, unless the Denturist reasonably believes there is serious risk of harm to the care of the patient or serious physical or emotional harm to the patient or another person.

Additionally, copies of patient records must be provided to the patient within a reasonable time on request, though a reasonable fee for the copying of a patient record may be collected first. (Denturists may refuse to release the record until such fees are paid, unless there is risk of harm to the patient if the information is not released.)

A Registered Denturist can share information and/or allows access to patient records for the purposes of:

- providing services or assisting in the provision of care;
- seeking legal counsel or insurer advice being sought by the member or required by the member's policy of insurance;
- complying with a subpoena; and/or
- complying with the *Regulated Health Professions* Act, (e.g. release patient records for the purpose of College Quality Assurance program or College investigation).

If the College is requesting a patient record for an investigation, the denturist must release the record to the College. Denturists should advise patients that their record may be disclosed to the College, as part of their privacy policy and form.

The Personal Health Information Protection Act, 2004 (PHIPA) allows for disclosures related to that Act or others, such as the Regulated Health Professions Act, 1991 (RHPA). For more information, please review the Standard of Practice: Confidentiality & Privacy and the Guide to the Standard of Practice: Confidentiality & Privacy for more information.

Multi-Disciplinary Practice:

Several professions acknowledge that in multi-disciplinary practices, it makes sense to have one record. This is likely more efficient and ensures that all members of the patient's team are aware of the care provided. Each regulated health professional will want to ensure that they comply with their respective college requirements when making such entries. Ideally, the organization who operates the multi-disciplinary practice will take all such requirements into account when stipulating how employees are to document in the record. The Personal Health Information Protection Act (PHIPA) and College standards

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must be complied with irrespective of the employer requirements. It is important to remember that each individual amending the record must be able to be identified (i.e. through a master signature/initial list).

With respect to billing and appointments, the same principle would apply. As long as the patient knows who provided the treatment on the common invoice, the College will likely be satisfied. The only caveat is if the denturist is practising through a professional corporation. IF that is the case, and the professional corporation is providing the invoice, no other regulated health professionals can bill from that denturist corporation.

There are certain colleges who mandate that dually registered members (i.e. members who are registered in more than one regulated health college) must maintain separate records and issue separate receipts for each separate profession. The College of Denturists of Ontario is not one of them.

Health Information Custodians and Agents:

A health information custodian is ultimately responsible for the personal health information in his or her custody or control, but may permit an agent to collect, use, disclose, retain or dispose of the information if certain requirements are met. The agent must ensure that the collection, use, disclosure, retention or disposal of the information is permitted by the custodian, is necessary for purposes of carrying out the agent's duties, is not contrary to law and complies with any specific restrictions imposed by the custodian.

Health information custodians have these additional administrative duties:

- to develop and comply with policies (known as "information practices") with respect to:
    - when, how and the purposes for which the custodian routinely collects, uses, modifies, discloses, retains or disposes of personal health information; and
    - the administrative, technical and physical safeguards and practices that the custodian maintains with respect to personal health information.
- to designate a contact person to:
    - facilitate the custodian's compliance with PHIPA;
    - ensure that all agents are informed of their duties under PHIPA;
    - respond to public inquiries about the custodian's policies;
    - respond to requests for access or correction; and
    - receive public complaints about alleged privacy breaches.
- to display or make available a written public statement that:
    - provides a general description of the custodian's privacy policies (including the purposes for which personal health information is collected, used and disclosed);
    - describes how to contact the contact person or the custodian;
    - describes how an individual can seek access to or correction of a record; and
    - describes how an individual can make a complaint to the custodian and to the Information and Privacy Commissioner of Ontario.

Health information custodians must also notify the individual about whom the information relates if the individual's personal health information is used or disclosed in a manner that is outside the scope of the description set out in the written public statement.

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Standard of Practice: Record Keeping - FAQs

Retention

Why is the retention period 7 years for patient records?

Through the mandatory 60-day consultation process, the profession validated that a retention period of 7 years is sufficient for patient records.

Can records be kept for longer than 7 years?

Yes, records can be kept for longer than 7 years.

If a patient has not been to a clinic for 2 years and the file is transferred to another denturist (say, in the sale of the clinic), does the new denturist have to keep the record for another full 7 years? Or just the remaining 5?

The denturist would have to keep the record for a total of 7 years from the date of the last visit. Therefore, in this example, the denturist would keep the record for the remaining 5 years.

If I find out that one of my patients is deceased, do I still have to keep their record for 7 years?

Yes. The estate trustee of the deceased patient may request access to the personal health information.

How long do I have to maintain multi-media such as patient pictures, old dentures, digital images or recordings?

Registered Denturists must ensure the maintenance of multi-media data (pictures of the patient, images of patient's teeth or oral cavity, patient's dentures, email messages, or other digital images or recordings) comply with the same collection, retention, use and disclosure legislation and standards as paper notes.

For which equipment do I have to maintain records?

The denturist must maintain records for all equipment utilized in the practice (including technological and laboratory equipment).

What is the time frame for maintaining financial records?

Financial information that is part of the patient record, such as invoices and receipts, should be kept for the duration that the patient record is active.

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Denturists should seek advice from Canada Revenue Agency and accounting or legal professionals to determine the retention requirements for other financial records such as tax returns and audits.

Should denturists keep the models or any other physical items related to a patient record?

Denturists can keep the models and other physical items related to the patient record. If storage space is a concern, denturists may consider documenting the materials (i.e. through notation and photographs) and keep that documentation in the patient record.

Can I store records in my home or in a storage unit?

Yes. However, it is very important to keep in mind that wherever you are storing records must be secure. In other words, only authorized individuals should have access to the patient records, regardless of where the documentation is stored.

Charting

When should I do my charting?

Registered Denturists should complete their charting during or soon after the services have been provided or events have occurred.

Does the commercial laboratory fee need to be given to the patient or kept in the patient's file?

The commercial laboratory fee information should be provided to the patient and kept in the patient record.

Does the unique identifier only have to be on the pages of the physical patient record?

In addition to the physical patient record, the unique identifier and date should be noted on all multi-media data (e.g. pictures of the patient, images of teeth /oral cavity, dentures, email messages, video tapes) as well as linked to the financial records. If electronic records are used, the unique identifier should be linked to all patient information in the system.

Why can't a Date of Birth (DOB) serve as a unique identifier?

The DOB can serve as part of a unique identifier. However, it is not uncommon for patients to have the same name and possibly the same birth date. To avoid confusion and reduce the risk of error, it is recommended that the denturist select another way to uniquely identify patient records.

Would the master signature list require a signing at each appointment?

The master signature list is a tool designed to specify the names of the individuals that accessed and/or amended the patient record. This list should be kept in the denturist practice and made available upon request if a patient record is needed for review. If someone new has amended or accessed a record, their name and initials should be added to the master list.

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Can I make up my own patient charts? Or do I have to use the chart created from one of the associations?

The College does not require that denturists use templates from any organization, including the associations. It is important to remember that the responsibility of adhering to the Standard of Practice for Record Keeping is the onus of the denturist. Therefore, denturists must ensure that any template they use is in accordance with the Standard.

Clarify what is required for charting information about advice provided and patient education given.

A denturist who provides advice or patient education should note the conversation in the patient record and can include, but is not limited to, the following information: the date, the advice/education provided, the reason for providing the information, and any questions that the patient asked.

How do I acknowledge in the record that the patient understood my advice?

A denturist should note that the patient indicated their understanding of the information being provided to them. When the level of risk warrants it, the denturist should obtain written informed consent through the informed consent process. See the Standard of Practice: Informed Consent and the Guide to the Standard of Practice: Informed Consent for more information.

If someone discloses a lock-box item, does it actually have to be written into the file somewhere? Like on a separate piece of paper?

If a patient discloses a lock box item, the denturist should create a written account of the conversation so that the information can be recalled if/when necessary. However, this document (physical or electronic) should be kept separate from the patient record. The unique identifier should be present so that the documentation can be matched up with the correct patient.

The notation in the patient record should indicate that information was shared but not disclosed in the record, at the patient's request.

Can I record patient visits on video? Is that sufficient for record keeping?

Denturists who operate video and/or surveillance equipment in their offices must ensure that visitors are aware that they are being recorded through the posting of noticeable signs, particularly in public areas, such as waiting rooms and operatories. Patient appointments may be recorded upon receipt of informed consent by the patient. Patient records should be transcribed after each appointment, either in hardcopy or electronically.

Do I have to transfer my old patient charts to a new chart form?

If you start to use a new chart template or form, you may consider transferring existing patient information to the new form to ensure that all of the required information is now being captured. Alternatively, you can start a new chart for an existing patient using the new template and include the old version of the chart as an appendix to the record.

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Patient-Related

What are some best practices for sending patient information or documentation electronically?

Registered Denturists should obtain the patient's informed consent before communicating by email and/or sending information electronically, explaining the potential risk of another person's access to information.

Additionally, Registered Denturists should ensure the intended recipient of a facsimile is named on the document and places a confidentiality statement on the bottom of the facsimile.

I attend a lot of house call appointments and take patient records with me on these appointments. Is there anything special I need to do?

Registered Denturists who transport patient files or information need to take reasonable steps to ensure security of information (e.g. moving from one office to another, bringing patient files home). Files should be stored securely in your vehicle and/or in your home.

If the patient refuses to provide any information about his or her medical history, should I treat this patient?

Denturists must be able to assess the patient's suitability for various treatment options. Refusing to provide information about medical history could put the patient at risk of harm. If there is something in the medical history that the patient does not want disclosed on the record, the denturist can make note that a disclosure was made but cannot be shared (the information was "lock boxed").

If the patient still refuses to provide this information, the denturist can refuse treatment.

If we are given fraudulent or incorrect info from patient, can we be accountable?

Denturists can include a disclaimer on their intake forms that requires patients to provide true, honest and accurate information and that assessment and treatment will be delivered based on the information that the patient provides. Denturists who receive fraudulent or incorrect information from a patient or on behalf of a patient should immediately note this in the patient record and consult a legal professional for further advice.

What are my mandatory reporting obligations to report any type of abuse to authorities when the patient has shared information they do not wish to be disclosed (i.e. "lock boxed").

If the patient is under the age of 18, the Child and Family Services Act (CFSA) could apply and permit the denturist to report to the police. However, that will only be triggered if the abuser is the child's parent.

If the CFSA does not apply, the denturist must comply with the Personal Health Information Protection Act (PHIPA).

If the denturist believes that the disclosure to the police or parents is necessary to eliminate or reduce a significant risk of serious bodily harm to the patient, then he/she will not be breaching PHIPA. This is in light of s. 40(1) of PHIPA which states the following:

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> 40. (1) A health information custodian may disclose personal health information about an individual 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. 2004, c. 3, Sched. A, s. 40 (1).

We strongly suggest that the denturist consult with a lawyer to see if he/she has the requisite belief in order to justify the disclosure.

If the patient has capacity (as set out in the Health Care Consent Act) he/she is authorized to provide instructions as to who can and cannot access their personal health information (PHI).

The "lock box" provision normally speaks to sharing PHI with other health care providers. For example, a health care provider is permitted to share PHI with health care providers who are within the circle of care. Express consent is not required for this disclosure. However, the "lock box" provision allows the patient to withhold or withdraw consent or may prohibit or place conditions on the disclosure.

According to PHIPA, once a patient says the PHI is to go in the lock box, it must remain there unless:

- The patient changes their mind and advises the denturist; and/or
- The denturist believes on reasonable and probable 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 denturist should still record the information provided to them by the patient. If using paper files, the information can be kept separately and securely away from the main chart with clear indications that part of the record has been removed under the lock-box provision.

The denturist may wish to ask the patient if he/she is still intent on keeping this information confidential. If they change their mind, this would permit the denturist to disclose the information. The denturist will likely want to provide the patient with resources so that he/she can obtain help.

What do I do if a patient record goes missing?

If personal health information has been stolen or lost or if it has been used or disclosed without authority (this includes the unauthorized viewing of health records):

- The health information custodian must notify the individual about whom the information relates at the first reasonable opportunity. The notice has to inform the individual that he or she is entitled to make a complaint to the Information and Privacy Commissioner of Ontario.
- As of October 1, 2017, health information custodians will also have to notify the Information and Privacy Commissioner directly of certain privacy breaches.
- An agent that handled the information must notify the responsible health information custodian at the first reasonable opportunity.

Health information custodians have additional reporting obligations to regulatory Colleges (which include the Colleges under the Regulated Health Professions Act, 1991 and the Ontario College of Social Workers and Social Service Workers) if the custodian takes disciplinary action against a member of a College for the unauthorized collection, use, disclosure, retention or disposal of personal health information.

For more information, please review the Standard of Practice: Confidentiality & Privacy and the Guide to the Standard of Practice: Confidentiality & Privacy for more information.

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Multi-Disciplinary Practice:

Who do the charts belong to if a denturist works for a dentist office as an associate?

Health professionals have different levels of responsibility depending on whether they are the health information custodian or an agent. If you are a regulated health professional or you operate a group practice, and you have custody and control of personal health information in connection with your duties, then you are a health information custodian for purposes of the Personal Health Information Protection Act (PHIPA).

However, even if you fall under the definition of a health information custodian, if you work for or on behalf of another custodian (such as another regulated health professional, a group practice or a hospital), then you are considered to be an agent of that health information custodian.

A health information custodian is ultimately responsible for the personal health information in his or her custody or control, but may permit an agent to collect, use, disclose, retain or dispose of the information if certain requirements are met.

For more information, please review the Standard of Practice: Confidentiality & Privacy and the Guide to the Standard of Practice: Confidentiality & Privacy for more information.

Practice Scenarios

Record Keeping No. 1

John, a denturist, owns a denture clinic. Carl, another denturist, is an associate of this clinic and therefore an agent of the records. Carl has been working in John's clinic for a number of years but has decided to open his own. Carl never signed a non-competition agreement. Can Carl notify the patients that he treats at John's clinic about his departure?

John is the custodian of the records and Carl is an agent. Carl and John need to have a professional conversation regarding how this change will be communicated to the patients. The denturists need to evaluate how the patients will be best served and work out the business details secondary to that. If the patients provide consent to release their information to Carl, and John agrees, copies of the records could be transferred to Carl's clinic.

Record Keeping No. 2

Debbie, a denturist, has been practising for 45 years in the same clinic, and has built up a busy and successful practice. She decides she is ready for retirement but wonders what she is supposed to do with her patient records. Does she have to retain them herself? Ordinarily she would have to retain patient records for seven years from the last interaction with the patient. But in this case Debbie may be selling her practice to another practitioner to take over the business and patients. If this is the case, she does not have to retain the records herself, but needs to notify the patients of the transfer of their patient records. This can be done through a combination of telling patients on their next visit, sending out letters and placing a notice in the local newspaper. All three of these strategies should be followed unless every patient has been reached in person and by letter.

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BRIEFING NOTE

To: **Council**

From: **Quality Assurance Committee - Panel B**

Date: **December 6, 2019**

Subject: **Standard of Practice: Professional Boundaries**

At the June 14th, 2019 meeting, Council considered the draft Standard of Practice: Professional Boundaries and the accompanying Guide.

Council requested modifications and returned the drafts to Quality Assurance - Panel B for revision. Specifically, Council requested the inclusion of language that articulated an expectation that Registered Denturists foster and practise in an environment that is free from harassment.

Quality Assurance Committee - Panel B considered this request at its November 1st, 2019 meeting and are returning the amended Standard for Council's consideration.

Options

After discussion and consideration of this matter, Council may elect to:

1. Approve the revised Standard of Practice – Professional Boundaries for release for stakeholder consultation.
2. Modify the revised Standard, approve the revised Standard for release for stakeholder consultation.
3. Other.

COLLEGE OF DENTURISTS OF ONTARIO

Standard of Practice: Professional Boundaries

Preamble

Professional relationships in health care are built on mutual trust and respect. Mutual trust and respect are fostered by appropriate management of boundaries between health care providers and patients.

Boundary violations may be inadvertent or intentional. They are frequently facilitated by the power imbalance that exists between a health care provider and a patient. Boundary violations can cause minor or major physical, emotional or economic harm to patients. Registered Denturists must exercise their professional judgement in a manner that establishes and manages appropriate boundaries in a wide variety of circumstances.

This Standard articulates the College's expectations for Registered Denturists regarding the appropriate management of professional boundaries.

Pursuant to *the Regulated Health Professions Act, 1991* a romantic or sexual relationship with any patient, including a spouse, is considered sexual abuse, even if the individuals involved "consent" to the relationship. Such sexual abuse can establish the grounds for professional misconduct.

The Standard

A denturist meets the Standard of Practice: Professional Boundaries when they:

1. Establish and engage in a clinical practice setting that maintains professional boundaries, free from harassment and sexual abuse.
2. Maintain professional behaviour towards patients, staff and other health care providers.
3. Communicate respectfully, professionally and appropriately.
4. Recognize and understand the power imbalance in the denturist-patient relationship.
5. Refrain from behaviours, remarks or gestures that increase the risk of boundary violations.
6. Do not treat anyone with whom they have/had a sexual or romantic relationship, including their spouse, within the timeframe and framework specified by the RHPA.
7. Comply with mandatory reporting obligations regarding the sexual abuse of patients as outlined in the RHPA.
8. Document unintentional boundary violations in the patient record.

Legislative References

Regulated Health Professions Act, 1991

Health Professions Procedural Code

O. Reg. 260/18: Patient Criteria Under Subsection 1 (6) of the Health Professions Procedural Code

Related Standards of Practice

Standard of Practice: Record Keeping

Standard of Practice: Confidentiality & Privacy

Council Approval Date	
Effective Date	

COLLEGE OF DENTURISTS OF ONTARIO

Guide to Standard of Practice: Professional Boundaries

How do I define professional boundaries?

A denturist must be careful to act as a professional health care provider, and not as a friend, to patients. Becoming too personal or too familiar with a patient is confusing to patients and will make them feel uncomfortable. Patients will be uncertain as to whether the professional advice or services are motivated by something else other than the best interests of the patient. It is also easier to provide professional services when there is a "professional distance" between them. It is a delicate balance between maintaining a suitable professional distance and being engaged with the patient. Being too distant or being too close can both compromise the patient's care.

Maintaining professional boundaries is about being reasonable in the circumstances.

A denturist should consider whether an action is a legitimate part of their role. What would a reasonable person think if they looked in on your interaction with a patient? Is the conduct appropriate?

What are boundary violations?

A boundary violation is the point at which the denturist-patient relationship changes from professional to personal. They can be one-offs or cumulative, expected or unexpected, accidental or intentional; initiated by the denturist, the patient or a third party.

What is the definition of sexual abuse?

Section 1(3) of the Health Professions Procedural Code states:

"sexual abuse" of a patient by a member means,
(a) sexual intercourse or other forms of physical sexual relations between the member and the patient,
(b) touching, of a sexual nature, of the patient by the member, or
(c) behaviour or remarks of a sexual nature by the member towards the patient.

Examples of sexual abuse can include but are not limited to:

- Telling a patient a sexual joke;
- Hanging a calendar on the wall with sexually suggestive pictures (e.g., women in bikinis, a "fire fighters" calendar);
- Non-clinical comments about a patient's physical appearance (e.g., "you look sexy today"); and
- Dating that involves physical sexual relations

Touching, behaviour or remarks of a clinical nature is not sexual abuse. For example, touching the mouth and face of a patient will often be clinically necessary (and, as discussed above, must be done only after receiving informed consent).

What are the potential consequences for findings of sexual abuse of patients?

In addition to the orders outlined in Section 51(2) of the Health Professions Procedural Code, under the RHPA, Section 51(5), states that if a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following:

- Reprimand the member;
- Suspend the member's Certificate of Registration if the sexual abuse does not consist of or include specific acts (identified below);

- Revoke the member's Certificate of Registration if the sexual abuse consisted of, or included, any of the following:
    i. Sexual intercourse.

    ii. Genital to genital, genital to anal, oral to genital or oral to anal contact.

    iii. Masturbation of the member by, or in the presence of, the patient.

    iv. Masturbation of the patient by the member.

    v. Encouraging the patient to masturbate in the presence of the member.

    vi. Touching of a sexual nature of the patient's genitals, anus, breasts or buttocks.

    vii. Other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the Regulated Health Professions Act, 1991.

What is the definition of a patient?

Ontario Regulation 260/18: Patient Criteria Under Subsection 1 (6) of the Health Professions Procedural Code (the "Code") states:

1. 1. An individual is a patient of a member if there is direct interaction between the member and the individual and any of the following conditions are satisfied:

i. The member has, in respect of a health care service provided by the member to the individual, charged or received payment from the individual or a third party on behalf of the individual.

ii. The member has contributed to a health record or file for the individual.

iii. The individual has consented to the health care service recommended by the member.

iv. The member prescribed a drug for which a prescription is needed to the individual.

2. Despite paragraph 1, an individual is not a patient of a member if all of the following conditions are satisfied:

i. There is, at the time the member provides the health care services, a sexual relationship between the individual and the member.

ii. The member provided the health care service to the individual in emergency circumstances or in circumstances where the service is minor in nature.

iii. The member has taken reasonable steps to transfer the care of the individual to another member or there is no reasonable opportunity to transfer care to another member.

Section 1(6) of the Health Professions Procedural Code specifies that a patient includes an individual who was a member's patient within one year (or such longer period as described) from the date on which the individual ceased to be the member's patient and that meets the criteria outlined above.

Can I have a relationship with a former patient?

Denturists are not permitted to have a romantic relationship with a former patient for one (1) year from the date the denturist-patient relationship ended.

If after the minimum one year waiting period a denturist wishes to enter into a romantic relationship with a former patient, it is advisable to proceed with caution and consider:

1) The *duration* of the therapeutic relationship – the longer the relationship, the more likely it may be considered to be inappropriate to initiate a romantic relationship
2) The patient's *vulnerability* – the more vulnerable the patient, the more likely it is that having a relationship may be considered an abuse of power.
3) *Continuing care* for other member's of the former patient's family – the combination of personal and professional relationships may be considered inappropriate.

Am I allowed to treat my spouse?

No. The RHPA clearly prohibits Registered Denturists from engaging in sexual relationships or other forms of affectionate or sexual behaviour with patients. **Denturists are prohibited from having any sexual relationship with any patients, including spouses, even if the patient or spouse consents to the sexual activity.**

Behaviours, gestures and/or remarks that may reasonably be perceived by patients as romantic, sexual, exploitive and/or abusive are considered to be sexual abuse.

What is self-disclosure?

When a practitioner shares personal details about his or her private life, it can confuse patients. Patients might assume that the practitioner wants to have more than a professional relationship. Self-disclosure suggests that the professional relationship is serving a personal need for the practitioner rather than serving the patient's best interests. Self-disclosure can result in the practitioner becoming dependent on the patient to serve the practitioner's own emotional needs, which is damaging to the relationship.

What consequences may I face if I violate professional boundaries with other staff?

Denturists may be found guilty of professional misconduct for sexual harassment of staff or boundary violations with staff if the conduct would reasonably be regarded by denturists as disgraceful, dishonourable, unprofessional or unethical, as set out in the Professional Misconduct Regulation.

Denturists may also face criminal charges.

How do I identify and address risks to safe practice such as harassment and sexual abuse?

Harassment involves aggressive pressure and/or intimidation. If a denturist notices harassment or abuse, sexual or otherwise, they should intervene immediately to stop the interaction. If the denturist is concerned about safety, they should notify the police immediately. The denturist must record the interaction in the patient record and the steps they took to address the issue(s). If the interaction involved another denturist or another regulated health practitioner, a mandatory report to the practitioner's regulator is required.

Why is the patient-denturist relationship unequal? How do I mitigate this inequality?

The practitioner-patient relationship involves a power imbalance in favour of the denturist. The fundamental concept of both our legal and health care systems is that patients should have control over their bodies and their healthcare. In part, this balances the power of the practitioner. Patients are seeking the denturist's expertise and are dependent upon them to provide professional services.

It is advisable, except in exceptional circumstances, to not treat family members or other relatives. Despite a denturists' intentions to deliver the best possible care, clinical objectivity may be compromised.

What are dual relationships?

A dual relationship is where the patient has an additional relationship with the practitioner other than just as a patient (e.g., where the patient is a relative of the practitioner).

Any dual relationship has the potential for the other relationship to interfere with the professional one (e.g., being both the individual's practitioner and employer). It is best to avoid dual relationships whenever possible.

Where the other relationship came before the professional one (e.g., a relative, a pre-existing friend), referring the patient to another practitioner is the preferred option. Where a referral is not possible (e.g., in a small town, where there is only one practitioner), special safeguards are essential (e.g., discussing the dual relationship with the patient and agreeing with the patient to be formal during visits and never talk about the issues outside of the office) and extra vigilance is required. Confidentiality must be maintained both inside and outside the practice and denturists must be cognizant not to violate privacy.

Becoming a personal friend with a patient is a form of a dual relationship. Patients should not be placed in the position where they feel they must become a friend of the practitioner in order to receive ongoing care. Practitioners bear the sole responsibility to not allow a personal friendship to develop during professional visits. It is difficult for all but the most assertive of patients to communicate that they do not want to be friends.

What is meant by "personal space"?

Personal space refers to someone's comfort zone. The size of this zone differs from person to person. It is important that you are aware of this space and act accordingly.

What if someone misunderstands or misinterprets my remarks, gestures or behaviours?

Everyone has personal opinions. Practitioners are no exception. However, practitioners should not use their position to push their personal opinions (e.g., religion, politics or even diet) on patients. Similarly, strongly held personal reactions (e.g., that a patient is unpleasant and obnoxious) should not be shared. Disclosing personal reactions does not help the professional relationship.

Communication is verbal and non-verbal, and it is affected by context, tone, word choice and body language. People come from various backgrounds and your actions and conversations are filtered through the context of the background, experience and beliefs of an individual with whom you are communicating. .

Comments or actions may be seen as inappropriate boundary crossings or violations.

Do not tell sexually suggestive jokes, make comments about a patient's or staff member's body, appearance or clothing, make inquiries about intimate aspects of the lives of patients or staff members and/or disclose intimate aspects of your life.

It is important to remember that just because someone discloses something personal to you about their life does not give you permission to reveal detailed personal information about your own life.

Additionally, people perceive touch differently depending on their personal backgrounds. It is the patient's perception of the interaction and not your intention that is the most important to remember.

It is considered inappropriate to hug or kiss a patient. Touching can be easily misinterpreted. A patient can view an act of encouragement by a practitioner (e.g., a hug) as an invasion of space or even a sexual gesture. Extreme care must be taken in any touching between practitioners and their patients.

The nature and purpose of any clinical touching must always be explained first and the patient should always give consent before the touching begins. Instruments or materials should never be placed on the patient's chest. Cultural sensitivities should be respected. The presence of a third party should be permitted and even offered where appropriate. The touching must always have a clinical relevance that is obvious to the patient.

Who is responsible for preventing sexual abuse from happening?

It is always the responsibility of the practitioner to prevent sexual abuse from happening. If a patient begins to tell a sexual joke, the practitioner must stop it. If the patient makes comments about the appearance or romantic life of the practitioner, the practitioner must stop it. If the patient asks for a date, the practitioner must say no (and explain why it would be inappropriate). If the patient touches the practitioner in a way that might be viewed as sexual touching (e.g., a kiss), the practitioner must stop it.

How do I document patient interactions in the patient record?

Proactive documentation serves the patient's interests and yours.

You should document any boundary crossing or violations by the patient and/or yourself, including if you have instinctively used touch to comfort a severely distressed patient or if a patient has made sexual comments or advances or has crossed boundaries – include your observations and note anyone else that was present.

How does this Standard apply to my workplace environment?

Abuse and harassment of staff members is a serious issue. As a regulated health professional, you are obligated to maintain a professional workplace that does not include sexually suggestive jokes, posters, pictures and/or documents that could be offensive to patients or staff.

You should be mindful of patient perceptions regarding the conversations that you have with staff members during treatment and around other patients.

Can I have video or photographic recording equipment in my clinic?

Using video or photographic recording equipment for security, assessment, treatment and educational purposes must be done with expressed informed consent from the patient accordance with the Standard of Practice: Informed Consent. You must secure, store and destroy this media in accordance with the Standard of Practice: Record Keeping; and collect, use and/or disclose this media in accordance with the Standard of Practice: Confidentiality & Privacy.

What are a member's mandatory reporting obligations regarding sexual abuse of patients?

Section 85.1(1) of the Health Professions Procedural Code requires members to file a mandatory report if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College has sexually abused a patient.

The report must be filed in writing with the Registrar of the College of the member who is the subject of the report, and filed within 30 days after the obligation to report arises, unless you believe on reasonable grounds that the member will continue to sexually abuse the patient or will sexually abuse other patients and there is urgent need for intervention, in which case the report must be filed immediately.

The report must contain:

(a) the name of the person filing the report;
(b) the name of the member who is the subject of the report;
(c) an explanation of the alleged sexual abuse;
(d) if the grounds of the person filing the report are related to a particular patient of the member who is the subject of the report, the name of that patient, subject to the consent of the patient.

The name of a patient who may have been sexually abused must not be included in a report unless the patient, or if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patient's name.

What are some suggestions for preventing sexual abuse?

- Do not engage in any form of sexual behaviour or comments around a patient.
- Intervene when others, such as colleagues and other patients, initiate sexual behaviour or comments.
- Do not display sexually suggestive or offensive pictures or materials. Monitor the advertising posters, calendars and magazines used in the clinic.
- If a patient initiates sexual behaviour, respectfully but firmly discourage it.
- Monitor warning signs. For example, avoid the temptation to afford special treatment to certain patients, such as engaging in excessive telephone conversations or scheduling visits outside of office hours. Be cautious about connecting with patients on social media.
- Unless there is a very good reason for doing so, avoid meetings outside of the office.
- Do not date patients.
- Avoid self-disclosure.
- Avoid comments that might be misinterpreted (e.g., “You are looking good today”).
- Do not touch a patient except when necessary for assessing or treating them. Before touching a patient, explain the nature of the touching first, the reason for the touching and be very clinical in one’s approach (e.g., wear gloves).
- Do not place instruments or materials on a patient’s chest.
- Be sensitive when offering physical assistance to patients who may not be mobile. Ask both whether and how best to help them before doing so.
- Avoid hugging and kissing patients.
- Be aware and mindful of cultural, religious, age, gender and other areas of differences. If in doubt ask if one’s proposed action is acceptable to the patient.
- Do not comment on a patient’s appearance or romantic life.
- Sufficiently document any clinical actions of a sexual nature and ensure that any incidents or misunderstandings are fully and immediately recorded.

How does the concept of professional boundaries apply to social media and the internet?

Professional boundaries concepts apply across all media, including social media platforms. For example, it would be inappropriate to use information gained from patient records to identify and find a patient on social media or on the internet.

Practice Scenario

Dayna, a denturist, is providing a denture for Penelope. Penelope is having difficulty deciding whether to marry her boyfriend and talks to Dayna about this isse a lot during their visits. To help Penelope make up her mind, Dayna decides to tell Penelope details of her own doubts in accepting the proposal from her first husband. Dayna tells of how those doubts had long-term consequences, gradually ruining her first marriage as both she and her husband had affairs. Penelope is offended by Dayna’s behaviour and stops coming for adjustments even though she still needs them. Eventually Penelope stops wearing the denture. Dayna’s self-disclosure was inappropriate and unprofessional.

Practice Scenario

Steve, a denturist, tells a colleague about his romantic weekend with his wife at Niagara-on-the-Lake for their anniversary. Steve makes a joke about how wine has the opposite effect on the libido of men and women. Samantha, a patient, is sitting in the reception area and overhears. When being treated by Steve, Samantha mentions that she overheard the remark and is curious as to what Steve meant by this, as in her experience, wine helps the libido of both partners. Has Steve engaged in sexual abuse?

Steve clearly has crossed boundaries by making the comment in a place where a patient could overhear it. However, the initial comment was not directed towards Samantha and was not meant to be heard by her. It would certainly be sexual abuse for Steve to continue the discussion with Samantha. Steve should apologize for making the comment in a place where Samantha could hear it. Steve needs to state his focus is on Samantha’s treatment.

Practice Scenario

Mr. Smith, an elderly man, makes a follow up appointment to see his denturist Elyse. Mr. Smith explains that he doesn't need additional denturism care – he is lonely and is looking for companionship, someone to have coffee with and accompany him on walks around his neighbourhood. Elyse feels badly for Mr. Smith but understands that meeting outside of the clinic for non-denturism reasons may be considered a professional boundary violation. She explains that violating this boundary would compromise the patient-denturist relationship and possibly, her clinical objectivity. Elyse suggests that Mr. Smith contact his local senior centre to inquire about activities or groups that he can join. Elyse also makes a note of the conversation, and the advice she provided in Mr. Smith's patient record.

Legislative References

O. Reg. 854/93: Professional Misconduct, paragraph 8 http://www.ontario.ca/laws/regulation/930854

Regulated Health Professions Act, 1991

Health Professions Procedural Code

O. Reg. 260/18: Patient Criteria Under Subsection 1 (6) of the Health Professions Procedural Code

References

Standard of Practice: Professional Boundaries

Important Legal Principles Practitioners Need to Know, Jurisprudence Handbook, College of Denturists of Ontario, 2017.

COLLEGE OF DENTURISTS OF ONTARIO

Agenda Item 13.1

BRIEFING NOTE

To: **Council**

From: **Quality Assurance Committee - Panel B**

Date: **December 6, 2019**

Subject: **Standard of Practice: Procedures**

At its December 4th, 2015 meeting, Council approved the Standard of Practice: Procedures for stakeholder consultation. The consultation was completed in March 2016. This Standard and the associated consultation report were shelved while the format of the Standards of Practice were modified and additional Standards of Practice were drafted. Council will be familiar with this work.

The draft Standard of Practice: Procedures and the 2016 consultation report were reviewed by the Quality Assurance Committee – Panel B at its November 1st, 2019 meeting. The Panel concluded that the content of the draft Standard had either been incorporated into other Standards developed in the new format or was best presented in regulatory instruments other than a Standard (i.e. Guideline, Advisory, Legislative Review). The Panel adopted a motion to recommend that the draft Standard be parked indefinitely.

Options:

After consideration of this draft Standard and discussion, Council may elect to:

1. Retire the draft Standard of Practice: Procedures
2. Request modifications to the Standard of Practice: Procedures for consideration by Council at its next meeting.
3. Other.

COLLEGE OF DENTURISTS OF ONTARIO

STANDARDS OF PRACTICE: PROCEDURES

Standards of Practice are a validated set of expectations that contribute to public protection. The standards define expectations for the profession, communicate denturists' accountability to the public and guide the denturist's practice. The College or other bodies may use the Standards of Practice in determining whether appropriate standards and professional responsibilities have been met.

Introduction

Making decisions about clinical procedures and who has the authority to perform them is a complex issue that has serious ramifications for the denturist and the public. When performing any procedure, it is important that denturists consider the profession's scope of practice and the controlled acts model; employ critical thinking and practise reflective decision-making; and ensure measures are in place for public safety throughout.

In Ontario the scope of practice of denturists is described as "*the assessment of arches missing some or all teeth and the design, construction, repair, alteration, ordering and fitting of removable dentures.*" The scope of practice statement is a descriptive guide as to what work each professional would normally do.

A practitioner is not legally precluded from performing a procedure beyond the profession's stated scope of practice, although he/she is precluded from performing controlled acts that the profession is not authorized to perform. The philosophy behind this approach is to move away from the exclusive scope of practice model for regulated professions, in order to permit professions to evolve and develop with changing technology. (*Federation of Health Regulatory Colleges of Ontario* website retrieved Nov. 12, 2015.)

There are two key concepts that must be included when a denturist assesses whether a procedure falls within the profession's scope of practice: 1) Principle Expectation of Practice and 2) the Controlled Acts Model.

1. *Principle expectation of practice (PEP)*

"Principal Expectations of Practice include *specific procedures and services that are generally understood to fall within the scope of practice for a profession for which its members have the authority to carry them out.*

They include those procedures where the knowledge base and clinical-practice experience required to competently perform them is obtained either through accredited entry-level programs or through a combination of formal or informal education and clinical experience that expands on baseline competencies provided in unaccredited entry programs. PEPs are dynamic. **They are based on what constitutes regular practice and evolve as new knowledge, technologies and practices emerge that enable a profession to address patient needs."** (*Federation of Health Regulatory Colleges of Ontario*, retrieved Nov. 12, 2015.)

Procedures within PEPs include:

- Controlled acts authorized to a profession (authorized acts) that are part of regular practice; and
- Procedures that are not controlled acts that fall within the scope of practice and competencies for the profession.

Therefore, it is important to ensure that the performance of both controlled and non-controlled activities by denturists who have the required knowledge, skill and judgement meet the standards outlined in this Standard of Practice.

2. Controlled Acts model

Currently the *Denturism Act, 1991* (section 4) authorizes denturists to perform one controlled act, and that act is limited to the fitting and dispensing of removable dentures. The regulations under the *Denturism Act* do not allow for any other controlled acts to be delegated to denturists. It is professional misconduct under Ontario Regulation 854/93 for a denturist to "perform a controlled act that has been delegated to the member unless the delegation is authorized by the regulations." (see Appendix B for the full list of controlled acts for health professionals in Ontario).

Purpose
This Standard of Practice is organized in a manner that supports denturists in making a decision about performing a procedure. It outlines the expectations for denturists when determining (a) if they have the authority to perform a procedure; (b) if it is appropriate for them to perform a procedure; and (c) if they are competent to perform the procedure.

This document follows the principles of self-regulation, allowing the denturist flexibility in practice while requiring professional accountability to protect the public interest.

Glossary

Controlled Act	An activity that is considered to be inherently harmful if performed by unqualified persons. A list of activities defined in legislation (see Appendix B).
Competence	Demonstrating the required knowledge, skill, judgment and attitude required of the profession.
Delegation	A formal process that transfers the authority to perform a controlled act from one regulated health professional who has the legislated authority and competence to perform a procedure to another person. Under the current regulations, denturists are not allowed to accept delegation from other health professionals.
Scope of practice	Scope of practice refers to both the legislative scope of practice statement and the controlled act model. Describes the range of procedures, actions and processes that a regulated health professional is permitted to undertake in keeping with legislation and regulations. A practitioner is not legally precluded from performing a procedure beyond the profession's stated scope of practice, although he/she is precluded from performing controlled acts that the profession is not authorized to perform. The philosophy behind this approach is to move away from the exclusive scope of practice model for regulated professions, in order to permit professions to evolve and develop with changing technology. However, be mindful that if a member acts outside the scope of practice, and the act carries with it a risk of serious bodily harm, the member may be breaching s. 30 of the RHPA.

Principal Expectations of Practice (PEP)	Principal Expectations of Practice (PEP) include procedures and services that are generally understood to fall within the scope of practice and the authority for a profession. They include those procedures where the knowledge base and clinical practice to competently perform them is provided through entry-level programs or is obtained through formal or informal education and clinical experience that expands on baseline competencies provided in entry programs. PEP are dynamic. They are based on what constitutes regular practice and evolve as a function of emerging knowledge, technologies and practices that enable a profession to address patient needs. Procedures within PEP include: • Controlled acts authorized to a profession (authorized acts) that are part of regular practice; and • Procedures that are not controlled acts that fall within scope and competencies for profession. Federation of Health Regulatory Colleges of Ontario
Procedures outside of scope and beyond PEP	Procedures that health professionals are not permitted to perform, including: • Controlled acts not authorized to the profession; • Authorized acts that are not part of regular practice; • Procedures that are not controlled acts and are not part of regular practice. Federation of Health Regulatory Colleges of Ontario
Removable dental prosthesis (dentures)	1. Any dental prosthesis that replaces some or all teeth in a partially dentate arch or edentate arch. It can be 1. removed from the mouth and replaced at will, 2. any dental prosthesis that can be readily inserted and removed by the patient. The means of retention of such prostheses include: tissue-retained removable dental prostheses; tooth-retained removable dental prostheses and implants; retained removable dental prostheses. Examples of tissue-retained removable dental prostheses include: complete removable dental prostheses, interim prostheses and provisional prostheses devoid of any attachment to natural teeth; tooth-retained partially removable dental prostheses includes interim and definitive partially removable dental prostheses retained by clasps or/and other connector devices to natural teeth or/and dental implants. J Prosther Dent. The glossary of prosthodontic terms. The Journal of Prosthetic Dentistry 1999; 94(1):10-92
Removable prosthodontics	The branch of prosthodontics concerned with the replacement of teeth and contiguous structures for edentulous or partially edentulous patients by artificial substitutes that are readily removed from the mouth. J Prosther Dent. The glossary of prosthodontic terms. The Journal of Prosthetic Dentistry 1999; 94(1):10-92

Denture	An artificial substitute for missing natural teeth and adjacent tissue. Harel Simon, DMD and Roy T Yanase. *Terminology for Implant Prostheses. International Journal of Oral and Maxillofacial Implants 2003; 18*
Resources	A source of supplies, supports or aids. Includes tools, equipment, staff resources, referral sources (other qualified professionals), current literature and documented evidence-based practice.

THE STANDARD

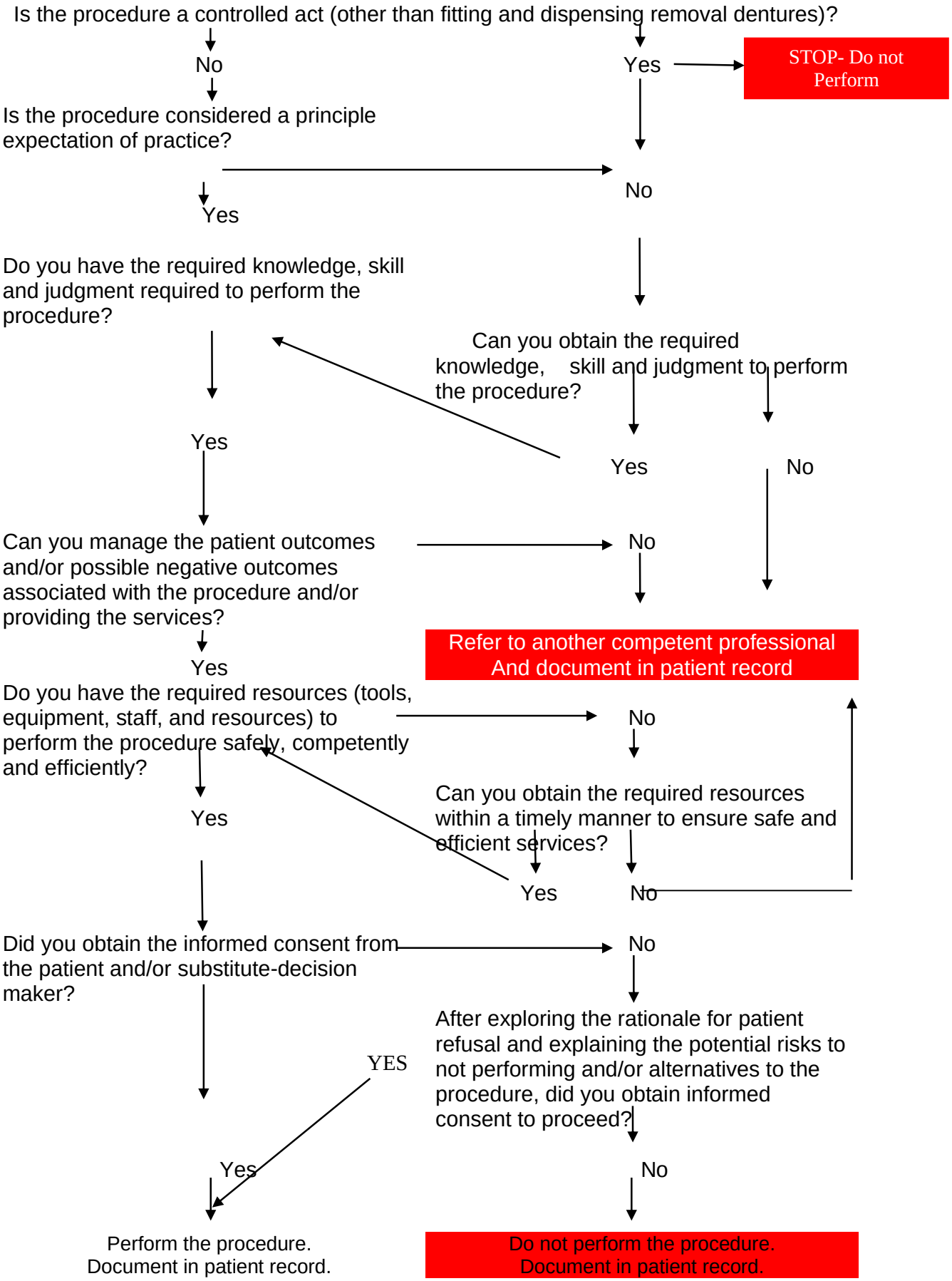
Standard Statement	**Performance Indicators** **Prior to performing a procedure, there is an expectation that the denturist:**
Denturists consider each situation separately to determine the appropriateness of performing the procedure.* *(see Appendix A, Decision Tree)	Determines if the procedure fits within the profession's scope and authority as per- principle expectations of practice (includes both controlled acts and non-controlled acts).
	Considers and confirms he/she has the required knowledge, skill and judgement required to perform the procedure competently, ethically and safely.
	Identifies and considers the associated risks of and potential contraindications for performing the procedure.
	Ensures that appropriate resources (personnel, tools, emergency equipment etc.) are in place.
	Determines the possible negative outcomes associated with specific patient factors and the circumstances, and ensures he/she has the knowledge, skill, judgement and resources to manage any negative outcomes.
	Ensures work policies, regulations and College position statements support him/her in performing the procedure.
	Declines performing the procedure if the procedure puts the client at risk or does not support safe care.
	Obtains informed consent from the patient and/or substitute decision-maker adhering to the Standards of Practice for consent and legislation.

Standard Statement	**Performance Indicators** **There is an expectation that the denturist:**
Denturists ensure they are competent to perform the procedure, prior to performing.	Knows that the procedure falls with principle practice and/or is a controlled act authorized to denturists.
	Has obtained the required education and has maintained the skill required to perform the procedure as outlined by the College, regulations and/or work environment.
	Demonstrates possession of cognitive and technical skills to perform the procedure.

Standard Statement	Performance Indicators There is an expectation that the denturist:
	Demonstrates knowledge of the following: • purpose and benefit of performing the procedure • risks to the patient • alternatives to performing the procedure • expected outcomes • actions to take if a complication arises • required supplies, equipment and tools • appropriate referral source
	Declines to perform the procedure if he/she is not competent to do so and/or to manage the potential negative outcomes.
	Seeks consultation and/or refers the patient to another professional when needed.
	Reflects on the situation and identifies any potential new learning opportunities to improve future practice.

Standard Statement	Performance Indicators There is an expectation that the denturist:
Denturists ensures, prior to performing the procedure, that he/she can manage the possible outcomes.	Identifies the expected patient outcomes, possible negative outcomes and next steps in the treatment process relative to patient factors and the situation.
	Determines if he/she has the required knowledge, skill and judgment to manage the outcome.
	Ensures the appropriate resources and/or referral sources are in place to help manage any possible negative outcomes and/or steps that are beyond his/her scope of practice and/or competence.
	Informs the patient of the expected outcomes and/or possible material negative outcomes and the limits of his/her practice and/or competence.
	Declines performing the procedure if he/she cannot manage the patient outcomes and/or possible negative outcomes and/or if the possible outcomes could require performing a controlled act not authorized to denturists.
	Seeks consultation and/or refers the patient to another professional when needed.

APPENDIX A: DECISION TREE



APPENDIX B: CONTROLLED ACTS

Regulated Health Professions Act, 1991 C. 25, S.4

A "controlled act" is any one of the following done with respect to an individual:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.

3. Setting or casting a fracture of a bone or a dislocation of a joint.

4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.

5. Administering a substance by injection or inhalation.

6. Putting an instrument, hand or finger,
   i. beyond the external ear canal,
   ii. beyond the point in the nasal passages where they normally narrow,
   iii. beyond the larynx,
   iv. beyond the opening of the urethra,
   v. beyond the labia majora,
   vi. beyond the anal verge, or
   vii. into an artificial opening into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.

8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.

9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.

10. Prescribing a hearing aid for a hearing impaired person.

11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.

12. Managing labour or conducting the delivery of a baby.

13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response. 1991, c. 18, s. 27 (2); 2007, c. 10, Sched. L, s. 32.

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule R, subsection 19 (1) by adding the following paragraph:

14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning

Practice Examples

Scenario 1

A patient presents with a severely over-closed vertical dimension of occlusion. The denturist determines an occlusal splint is needed on the patient's denture. The denturist performs all fabrication activities in his clinic's laboratory. Before beginning the process to treat this patient, the denturist asks himself the following questions:

Is fabricating an occlusal splint a controlled act?
Yes. Fitting the splint to re-establish a correct vertical dimension of occlusion is a controlled act. This fitting and dispensing of the occlusal splint falls under Controlled Act #11: "Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning."

Do denturists have access to this controlled act?
Yes, with limitations. Under the *Denturism Act*, Controlled Act #11 is limited to the fitting and dispensing of removable dentures. Fabricating an occlusal splint for the denture would be an activity related to the fitting and dispensing of removable dentures.

Does the denturist have the knowledge, skill and judgement to fabricate the occlusal splint?
Yes, because fabricating an occlusal splint is foundational knowledge for denturism. It is an entry-level expectation. However the denturist must also consider if his/her knowledge and skill are current and if he/she is still competent to fabricate an effective and safe splint.

Does the denturist have the resources needed to provide the required services?
Yes, the denturist confirmed that his in-house laboratory is equipped to fabricate the occlusal splint. In situations where an in-house laboratory is not available, the denturist would need to have established a relationship with an external laboratory which he/she is confident provides safe, effective and ethical services. In all cases, the denturist holds accountability for the delivery of the product to the patient.

Can the denturist manage the possible negative outcomes?
Yes. The denturist considered all possible negative occurrences and any risk to the patient before fabricating the splint. Then the denturist determines if he has the required knowledge and skill and the available resources to manage any negative situation that might arise. For example, can the denturist make the required adjustments during the fitting? Does he/she have the skills to recognize instability and/or masticatory issues? Does the patient present any unique risk factors (e.g. history of TMJ) that could cause difficulties during the fabrication and/or fitting of the splint?

Has the denturist obtained informed consent from the patient?
Yes. Prior to initiating the service, the denturist explained to the patient the assessment process and the cost associated with the initial assessment. Then, the denturist communicated his clinical findings and possible resolutions or interventions. Prior to fabricating the splint the denturist also explains the purpose of the splint, alternative solutions to managing the loss of vertical dimension, benefits and disadvantages, any potential material risks and all associated costs associated with the fabrication and fitting of the splint. The denturist poses questions to the patient to confirm his or her understanding of the information presented.

In this scenario, all the decision-making steps have been satisfied; therefore, the denturist proceeds with the fabrication and fitting of the occlusal splint, and documents in the patient record his assessment findings, clinical opinion, treatment plan and the informed consent process undertaken with this patient.

Scenario 2

During a yearly follow-up appointment a patient asks the denturist if he is a candidate for implants for his missing teeth. How should the denturist respond to this question?

Discussion

In this situation the denturist might recognize that he has the knowledge to answer many of the patient's questions, but he does not have the skill to confirm if the patient is a candidate for implants or to have an in-depth conversation about the surgery. Therefore, the denturist would explain to the patient that to determine if he is a candidate for implants a referral to a dentist is required (as the denturist does not have the authority to order and/or perform a radiograph and/or cone-beam scan and cannot provide a diagnosis) Applying and ordering a form of energy (e.g. x-ray, cone-beam scan) is a procedure *not* authorized to denturists, and the in-depth knowledge of implant surgery is not a principal practice. The denturist would therefore provide to the patient a few names of dentists known to be skilled in implant therapy, and would document the advice being given in the patient record.

Scenario 3

Jon, a denturist, has had many requests from his patients to perform teeth whitening. Jon is exploring the possibility of offering this service.

1. **What College documents support Jon's decision making process?**

Jon first reviews information posted on the College's website and the *Regulated Health Professions Act* to obtain a list of controlled acts that denturists are authorized to perform. He confirms that he would not be performing any controlled acts if he were to provide teeth whitening services. Jon also reviewed the College's *Standards of Practice* to confirm that there are no specific College requirements for this type of service, if provided by a denturist.

Jon confirms that many of his colleagues have been performing teeth whitening services. However, Jon has never performed this procedure himself.

2. **What additional steps must Jon take before performing the procedure?**
3. **How can Jon ensure that he is providing safe and competent care?**

Jon speaks with a colleague who suggests that he speak with a teeth-whitening supply manufacturer. Jon attends a session offered by the manufacturer, and reads several articles posted on different manufacturers' websites. Jon considers the possible side effects (such as tooth sensitivity) and patient risk factors (e.g. gingival recession) and develops a patient education brochure to help explain both the possible side effects and interventions to cope with any side effects that might arise. Jon also observed a few treatment sessions performed by his colleague before providing the service the first time to one of his own patients.

Discussion

In this situation, Jon first confirmed if any activity associated with performing teeth whitening was a controlled act. He also considered if the activity was a principle practice for denturists. Jon then obtained the required knowledge, skill and judgment prior to performing the procedure. Jon also considered the possible negative outcomes associated with teeth whitening and determined he could provide education to patients to help them manage the possible side-effects.

Scenario 4

A patient presents at Kathy's office with a possible abscess. Kathy observes the patient's oral cavity and sees swelling and redness around the base of an existing tooth. Further observation reveals a fistula and tooth decay. The patient is complaining of pain in this area. The patient asks Kathy what she thinks is the problem.

1. **Can Kathy communicate her findings to the patient?**
2. **Can Kathy offer treatment?**

Even though Kathy highly suspects an abscessed tooth cavity, she knows she cannot share this information with the patient, as it would be performing the controlled act of communicating a diagnosis—which denturists are not authorized to carry out. However, Kathy does communicate her assessment findings, red and swollen gingival tissue with a fistula. Then she suggests a care provider who *does* have the authority to communicate a diagnosis, and offers to make a referral to a dentist. She writes her assessment findings and referral in the patient's record.

Discussion

In this situation, Kathy's decision-making process began with her confirmation that communicating a diagnosis to a patient is a controlled act *not* authorized to denturists. Kathy was aware that the communication of assessment findings and making recommendations for seeking professional services by another health care practitioner who is authorized to provide diagnoses was within her scope of practice.

References

Denturism Act, 1991, S.O. 1991, Chapter 25.

Ontario Regulation 854/93, Professional Misconduct.

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An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario. Federation of Health Regulatory Colleges of Ontario website, retrieved September 20, 2015. http://www.mdguide.regulatedhealthprofessions.on.ca/authorize/default.asp

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COLLEGE OF DENTURISTS OF ONTARIO

Agenda Item 14.1

BRIEFING NOTE

To:	**Council**
From:	**Registration Committee**
Date:	**December 6, 2019**
Subject:	**Language Proficiency Requirements Policy – Amendment**

Background:

Council approved amendments to the Language Proficiency Requirements Policy in March 2019.

There are 2 new language proficiency tests that are being administered in Canada:

1) CAEL CE - "Canadian Academic English Language Test, Computer Edition"
2) CELPIP – "Canadian English Language Proficiency Index Program"

Some Canadian regulators now accept the CAEL CE test, with minimum scores in the 60-70 range, as part of their language proficiency requirements. The BC Real Estate Council now accepts the CELPIP at a minimum level of 7.

At its November 7th, 2019 meeting, the Registration Committee considered both language proficiency tests and moved to recommend including them in the Appendix to the Language Proficiency Requirements Policy. The amended policy is attached for consideration.

Options:

1) Accept both the CAEL CE and CELPIP language proficiency tests toward the College's language proficiency requirements;
2) Accept either the CAEL CE or CELPIP language proficiency tests toward the College's language proficiency requirements;
3) Other.

COLLEGE OF DENTURISTS OF ONTARIO

TYPE	**Registration**
NAME	**Language Proficiency Requirements Policy**
DATE APPROVED BY COUNCIL	**December 12, 2014**
DATE REVISED BY COUNCIL	**March 22, 2019**

INTENT

This policy outlines the minimum language proficiency requirements that must be demonstrated in order to satisfy Section 2.5. of the Registration Regulation (833/93), which states:

> *The applicant must have reasonable fluency in either English or French. O. Reg. 833/93, s. 2.*

BACKGROUND

English and French are the official languages used in the health care system in Ontario. All health care professionals need to be able to communicate (speak, read and write) in either English or French with reasonable fluency.

Language proficiency assessment contributes to public protection by ensuring that registrants can communicate effectively with patients, other members of the health care team, and the College. Candidates, applicants and registrants must be able to communicate effectively with the College, Registered Denturists must be able to understand and respond to College materials that are related to registration, quality assurance, and complaints, and discipline This is an essential part of a Denturist's accountability to the College as a regulated health professional.

THE POLICY

An applicant whose first language is English or French, and/or their relevant health care education and instruction was in English or French is considered to have demonstrated fluency in either language.

An applicant whose first language is not English or French or did not complete their relevant health care education and instruction in English or French is required to demonstrate proficiency either through a test of language proficiency or by providing non-objective evidence of language proficiency at the time of application for a Certificate of Registration

While examination candidates are not required to provide proof of language proficiency prior to attempting the Qualifying Examination, language proficiency is an essential component for success in both the written and Objective Structured Clinical Examination (OSCE) portions of the Qualifying Examination.

1. Demonstrating Language Fluency:

An applicant whose first language is not English or French or did not complete their relevant health care education and instruction in English or French are required to either:

a) Complete a standardized language proficiency test administered by a recognized 3rd party testing agency and meet or exceed the minimum cut-off score for that test (Appendix A). The cut-off scores required in the approved language tests reflect the minimum level of English or French language proficiency the

College believes is necessary for a prospective applicant to function successfully as a Registered Denturist.

Applicants are responsible for the cost of language proficiency tests.

Test results will be considered valid for 2 years from the date the test was administered and must be sent directly from the language testing agency to the College.

OR

b) Provide non-objective evidence of language proficiency. The College accepts alternatives to a standardized language proficiency test. An applicant who wishes to meet the language proficiency registration requirement through non-objective evidence (NOE) of their language proficiency must submit at least TWO of the following four:

1. Successful completion of relevant professional health care education in a majority English or French country;
2. Relevant health care employment in a country in which English or French is the majority language in a role with a scope of practice similar to that associated with the Certificate of Registration for which the application is being made;
3. Successful completion of the four final years of school in Canada that establishes eligibility to apply for university or college; or
4. Successful completion of a Canadian college or university degree.

An applicant who cannot provide sufficient evidence of language proficiency will have their application for a Certificate of Registration referred to the Registration Committee.

2. Extending the Period of Validity of Language Proficiency Test Scores

The College may extend the validity of an applicant's language proficiency test scores when the applicant meets the following Decision Criteria:

1. The applicant is actively engaged in or has recently successfully completed the education required to become registered as a denturist;
2. The original test scores meet the language proficiency requirements outlined in Appendix A;
3. The original test scores have expired within the past two years; and
4. In the opinion of the Registrar, there is no other evidence to suggest the applicant is not sufficiently proficient in English or French to be a member of the College.

An extension is valid for a period of up to one year. A second extension of up to one year following the end of the first extension period may be requested. When an applicant's request for extension of the period of validity of language proficiency test scores is denied, the application will be referred to the Registration for review.

RELATED LEGISLATION

Ontario Regulation 833/93 (Registration)

Appendix A: Recognized Language Proficiency Test & Cut-Scores

Language Proficiency Test	Minimum Score
TOEFL (Internet-based & Paper-based) http://www.ets.org/toefl/	Overall minimum of 89 Including a minimum of Reading 20/30 Listening 21/30 Speaking 24/30 Writing 21/30
IELTS http://www.ieltscanada.ca/ (Academic of General Training)	Overall minimum of 7.0 (academic and/or general training) Including a minimum of Reading 6.5 Listening 7.0 Speaking 7.0 Writing 6.5
CanTEST http://www.cantest.uottawa.ca/	Overall minimum of 4.0 including a minimum of: Reading 4.0 Listening 4.0 Speaking 4.0 Writing 4.0
TESTCan http:// www.testcan.uottawa.ca/	Overall minimum of 4.0 including a minimum of: Reading 4.0 Listening 4.0 Speaking 4.0 Writing 4.0
Canadian Language Benchmark Assessment (CLBA) Canadian Language Benchmark Placement Test (CLBPT) www.language.ca	Reading 7.0 Listening 7.0 Speaking 7.0 Writing 7.0
Canadian Academic English Language Test, Computer Edition (CAEL CE) https://www.cael.ca/	Reading 60 Listening 60 Speaking 60 Writing 60
Canadian English Language Proficiency Index Program (CELPIP) https://www.celpip.ca/	Reading 7.0 Listening 7.0 Speaking 7.0 Writing 7.0

DEFINITIONS

Applicant – an individual that has made an application to the College for registration

IELTS – The International English Language Testing System –

TOEFL®iBT -Test of English as a Foreign Language – Internet Based

TOEFL®PBT- Test of English as a Foreign Language- Paper Based

CanTEST -The Canadian Test of English for Scholars and Trainees

TESTCan (pour étudiants et stagiaires au Canada) is the French version of CanTEST

CLB – Canadian Language Benchmark

CLBPT – Canadian Language Benchmark Placement Test

CLBA – Canadian Language Benchmark Assessment

CAEL CE – Canadian Academic English Language Test, Computer Edition

CELPIP – Canadian English Language Proficiency Index Program

REVISION CONTROL

Date	Revision	Effective
March 22, 2019	• Remove requirement for demonstration of language proficiency prior to attempt the Qualifying Examination • Add CLBA and CLBPT to list of accepted standardized test for English Language Proficiency • Update of minimum cut-off scores • Add "extending the period of validity of language proficiency test scores" provision • Add "acceptance of non-objective evidence (NOE) of language proficiency" provision	March 22, 2019
December 6, 2019	• Add CAEL CE and CELPIP to list of accepted standardized tests for English Language Proficiency	

COLLEGE OF DENTURISTS OF ONTARIO

BRIEFING NOTE

To:	**Council**
From:	**Registration Committee**
Date:	**December 6, 2019**
Subject:	**Credential Authentication Policy**

Background:

As part of the policy revision and coordination project, the Registration Committee considered information regarding the current Credential Authentication Policy.

An environmental scan conducted in 2018 demonstrated that several regulators accept credential authentication reports by any member of the **Alliance of Credential Evaluation Services of Canada**.

Currently, the Alliance has 6 members:

- Comparative Education Service (CES);
- International Credential Assessment Service of Canada (ICAS);
- International Qualifications Assessment Service (IQAS);
- International Credential Evaluation Service (ICES);
- Ministère de l'Immigration, de la Diversité et de l'Inclusion du Québec (MIDI); and
- World Education Services Canada (WES)

The Alliance works collaboratively with the Canadian Information Centre for International Credentials (CICIC) to ensure compliance with UNESCO (United Nations Educational, Scientific and Cultural Organization) conventions related to the recognition of qualifications in Canada.

In their report, Study of Qualifications Assessment Agencies (March 2009), the Ontario Fairness Commissioner (OFC) offered the following recommendation to regulatory bodies:

Whenever a regulatory body relies on an external agency to make qualifications assessments, it is the responsibility of the regulator to ensure that the practices of the agency are consistent with the principles of fairness outlined in the legislation to which the regulatory body is subject.

Regulatory bodies must take this responsibility seriously not only because it is the law, but also because of the impact that qualification assessment agencies have on applicants and the professions that they regulate.

It is incumbent upon the regulatory bodies to ensure that the practices of their external partners are keeping with the fair registration practices that they themselves are working toward.

As a first step, regulators should engage directly with the qualification assessment agencies that they rely on. Regulators and assessment agencies should establish an ongoing dialogue about how their processes can align most effectively. Every effort should be made to streamline processes and eliminate duplication so that the costs borne by the applicants and the time needed to complete assessments is reduced.

The regulators that accept credential authentication reports from the Alliance members have indicated to the OFC that members of the Alliance undergo a rigorous self-evaluation process and that members of the Alliance must demonstrate compliance with rigorous membership terms and established quality standards. provided the following response to the OFC for the purposes of assessing their registration practices. The OFC has accepted this response for those assessments.

At the November 7th, 2019 meeting, the Committee recommended amendments to the current policy for Council's consideration. The revised draft policy and process guidelines are attached for Council's consideration.

Options:

1) Approve the revised policy;
2) Make amendments to the draft policy and approve the amended draft policy;
3) Other.

COLLEGE OF DENTURISTS OF ONTARIO

TYPE	**Registration**
NAME	**Credential Authentication Policy**
DATE APPROVED BY COUNCIL	**December 12, 2014**

INTENT

Dictated by Ontario Regulation 833/93 (Registration) as a non-exemptible requirement, all applicants for a certificate of registration must have a diploma or degree that, in the opinion of the Registration Committee, is equivalent to the diploma in dental therapy or denturism offered by George Brown College. Listed in the Registration Regulation Schedule, are the educational courses upon which an applicant's degree or diploma will be assessed for equivalency. This policy outlines what information is required for the Registration Committee to determine whether a diploma or degree from another institution is equivalent. The intent of this policy is to outline the requirement for documentation, including diplomas and/or degrees, to be authenticated through a third party.

THE POLICY

The Registration Committee will review courses that an applicant has taken as part of their diploma and/ or degree to determine whether those courses are equivalent to the courses listed in the Schedule of Registration Regulation. In order to do this, the documents need to be verified and authenticated through a third party credential assessment agency.

The College has determined that the verification process will be provided through World Education Services (WES) and has developed an agreement with WES to ensure that the College's standards for transparency, objectivity, impartiality and fairness are met. Applicants must apply directly to WES and must provide all educational documents to WES before having their education equivalency assessed by the College. WES may have different rules on how information on courses/diplomas/degrees will be gathered and what type of documentation is required. The College requires applicants to follow those procedures when dealing with WES.

RELATED LEGISLATION AND DOCUMENTS

Denturism Act, 1991
Ontario Regulation 833/93 (Registration)
Registration Guide
Qualifying Examination Appeals Policy

PROCESS AND PROCEDURES

1. It is a non-exemptible requirement for applicants to have obtained a diploma in denture therapy or denturism from George Brown College or any other institution deemed equivalent by the Registration Committee.

2. Applicants who have been educated outside of Canada need to have academic qualifications assessed to see if they are equivalent.

3. The first step in the assessment is to have the documents verified as authentic and original.

4. Applicants need to contact WES directly and follow the process as indicated by WES. This can be done either online at http://www.wes.org/ca/ or by contacting WES directly for an application.

   WORLD EDUCATION
   SERVICES 2 Carlton Street,
   Suite 1400 Toronto, ON,
   M5B 1J3 Website:
   www.wes.org/ca/ Email:
   contactca@wes.org

5. WES will attest to the authenticity of the documents provided and send a report directly to the College.

6. In order to prevent duplication of documents, the College will also accept original diplomas and other documentation that have been delivered to WES for the purposes of the Report.

7. The College's Registration Committee reviews the Report and determines whether educational equivalency has been met and whether the applicant is deemed eligible to attempt the qualifying examination.

DEFINITIONS

"Act" means the *Denturism Act, 1991* and includes the regulations made under it

"Report" means Course-by-Course Report and/or International Credential Advantage Package Report (ICAP)

REVISION CONTROL

Date	Revision	Effective

COLLEGE OF DENTURISTS OF ONTARIO

TYPE	**Registration**
NAME	**Academic Credential Authentication Policy**
DATE APPROVED BY COUNCIL	**December 12, 2014**

INTENT

A diploma or degree that, in the opinion of the Registration Committee, is equivalent to the diploma in denture therapy or denturism offered by George Brown College is one of the non-exemptible requirements for a Certificate of Registration (Ontario Regulation 833/93). Establishing equivalency may involve an academic assessment that includes the authentication of internationally obtained academic credentials.

This policy describes the College's requirement that international academic credentials be authenticated by an approved third-party academic credential assessment agency.

THE POLICY

Internationally educated individuals are required to establish equivalency of their academic credentials for the purpose of meeting one of the non-exemptible requirements for a Certificate of Registration. Academic credentials used to establish equivalency must be authenticated by a third-party credential assessment agency approved by the College.

The College recognizes any member of the Alliance of Credential Evaluation Services of Canada (ACESC) as an approved assessment agency.

A current list of member organizations can be found here: https://canalliance.org/en/.

RELATED LEGISLATION

Denturism Act, 1991

Ontario Regulation 833/93 (Registration)

REVISION CONTROL

Date	Revision	Effective

COLLEGE OF DENTURISTS OF ONTARIO

Academic Credential Authentication – Process Guidelines

1. Internationally educated applicants must apply to an organization that is a member of the Alliance of Credential Evaluation Services of Canada (ACESC) to have their academic credentials authenticated.

   Applicants should check the Alliance's website to confirm that the organization is a member: https://canalliance.org/en/

   Current members include:

   - Comparative Education Service (CES);
   - International Credential Assessment Service of Canada (ICAS);
   - International Qualifications Assessment Service (IQAS);
   - International Credential Evaluation Service (ICES);
   - *Ministère de l'Immigration, de la Diversité et de l'Inclusion du Québec (MIDI)*; and
   - World Education Services Canada (WES).

2. Once the evaluation has been completed, the applicant must arrange for the report to be sent directly to the College of Denturists of Ontario from the credential agency.

3. The evaluation report must:

   - verify the credentials as authentic and original;
   - confirm that the institution is recognized in Canada; and
   - identify the level of Canadian equivalency.

   The evaluation report can also contain certified true copies of the official transcripts and diplomas that were used for the evaluation.

4. The College's Registration Committee will review the report as part of the academic assessment process to determine whether educational equivalency has been met and whether the applicant is eligible to attempt the Qualifying Examination.

COLLEGE OF DENTURISTS OF ONTARIO

BRIEFING NOTE

To:	**Council**
From:	**Registration Committee**
Date:	**December 6, 2019**
Subject:	**Insufficient and/or Incomplete Documentation Policy**

Background:

As part of the policy revision and coordination project, the Registration Committee considered information regarding the current Insufficient and/or Incomplete Documentation Policy.

Rare and exceptional circumstances may render it difficult or impossible for an individual to obtain sufficient original documentation to support their application for a Certificate of Registration.

The Insufficient and/or Incomplete Documentation Policy dictates that an individual who can provide evidence that they made an effort, albeit unsuccessful, to obtain any required documentation may provide alternative evidence for consideration.

At the November 7th, 2019 meeting, the Committee adopted a motion to recommend amendments to the current policy for Council's consideration. The revised draft policy is attached for consideration.

Options:

Following consideration of this matter, Council may elect to:

1) Approve the revised policy
2) Make additional revisions and approve the revised policy
3) Other

COLLEGE OF DENTURISTS OF ONTARIO

TYPE	**Registration**
NAME	**Insufficient or Incomplete Documentation Policy**
DATE APPROVED BY COUNCIL	**December 12, 2014**

INTENT

The College requires that ***original*** academic documents be submitted for assessment or in support of an application for a Certificate of Registration.

This policy addresses those instances where individuals are not able to submit the required ***original*** documentation.

THE POLICY

Exceptional circumstances such as war, natural disaster, or personal persecution, may render it difficult or impossible for an individual to obtain sufficient ***original*** documentation for an academic assessment.

An individual who can demonstrate efforts, although unsuccessful, to obtain ***original*** documentation may provide alternative evidence to the Registration Committee.

Alternative evidence may include but is not limited to a combination of the following:

- Copies of documents from the applicant or other available resources;
- Signed affidavits attesting to the applicant's possession of some or all of the application requirements;
- Professional portfolio;
- Documentary evidence from academic instructor;
- Education, work and academic reference(s);
- Peer assessment(s) and/or,
- Other skills/competency assessment(s).

It is ideal, but not necessary, that this alternative documentation be provided directly to the College from the source.

The Committee may request additional documentation or information from individuals who are unable to demonstrate that they have made appropriate efforts to obtain original documentation.

If the Committee is of the opinion that the individual has not made appropriate efforts to obtain original documentation, the Committee may deem the individual to not have met the requirement(s).

RELATED LEGISLATION AND DOCUMENTS

Ontario Regulation 833/93 (Registration) Registration

REVISION CONTROL

Date	Revision	Effective

COLLEGE OF DENTURISTS OF ONTARIO

TYPE	**Registration**
NAME	**Insufficient and or Incomplete Documentation Policy**
DATE APPROVED BY COUNCIL	**December 12, 2014**

INTENT

An application for a certificate of registration requires an applicant to submit, and where applicable, original documentation to determine his/her eligibility for registration. This policy sets out the requirements for insufficient and/or incomplete documentation for applicants who are not able to obtain the required documents through traditional means.

THE POLICY

Exceptional circumstances such as war, natural disaster, or personal persecution, may render it difficult or impossible for an applicant to obtain sufficient original documentation to support an application for registration. An applicant, who can provide evidence that attempts were made, but was unsuccessful in obtaining the required documentation, may ask the Registration Committee to consider alternative documentation or evidence to assess whether he/she has met a specific requirement of registration.

RELATED LEGISLATION AND DOCUMENTS

Ontario Regulation 833/93 (Registration)

Registration Appeal Policy

PROCESS AND PROCEDURES

1. Applicants will submit the completed application to the College for registration.
2. If documentation is unavailable from its original source, the applicant should include this information in addition to the application package citing the circumstances for any missing information and documentation to prove the circumstances.
3. The application will be referred to the Registration Committee for review. Each request will be considered on a case-by-case basis.
4. The applicant may be requested to provide:
   a. Persuasive evidence regarding why they cannot obtain the proper or original documentation from original sources to meet the registration requirements, and/or
   b. Alternative documentation/evidence to meet the requirement(s).

5. Alternative documentation/evidence that may be considered by the Registration Committee, and will be adapted to the individual circumstances of the applicant, may include, but is not limited to, a combination of the following:

   - Copies of documents from the applicant or other available resources;
   - Signed affidavits attesting to requirements completed;
   - Professional portfolio;
   - Documentary evidence from an instructor(s);
   - Education, work and academic reference(s);
   - Peer assessment(s) and/or,
   - Other skills/competency assessment(s).

6. The alternative documentation/evidence should ideally be provided from the original source(s) directly to the College, but all documentation/evidence the applicant is able to provide will be considered.
7. If the Registration Committee is satisfied that the applicant has made efforts to provide original documentation, having provided persuasive evidence to that effect, but is not satisfied that the alternative documentation meets the requirements, the applicant may be directed to:

   - Provide additional information;
   - Undertake additional education; or
   - Provide other evidence to satisfy the Committee that they have met the requirements.

8. If the Registration Committee is not satisfied that the applicant has made efforts to provide the original documentation and has failed to provide persuasive evidence to that effect, the applicant may be requested to make additional efforts.
9. If the applicant does not make additional efforts to the satisfaction of the Registration Committee, the Committee may deem that the applicant has not met one or more requirements.

DEFINITIONS

"Act" means the *Denturism Act, 1991* and includes the regulations made under it

"Code" means the Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act, 1991*

"Member" means a person registered with the College

"Certificate of Registration" means a certificate of registration issued by the Registrar

REVISION CONTROL

Date	Revision	Effective

COLLEGE OF DENTURISTS OF ONTARIO

Agenda Item 18.0

BRIEFING NOTE

To: **Council**

From: **Glenn Pettifer, Registrar & CEO**

Date: **December 6, 2019**

Subject: **Committee Memberships**

With the expiration of Mr. Weinberger's appointment on December 4, 2019 and the anticipated non-renewal and expiration of Ms. Kiriakou's appointment on January 12, 2020, there are immediate and anticipated vacancies on some of the College Committees:

1. Registration Committee is absent one member (Wangari) and will be absent a second public member (Anita) come January 12, 2020.

2. Patient Relations Committee is absent one member (Hanno) and will be absent a second public member (Anita) come January 12, 2020.

3. Quality Assurance – Panel B – is absent its only public member (Hanno).

4. Quality Assurance – Panel A – is absent one public member (Hanno) and will be absent a second public member come January 12, 2020.

5. Qualifying Examination Committee – will be absent its only public member come January 12, 2020.

6. Executive Committee – is absent one public member (Hanno) who was also President.

Despite these vacancies, the Committees remain properly constituted. Article 23.04 of the College By-laws states: "a Committee is properly constituted despite any vacancy so long as there are sufficient Members to form a quorum of the Committee or a Panel of the Committee". As prescribed in the By-laws, quorum of a College Committee is 3 members. Despite this relief, the absence of public appointees on College committees increases the work load of those Public Appointees who are on the Committees. Perhaps more importantly, the public voice on these Commitees is diluted when there is a reduced number of Public Appointees.

With the appointment of new Public Appointees, there is an opportunity to appoint these individuals to College Committees.

The following appointments are recommended:

Ms. Lilieath Claire:

Registration Committee
Quality Assurance Committee – Panel A
Patient Relations Committee

Mr. Gord White

Quality Assurance Committee – Panel B
Qualifying Examination Committee

Options:

Following consideration and discussion of this matter, Council may elect to:

1. Adopt a motion making the appointments outlined above;
2. Revise the appointments outlined above and adopt a motion making those revised appointments; or
3. Other

Executive Committee

With the expiration of Mr. Weinberger's appointment, the College is absent a President and one Public Appointee on the Executive Committee. The Executive Committee is still properly constituted as noted above. The following Articles of the College By-laws apply:

6.03 Filling Vacancies (President) In the event that the President is removed from office, resigns or dies or the position of President becomes vacant for any reason, the Vice-President shall become the President for the remaining term of the office and the office of the Vice-President shall become vacant.

6.04 Filling Vacancies (Vice-President) In the event that the Vice-President is removed from office, resigns or dies or the position of VicePresident becomes vacant for any any reason, Council may elect a new Vice-President to hold office for the remainder of the term.

Schedule 1 of the By-laws – Process for Election of Officers

Given the By-law Articles and Schedule 1, the following are indicated:

1. Dr. McFarlane moves from the position of Vice-President to President for the remainder of the term of office (until the Council meeting in June).

2. Council may elect a new Vice-President. The Executive Committee must be composed of 3 Members (of the Profession) and 2 Public Appointees, therefore, if Council wishes to elect a new Vice-President, that individual must be a Public Appointee. Such an election may take place at the next Council meeting (March 27, 2020) since Schedule 1 of the By-laws suggest a notice period prior to the election occurring

at a regularly scheduled meeting of Council. If Council wishes to hold the election for Vice-President on this date, then this would give the new Public Appointees an opportunity to settle into their position on College Council and provide more time for Public Appointees to consider the position of Vice President. Council may consider postponing election of a new Vice-President until the June meeting of Council when elections are held for all Officers. The demands on the Vice-President are very modest, suggesting that postponing elect of a new Vice-President could be very reasonably postponed until June 2020.