The Health Profession Assistant: Consideration for the Dental Assistant Application for Regulation

Volume 1
April 19, 2013

The Honourable Deb Matthews
Minister of Health and Long-Term Care
10th Floor Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister,

We are pleased to present our report on whether Dental Assistants (DAs) should be regulated under the Regulated Health Professions Act, 1991 (RHPA). Our recommendation recognizes the important role that DAs play in providing dental care to Ontarians and the importance of protecting both patients and the public.

As part of our standard process, we completed literature, jurisdiction and jurisprudence reviews. We also conducted a consultation program, during which we heard from a range of stakeholders, including members of the profession; other regulated health professions’ colleges, and associations; and key stakeholders, such as the Ontario Dental Association, the College of Dental Hygienists of Ontario, the Ontario Dental Hygienists Association and the Royal College of Dental Surgeons of Ontario. We also heard from dental assisting regulators in other Canadian jurisdictions.

The consultation highlighted stakeholders’ concerns about the current method of approving the X-ray curriculum for Ontario dental assisting programs. It also highlighted how existing policies governing the assignment of intra-oral duties to DAs and of delegation authority could be revised to improve both efficiencies and the transparency of dental care in Ontario.

In considering this request, we took into account the supervisory relationship between DAs and the dentists by whom they are employed. We determined that this relationship would not likely change with regulation. We also noted the lack of relevant available research related specifically to the risk of harm in the practice of the profession.

This application did not meet our primary criterion threshold for risk of harm, thereby making an assessment of the secondary criteria unnecessary. The recommendation was based on the information available to us during the referral period. We recognize that Ontario remains one of the few Canadian jurisdictions that do not regulate DAs; however, our review of the existing legislation and oversight mechanism shows that they are adequate enough to address any residual risk related to the duties of the profession.

We look forward to meeting with you to discuss the findings in this report and our recommendations.
Sincerely,

Original signed by
Thomas Corcoran, Chair

Original signed by
Bob Carman, Member

Original signed by
Rex Roman, Member

Original signed by
Said Tsouli, Member

Original signed by
Peggy Taillon, Member
The Health Profession Assistant: Consideration of the Dental Assistant Application for Regulation

Report by the Health Professions Regulatory Advisory Council

April 2013
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Executive Summary

On June 28, 2007, the Minister of Health and Long-Term Care (MOHLTC) asked HPRAC in a letter to “advise whether the practice of dental assistants ought to be regulated under the [Regulated Health Professions Act, 1991] (RHPA) and if so, what would be the appropriate scope of practice, controlled acts and titles authorized to the profession.” The Minister also asked HPRAC to “take into account the activities these practitioners undertake with respect to X-rays and other forms of energy and the circumstances in which these are being done.”

The dental assisting profession has existed for at least a century, and even longer in some jurisdictions. Dental assistants (DAs) work in a variety of practice settings, including solo dental practices, group practices, specialty practices, hospital dental clinics, dental school clinics and the military. Some are employed in public health units and community oral health clinics. Dental assistants assist other dental professions during the examination and treatment of a patient, perform administrative tasks and are responsible for sterilizing dental equipment and work surfaces.

In Ontario, the dental assisting profession is classified into two levels: level I and level II DAs. Ontario’s DAs’ practice does not include performing any controlled acts, and DAs are not authorized to provide care independent of the supervising dental professional.

The regulation of DAs varies by jurisdictions. Some DAs are self-regulated, while many are regulated by interprofessional regulatory bodies or via regulation under the dental profession. In Ontario, DAs are not regulated. HPRAC invited the Ontario Dental Assistants Association (ODAA), the DAs’ provincial association, to submit an application to regulate DAs under the RHPA. In November 2011, ODAA submitted that application.

This report outlines the results of HPRAC’s review of ODAA’s application and the additional information available at this time. Regulatory oversight must be proportional to risk and promote safe, effective and patient-centred health care, clearly and simply.

HPRAC’s review process did not include an assessment of the merits of the profession seeking regulation. HPRAC’s criteria are used to decide whether to recommend a health profession for regulation. Applicants from professions seeking regulation under the RHPA must meet a “risk of harm threshold” and demonstrate with evidence that there is a risk to the public if the profession remains unregulated. They must also demonstrate that it is otherwise in the public interest that the particular profession be regulated under the RHPA. HPRAC then considers whether it should recommend regulating a profession (or recommend another mitigating measure) for a profession that poses a risk of harm to the public if it is not regulated.

As part of its assessment, HPRAC also conducted an extensive public consultation program between December 2011 and February 2012, asking a number of organizations and individuals to comment on the issue. The program brought in a total of 1,147 responses. Key informant interviews were also conducted, in order to identify and confirm interests and concerns from the consultation process. As well, HPRAC considered the existing legislative framework and the existing policies of regulated dental professionals that affect DAs, and whether an additional layer of oversight is needed in the form of self-regulation under the RHPA.
The principle guiding HPRAC’s recommendation is whether the submission met the risk of harm threshold. Based on HPRAC’s criteria, the submission and additional information available at this time, there is insufficient evidence to meet the risk of harm threshold. HPRAC therefore recommends that:

1. Dental assistants not be regulated as an independent regulatory college under the *Regulated Health Professions Act, 1991* (RHPA).
2. Appropriate changes be made to existing policies to ensure that intra-oral duties are assigned to qualified individuals and that adequate supervision is provided when these duties are performed. These policies should also be communicated broadly to all members of the dental community, including DAs.
3. The dental colleges collaborate to develop common standards and guidelines as they relate to shared practices within a dental office.
4. MOHLTC collaborate with regulated dental colleges and ODAA to review existing delegation policies for dental care in Ontario, especially as they relate to dental assistants’ duties and, where necessary, amend the existing regulation on delegation under the *Dentistry Act, 1991*.

Under the existing regulatory framework, in which DAs are not delegated controlled acts and do not practise independent of another dental profession (chiefly dentists and dental hygienists), there is insufficient evidence that DAs meet the risk of harm threshold for self-regulation under the RHPA. HPRAC does recognize, however, that the policies affecting dental care in Ontario could be refined to ensure better patient protection and promote better patient experience through more collaborative dental practices.
Chapter I: Recommendation

The Health Professions Regulatory Advisory Council (HPRAC) recognizes the valuable role that dental assistants (DAs) play in providing dental care to Ontarians. DAs facilitate the work of other dental professionals. Within this context, and after careful review of the application provided by the Ontario Dental Assistants Association (ODAA), along with consultation and further research, HPRAC recommends that:

1. Dental assistants not be regulated as an independent regulatory college under the Regulated Health Professions Act, 1991 (RHPA).
2. Appropriate changes be made to existing policies to ensure that intra-oral duties are assigned to qualified individuals and that adequate supervision is provided when these duties are performed. These policies should also be communicated broadly to all members of the dental community, including DAs.
3. The dental colleges collaborate to develop common standards and guidelines as they relate to shared practices within a dental office.
4. MOHLTC collaborate with regulated dental colleges and ODAA to review existing delegation policies for dental care in Ontario, especially as they relate to dental assistants’ duties and where necessary amend the existing regulation on delegation under the Dentistry Act, 1991.

Under the existing regulatory framework, in which DAs are not delegated controlled acts and do not practise independent of another dental profession (chiefly dentists and dental hygienists), there is insufficient evidence that DAs meet the risk of harm threshold for self-regulation under the RHPA. HPRAC does recognize, however, that the policies affecting dental care in Ontario could be refined to ensure better patient protection and promote better patient experience through more collaborative dental practices.

The Minister had asked HPRAC to consider the DA’s duties as they relate to X-rays and other forms of energy. Additional research was conducted to determine the existing oversight mechanism and the process for DAs to be authorized to take and expose dental radiographs. Chapters III and V provide a summary and analysis of this work.

Why This Decision?

The principle guiding this recommendation is whether the submission met the risk of harm threshold. Based on HPRAC criteria, the submission and additional information available since the submission, there is insufficient evidence to meet the risk of harm threshold.

HPRAC’s criteria to assess whether a health profession should be regulated are based on a two-part process. During the first part of the assessment (the primary criterion stage), HPRAC determines whether the applicant meets the risk of harm threshold. In determining whether this threshold has been met, HPRAC relies on relevant, verifiable evidence from the applicant. Information on the types of evidence that inform the policy process can be found in HPRAC’s guide, Regulation of a New Health Profession under the Regulated Health Professions Act, (RHPA), 1991: Criteria and Process.

At this time, there is insufficient evidence to demonstrate that the applicant meets the risk of harm threshold in the realm of oral health care. Furthermore, there is insufficient evidence to
demonstrate that the deficiencies of existing regulatory mechanisms are such that public safety is at risk.

HPRAC proposes that the existing policies and legislation affecting the DA practice be reviewed in order to maximize Ontario’s DAs’ ability to perform their full national skill set. The existing policies that enforce the appropriate assigning of intra-oral care duties (as it relates to DAs) should also be reviewed and their enforcement clarified to ensure that only certified level II DAs in Ontario perform intra-oral care. HPRAC also supports ODAA’s continued strong role of governance over certified DAs in Ontario, and encourages ODAA’s continued leadership of the dental assisting profession by advocating for higher standards of education and training as well as collaborating with other dental health professionals to improve oral health care in Ontario.
Chapter II: Background

Referral Question

On June 28, 2007, the Minister of Health and Long-Term Care (MOHLTC), The Honourable George Smitherman, asked HPRAC to “advise whether the practice of dental assistants ought to be regulated under the RHPA and if so, what would be the appropriate scope of practice, controlled acts and titles authorized to the profession.” The Minister also asked HPRAC to “take into account the activities these practitioners undertake with respect to X-rays and other forms of energy and the circumstances in which these are being done.”

This request for advice was subsequently reiterated by the current Minister of Health, The Honourable Deb Matthews, in her March 26, 2010, letter, when she extended the timeline for receipt of the advice.

HPRAC invited ODAA to submit an application to regulate dental assistants (DAs) under the RHPA. In November 2011, ODAA submitted that application.

Dental Care

Unlike medical care, which is publicly funded in Canada (and access to which is protected by the Canada Health Act), oral care is mainly funded by patients and private insurance providers. According to the Canadian Institute for Health Information (CIHI), Canadians spent $12.1 billion on private dental care in 2010, with $6.5 billion of that paid by private insurance and $5.6 billion by households, whereas $732 million of public health care expenditures went to dental services.¹

Even though dental care is not publicly funded, many Canadians are able to afford dental services. According to Statistics Canada’s Canadian Health Measures Survey’s Oral Health Module, between 2007 and 2009, 74.5% of Canadians surveyed reported that they have visited a dental professional in the previous 12 months, and 85.7% had visited within the last two years.²

In Ontario, access to dental care is largely restricted to those who can pay out-of-pocket or via their dental insurance plans.³ Public dental programs offer limited oral care for low-income

² Statistics Canada, Canada Health Measures Survey (CHMS), 29, accessed November 2, 2012, www.fptdwg.ca/English/e-documents.html. Data were collected by Statistic Canada from 6,000 people in 15 communities randomly selected across Canada. The sample represents 97% of the Canadian population aged six to 79.
Ontarians or those on social or disability assistance. The eligible population for these programs is mostly limited to children and adolescents.

Nevertheless, a recent policy report has expressed concerns over the lack of affordable oral health care for all Canadians and the correlation between poor oral health and those who cannot afford private insurance for dental care. This poor oral care, in turn, affects overall health. According to the Canadian Centre for Policy Alternatives’ (CCPA’s) report on the future of dental care in Canada, “A mounting body of evidence shows a correlation between poor oral health and higher incidence of diabetes, cardiovascular disease, pneumonia and Alzheimer’s.” The authors of this report also note that dental decay can largely be prevented through early treatment by dental care professionals.

Various dental health professionals make up the dental care team. Of the 23 regulated health professions in Ontario, four are dental care professions (i.e., dentists, dental hygienists, denturists and dental technologists). Most dentists are in “sole practitioner” private practice (54%), with 19% in partnerships and 19% working as associates in a private practice. Depending on the type of dental practice, the dental team can include all four dental care professions as well as DAs. Dental assistants assist oral health care professionals during the examination and treatment of patients. They may also perform clerical duties in dental offices.

**Dental Assistants in Canada**

It is estimated that there are between 26,000 and 29,000 DAs in Canada. Approximately 20,000 DAs are registered with a provincial dental assisting association, and 74% of those are certified/licensed. DAs work in a variety of practice settings, including “sole practitioner” dental practices, group practices, specialty practices, hospital dental clinics, dental school clinics and the military. Some are employed in public health units and community oral health clinics.

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4 Ibid.
5 Ibid.
7 CCPA, *Putting our money where our mouth is*, 7.
8 Ibid., 8.
9 At the time of writing, Ontario had 23 health professions, which were regulated by 21 regulatory colleges.
13 Ibid.
14 HPRAC literature review, 11 (see Volume 2).
15 Ibid., 22.
However, most DAs are employed in the offices of licensed/registered dentists and dental surgeons.\(^1^6\)

The dental assisting profession has existed for at least a century, and even longer in some jurisdictions.\(^1^7\) Women dominate the profession: the Canadian Dental Assistants Association (CDAA) estimates that 99% of the profession is female.\(^1^8\) DAs fall under two classifications: level I and level II DAs.

## Level I Dental Assistants

Level I DAs are mainly responsible for the performance of “chair-side” assistant roles, including sterilizing dental instruments and the clinical area, charting patient information, exposing and processing radiographs, preparing cast models and providing patient education and post-operative instructions.\(^1^9\) Level I DAs may also perform some administrative duties, such as maintaining and ordering dental supplies.\(^2^0\)

Historically, level I DAs received on-the-job training; however, some jurisdictions, including Ontario, have formal training programs. Ontario graduates of level I DA programs are not recognized in other parts of Canada, because there is no accreditation of level I DA programs in this country.\(^2^1\)

Ontario offers formal level I DA training programs in both publicly funded and private career colleges.\(^2^2\) According to the ODAA, individuals may also receive training in a high school technical program, and some opportunities still exist for level I DAs to be trained on the job.\(^2^3\) In Ontario certification for level I DAs can be obtained through ODAA.

## Level II Dental Assistants

Level II DAs can perform all the duties of level I DAs as well as “intra-oral duties,” including taking dental radiography, polishing the coronal part of the teeth, placing and removing dental dams, obtaining impressions of the teeth, providing intra-oral hygiene instructions, applying topical anesthetics, applying pit and fissure sealants and applying desensitizing agents.\(^2^4\) In some

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16 HPRAC jurisdictional review, 5 (see Volume 2).
17 HPRAC literature review, 3.
18 CDAA, “Dental Assisting in Canada.”
20 Ibid.
22 ODAA application, 25 (see Appendix D).
23 Ibid.
24 Ibid., 6-7.
jurisdictions, level II DAs may perform other duties, including suture removal, pulp vitality testing, periodontal screening and periodontal recording.25

Level II DAs in Canada must have a community college-level education from an accredited institution (or be subject to program review) and be certified through the national certifying body, the National Dental Assisting Examining Board (NDAEB).26 NDAEB is the national body responsible for identifying common skills and competencies for level II DAs, as well as administering the certification examination, which was established in 1997.27 This examination ensures that DAs are competent in the 13 common skills that all level II DAs in Canada must possess.28 Successful completion of the examination results in certification as a level II DA, which is required by most Canadian jurisdictions for licensing by and registration with the regulatory body or association.29

Applicants pursuing NDAEB certification must qualify for the certifying examination. To qualify, applicants must successfully complete the necessary theoretical and clinical education at a recognized DA program (a program that has been accredited by the Commission on Dental Accreditation of Canada [CDAC]).30 If a DA has graduated from a non-accredited dental assisting program, he or she must have his or her credentials reviewed by NDAEB’s Candidate Eligibility Assessment Committee prior to being granted eligibility to take the examination.31 In some provinces, those who have graduated from non-accredited programs may also be required to take NDAEB’s Clinical Practical Evaluation (CPE) in order to be licensed/registered to practise.32

NDAEB’s Domain Description for Dental Assisting outlines the national core skills tested in the examination.33 The Description lists the knowledge, skills, attitudes and behaviours that all level II DAs should possess upon entry/re-entry into practice.34 It is a working document that reflects the national standards of practice established for dental assisting, and includes all core skills agreed upon by NDAEB and stakeholders of the profession (a list of the national skill set can be found in the appendices of ODAA’s application).35

26 HPRAC jurisdictional review, 21.
28 Ontario DAs are trained to apply treatment liners, matrices and wedges, but are not permitted to perform these duties. CDAA, “Canadian Dental Assisting Legal Scope of Practice by Province.”
29 National Dental Assisting Examining Board (NDAEB), “About Us.”
31 Ibid.
33 NDAEB, “Candidate Handbook for the NDAEB Written Examination.”
34 Ibid.
35 Ibid.
ODAA and Dental Assistants in Ontario

In Ontario, ODAA has been the certifying body for DAs since 1961. Established in 1934, ODAA is the professional association for Ontario’s DAs, and its members include both level I and level II DAs, as well as receptionists, practice managers, treatment coordinators and educators. Because membership in the association is voluntary, not all DAs in Ontario are members of ODAA. At the time of this review, ODAA had close to 8,500 members; however, the association estimates there may be 13,000–15,000 DAs working in various dental clinics in Ontario. The association promotes the profession’s interest and advocates on its behalf. It also provides membership support and benefits.

According to ODAA, before level II DAs were introduced in Ontario, preventative dental assistants (PDAs) were a class of DAs registered with RCDSO; they were level I DAs with additional skills that enabled them to perform five intra-oral duties. ODAA reports that many PDAs have upgraded to become level II DAs, but that a number of PDAs are still working in Ontario (ODAA reports 263 of its members are PDAs). Currently, all certified DAs in Ontario have either level I or II classification, as there have been no new PDA graduates since 2000. Level II DAs conform to NDAEB core skills, and those who wish to be certified must complete the NDAEB examination process. Table 1 lists the duties of three different classes of DAs in Ontario.

Table 1: Ontario DAs’ Duties

<table>
<thead>
<tr>
<th>Duties</th>
<th>Level I DA</th>
<th>PDA</th>
<th>Level II DA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of the treatment/clinical area</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cleaning and sterilization of instruments and handpieces</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Passing instruments to the dentist or hygienist (single- and two-handed technique)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Proper use of high-volume evacuator within the oral cavity</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Preparation of restorative materials</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Performing simple laboratory procedures such as the pouring and application of matrices and wedges, and application of treatment liners.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

36 ODAA application, 4.
38 ODAA application, 47.
40 Personal communications with ODAA.
42 The following skills cannot be performed by level II DAs in Ontario at this time because they are controlled acts: application of matrices and wedges, and application of treatment liners.
### ODAA’s Request for Regulation

As both the profession’s association and the certifying body for Ontario DAs for more than 50 years, ODAA has collaborated with RCDSO and the Ontario Dental Association (ODA) to promote the certification of all Ontario DAs. In November 2011, ODAA submitted an application to request the regulation of DAs under the RHPA. ODAA’s submission argues that as long as DAs remain unregulated, those who do not have formal training or who have been
trained at an unaccredited program may pose a risk of harm to the public. In its submission, ODAA identified three areas of DA practice that pose a risk of harm to the public: infection control, dental radiography and intra-oral duties. As well, ODAA has argued that the existing oversight of DAs by supervising dentists is inadequate, and that therefore the profession requires regulation.43

Infection Control

DAs are responsible for the sterilization of dental equipment, sanitation of the clinical area and proper handling of dental waste. In its submission, ODAA expressed its concerns about dentists who assign “infection control procedures and protocols to personnel with no formalized education in asepsis, with little or no knowledge of the potential gravity of an error or omission; [this] is both unfair and nothing short of dangerous for patients.”44 According to ODAA, while it is true that the dentist owns the dental practice and therefore oversees its overall operation, dentists rarely directly supervise the sanitization and disinfection of operatories, the sterilization of instruments or biological monitoring procedures.45

Radiography

In many dental offices, DAs are primarily responsible for exposing, mounting and processing radiographs. In its application, ODAA also expressed concern about dentists who assign dental radiographic exposure duties to DAs who have not been properly educated. ODAA stated in its submission that the existing process to approve radiography educational curriculum in DA programs is problematic, because it is based on a one-time approval review of curriculum and equipment.46 Even when radiography curricula are approved in accordance with the administration of the Healing Arts Radiation Protection Act (HARPA), the programs are not regularly monitored.47 ODAA is particularly concerned about non-accredited DA programs in Ontario, stating that:

Many Ontario dental assisting educational programs are not accredited and thus there are unknown standards with respect to the faculty hired to teach radiography at many of these facilities. Though these programs may be HARP approved, the HARP Commission no longer exists and Ministry of Health and Long-Term Care personnel do not regularly monitor the program, review the curriculum or review the credentials of the teaching staff.48

43 ODAA application, 15
44 Ibid., 11.
46 Ibid., 24.
47 Ibid., 11.
48 Ibid., 11.
According to ODAA, this situation creates a potential risk of harm for patients, who may experience overexposure to ionizing radiation because of operator errors or retake exposure.\(^{49}\)

**Intra-Oral Duties**

Level II DAs perform a number of intra-oral duties (e.g., applying pit and fissure sealants, desensitizing agents, topical anesthetics and acid etch; performing coronal polishing; whitening the coronal portion of the tooth; applying and removing dental dams; performing fluoride treatments; and obtaining alginate impressions) that, the ODAA asserts, can cause patient discomfort and potential exposure to harmful substances if performed incorrectly.\(^{50}\)

ODAA reported in its submission that “[t]here is a common perception that both level 1 and level 2 dental assistants are directly supervised by their dentist/employer. ODAA’s surveys and interaction with its members reflect exactly the contrary. [The] feedback suggests while dentists may be on the premises, their supervision of dental assistants is very indirect.”\(^{51}\)

ODAA supports the idea of indirect supervision\(^{52}\) when key elements of education, qualification and accountability are in place. ODAA’s application noted how regulating DAs would help enforce the profession’s educational and training standards. Patients are at risk of harm unless a DA who performs at-risk tasks (intra-oral care, dental radiographs and infection control) is properly trained and certified. ODAA is concerned about DAs who are trained on the job or who graduate from non-accredited programs, because there is no additional accountability or oversight other than the supervising dental profession. According to ODAA, graduates from private career colleges that offer non-accredited dental assisting programs should undergo the national certification process (which includes completing the CPE) by NDAEB. There is no authority to enforce this requirement, however.\(^{53}\) Moreover, ODAA has noted the insufficiency of such oversight: its members have reported that inappropriate duty assignments have been made to DAs, including the delegation of controlled acts, by dentists.\(^{54}\) ODAA argues, therefore, that DAs must be regulated under the RHPA.

ODAA also opposes the idea of another profession checking a DA’s NDAEB credentials, because the Association considers it to be “unofficial, ineffective, antiquated and patriarchal.”\(^{55}\)

**The Regulation of DAs**

If DAs were to be regulated in Ontario, ODAA proposes creating three classes of registrants: level I DAs, PDAs and level II DAs. ODAA currently certifies level I DAs who have graduated

\(^{49}\) Ibid., 18.

\(^{50}\) Ibid., 11.

\(^{51}\) Ibid., 16.

\(^{52}\) The ODAA application notes that direct supervision means physical proximity; thus, if the dentist is on the premises but does not provide direct oversight to the DA, this is considered indirect supervision.

\(^{53}\) ODAA application, 15.

\(^{54}\) Ibid., 24.

\(^{55}\) Ibid., 12.
from a HARPA-approved DA program. However, in order to align with other Canadian jurisdictions, ODAA believes that level I DAs will eventually be phased out.\textsuperscript{56} Since 2000, there have been no new PDA registrants, and most PDAs have now upgraded to become level II DAs (although a couple of hundred have not); hence the need to include this class of registrants. Ultimately, ODAA seeks to recognize only one standard of dental assisting: level II DAs.\textsuperscript{57}

ODAA proposed that graduates from accredited level II DA programs be registered to practise after meeting the existing NDAEB certification requirements. Graduates from non-accredited DA programs must also complete the CPE in addition to the NDAEB examination in order to register as level II DAs. ODAA also proposed that level II DAs be authorized to perform the controlled acts that are part of DAs’ national skill set (including the placement and removal of matrices, wedges and treatment liners). This would allow Ontario DAs to practise within the same national scope of practice as their colleagues in other Canadian jurisdictions. If regulated, ODAA also proposed that Ontario’s level II DAs be allowed to take on expanded duties by developing post-graduate modules (such as limited scaling, orthodontic and prosthodontics training).\textsuperscript{58}

\section*{HPRAC’s Criteria}

ODAA’s request for regulation was considered via the application of HPRAC’s criteria for regulation of a new profession under RHPA.

For referrals, the primary criterion addresses whether the health profession seeking regulation poses a risk of harm to the health and safety of the public. This criterion acts as a gating mechanism: the applicant must present a solid, evidence-based argument, based on a preponderance of evidence, that there is a risk of harm to the public before its application moves to the next level. Once an applicant meets the primary criterion threshold, it is then assessed on the extent to which it meets the secondary criteria. HPRAC applies the secondary criteria to determine whether regulation under the RHPA is the most appropriate course of action or whether another approach to risk mitigation would lead to a better outcome. This level of assessment focuses on profession-specific factors and assesses whether regulation under the RHPA is, in fact, the best way to protect the public.

To assist applicants, HPRAC has produced a process and criteria guide, \textit{Regulation of a New Health Profession under the Regulated Health Professions Act, (RHPA), 1991: Criteria and Process}. See Volume 2 for more information on HPRAC’s criteria and process, and Chapter V: Rationale, for information on how the criteria were applied to the application.

\begin{flushright}
\textsuperscript{56} ODAA application, 50.
\textsuperscript{57} Ibid., 34
\textsuperscript{58} Ibid., 34, 40.
\end{flushright}
Chapter Summary

As part of the dental care team, DAs are frontline health care practitioners who provide clinical as well as administrative support to other dental health professionals on the team. ODAA submitted an application to regulate DAs under RHPA and cited infection control, radiography and intra-oral care as areas of practice in which the association believes that public safety is at risk if these duties are performed by unqualified practitioners. ODAA also stated in its application that the current supervision of DAs’ duties by dentist is inadequate, and thus, without regulation of the profession, unqualified practitioners may be hired to perform DA duties. ODAA seeks to mitigate this risk through regulation of the profession.
Chapter III: What We Learned

Three major reviews were completed in support of HPRAC’s recommendation. Information from these reviews was made publicly available during the consultation period. For the full text of the reviews, including search methodology, see Volume 2.

Additional research was conducted by HPRAC on a range of topics in order to better understand the risk of harm and public interest issues related to dental assistants in Ontario. This included a review of the current oversight structure for the DA practice and Ontario’s existing legislation on radiographic imaging.

Literature Review

HPRAC commissioned a literature review of both recent and seminal documents related to the profession of dental assistants. The review’s findings support HPRAC’s evidence-informed policy development process. It focused on the determination of risk of harm (physical, mental, physiological and psychological) and the impact of the practice of the DA profession on patient safety.

The review also identified three areas of dental assisting duties with the potential to cause harm:

- dental X-rays,
- sterilization procedures, and
- inhalation sedation.

The review was completed prior to the receipt of ODAA’s application and therefore the items identified as having the potential to cause harm differ from the areas of risk ODAA has identified in its application. Further research on intra-oral care was also done; see “RCDSO Intra-Oral Activities’ Assignment Policy,” below.

Dental X-Rays

Exposure to high doses of ionizing radiation can increase a person’s lifetime risk of developing various types of cancers.\(^5\)\(^9\) Evidence that HPRAC reviewed regarding ionizing radiation exposure from medical and dental X-rays is less conclusive:

No literature was identified that assessed patient safety issues in terms of DAs specifically using X-rays/radiography; however, a broader search in terms of patient safety and dental radiography in general identified 11 relevant sources. Overall, this literature suggests that the risks from dental x-rays are low, and compared to other

sources of radiation (e.g., medical exams involving radiation exposure and natural sources), risks from exposure to dental X-rays is small.\textsuperscript{60}

Regular dental check-ups often include taking a set of dental X-rays. These X-rays are used to diagnose dental problems that cannot be seen through a clinical exam, including between-teeth decay, bone loss or the presence of dental infections.\textsuperscript{61} The benefits of the information gained from an X-ray may outweigh any potential risk of radiation exposure associated with the procedure.

Recently, the media have reported rising thyroid cancer rates; indeed, over the past 30 years, the thyroid cancer rate has doubled, and the attributable cause is the excessive use of dental X-rays.\textsuperscript{62} HPRAC’s literature review confirmed reports of the increased use of dental X-rays across jurisdictions.\textsuperscript{63} The evidence suggests, however, that the risk of developing cancer from dental X-ray radiation exposure is still low compared to other sources of radiation. For example, one study found that the estimated risk of developing a fatal cancer from two intra-oral bitewing exposures, or from a dental panoramic tomography, is approximately one tumour for every two million exposures.\textsuperscript{64} This translates to a lifetime risk of cancer to 0.02–0.6 tumour per million exposures for bitewing X-rays, and 0.21–1.9 per million for panoramic dental X-rays.\textsuperscript{65} Exposure to natural sources of radiation is believed to pose a higher risk for cancer than does exposure from these types of dental X-rays.\textsuperscript{66}

**Sterilization Procedures**

Inadequate sterilization of equipment has also been identified as potentially carrying a risk of harm, since inadequate infection control protocols in a dental office can transmit disease. As part of their duties, DAs sterilize dental equipment and sanitize the clinical area. No research was identified, however, that specifically examined the risk involved in sterilization procedures carried out by DAs versus other dental professionals.\textsuperscript{67} One commentary, though, which was

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\textsuperscript{60} HPRAC literature review, 5.


\textsuperscript{62} Fiona Macrae, “Ten dental X-rays ‘raise cancer risk’,” Mail Online (June 8, 2010); Christian Nordqvist, “Multiple Dental X-rays Raise Risk of Thyroid Cancer,” Medical News Today (June 6, 2010); “Are dental X-rays dangerous?” CNN (September 15, 2011).

\textsuperscript{63} HPRAC literature review, 5.

\textsuperscript{64} Ibid., 3.


\textsuperscript{67} V.M Ng, G. Sidhu, & A.J. Woods, “Digital radiography for the dental assistant,” The Dental Assistant, (September–October), 22-7; B. Moffat, “21\textsuperscript{st} century dental assistants are knowledge workers,” The Dental Assistant (May/June 2003). Reprinted from the Journal of the Canadian Dental Association (June 2002).
written by the president of the Canadian Dental Assistants’ Association, endorsed the formal education and licensure of DAs to ensure patient safety as it relates to infection control.68

The literature review was broadened to determine the general risk of harm to patients in the context of infection control in dental offices. The review found that the overall risk of disease transmission from prion diseases (e.g., Creutzfeldt-Jakob disease) and opportunistic pathogens in dental settings remains low.69 Nevertheless, strict infection-control standards and decontamination procedures must be in place in dental offices in order to prevent the transmission of contaminants.70 One study noted that the practice of dentistry has developed definitive guidelines for infection control and, if followed properly, that these protocols can produce sterile instrumentation consistently.71 The same study also asserted that sterilization is a complex process that requires specialized equipment, adequate space and qualified personnel who undergo ongoing training.72 It did not, however, isolate dental assisting as the dental profession that should be responsible for this task, but noted instead that adequate sterilization is the dental team’s collective responsibility.73

Inhalation Sedation

The literature review also searched for evidence on the risk of harm when DAs apply inhalation sedation. No studies were found that examined this risk, however. As well, the practice of applying inhalation sedation appears to be limited to DAs in the United States, as this duty is not part of the national scope of practice for DAs in Canada.74

Jurisprudence Review

HPRAC conducted a jurisprudence review to explore legal cases relevant to the DA profession, and to provide insight into the risk posed to the public by DAs.

68 B. Moffat, “21st century dental assistants are knowledge workers.”
72 Ibid.
73 Ibid.
74 CDAA, “Canadian Dental Assisting Legal Scope of Practice by Province.”
The review found nine relevant cases related to the profession, two of which were from Ontario. None of the cases were related to harm caused directly by DAs; rather, they addressed errors of a procedural and competency nature that could potentially lead to harm. Improper delegation was alleged by the complainant in several decisions, speaking to the need for DAs to understand their professional limits and for dentists to comply with the laws addressing delegation. When a risk is identified, the courts usually point to the dentist as being ultimately responsible for the harm caused.75

Jurisdictional Review

HPRAC undertook a jurisdictional review to determine if and how DAs are regulated in other jurisdictions. A total of 19 jurisdictions were reviewed, including 10 Canadian provinces and six selected jurisdictions in the United States, as well as one each in the United Kingdom, Australia and South Africa. The review found that there is no uniform model of regulation among the 19 jurisdictions. Furthermore, it found that autonomous self-regulation is not the model of choice in most jurisdictions; instead, a spectrum of regulation governance is used for DAs.76

For example, Nova Scotia, Manitoba, British Columbia, Michigan and Minnesota permit DAs working in these jurisdictions to sit on governing councils/boards or statutory committees and to share regulatory duties with other dental professions at the executive level.77 Other jurisdictions (e.g., New Brunswick, Newfoundland and Labrador, California and New York) have adopted models of regulation wherein DAs have limited involvement in regulatory duties. In these jurisdictions, DAs are not invited to sit on boards or governing councils and are not normally included in committee work.78

In Canada, only level II DAs are regulated, mainly through the regulations and by-laws of dentists’ and dental surgeons’ regulatory bodies or through DA membership on executive board/councils or statutory committees. DAs are self-regulated in only two provinces (Alberta and Saskatchewan), and are not regulated in Ontario and Quebec.

In the unregulated provinces, public protection falls on mechanisms such as the province’s labour standards, occupational health and safety legislation, employer’s liability insurance, certification opportunities through an examination board and on-going professional development as a condition of membership in a professional association.79 In Ontario, ODAA is the certifying body for DAs; however, this certification is voluntary.

75 HPRAC jurisprudence review, 4.
76 HPRAC jurisdictional review, 8.
77 Ibid., 8-9.
78 Ibid.
79 Ibid., 3.
Scope of Practice and Settings

DAs work in many different types of settings, including private practices for general dentists and specialists, public health units, dental hygiene clinics, denture clinics, dental labs, community and private colleges, industry-related companies and insurance companies. HPRAC’s review looked at the DAs’ practice to determine if the scopes of practice differ significantly across these settings.

Across the jurisdictions, HPRAC’s review found considerable consistency in the core activities that DAs perform. Since DAs primarily function under the direction of another dental professional, a complete list of their tasks and duties may not be captured in statute. This is particularly true for level I DAs, who are not regulated in most of the jurisdictions HPRAC reviewed.80 It is possible, therefore, that, under the direct supervision of their employing dental professional, some level I DAs perform some procedures that are not formally documented. Although the scope of practice for level I DAs encompasses mainly extra-oral duties,81 some Canadian jurisdictions allow level I DAs to perform a limited number of intra-oral duties as long as they have some additional training.82 The one exception to this practice is in Nova Scotia, where level I DAs are explicitly prohibited from performing any intra-oral duties.83

In all the jurisdictions reviewed, the scope of practice for level II DAs includes all level I DA duties as well as certain intra-oral duties. HPRAC’s jurisdictional review found 66 different skills and competencies a level II DA can perform, depending on the jurisdiction.84 The majority of jurisdictions, however, shared the following core competencies/skills (a detailed chart of DAs’ legal scopes of practice in Canada can be found in the appendices of ODAA’s application):

- chair-side/extra-oral care
- operating X-ray equipment and performing dental radiologic procedures
- taking impressions for study casts or diagnostic casts, and for space maintainers, orthodontic appliances and occlusal guards
- placing and removing rubber dams
- placing and removing matrices and wedges
- oral hygiene instruction
- fluoride application
- topical anaesthetic
- suture removal
- applying desensitizing agents

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80 HPRAC jurisdictional review, 10.
81 According to the Canadian Dental Assistants Association, extra-oral duties refer to the chair-side activities a level I DA is responsible for, such as preparing the clinical area, sterilizing instruments, preparing dental materials and cements, assisting in dental procedures and processing and mounting radiographs.
82 HPRAC jurisdictional review, 11.
83 Dental Assistants Regulation, NS Reg 92/94, s. 5(3).
84 HPRAC jurisdictional review, 13.
• orthodontic modules (learning duties such as the placement of arch wires, elastics and bands)

In some U.S. states, DAs also monitor and assist in the administration of nitrous oxide and oxygen. In some Canadian provinces, level II DAs can be assigned orthodontic and prosthodontic duties, and limited scaling duties. These duties often require the DA to complete further training modules in order to perform them, however. Ontario’s level II DAs’ scope of practice follows the NDAEB national skill set except for two activities: the placing of treatment liners, and the placing of matrices and wedges.

Ontario DAs are not authorized to independently perform any controlled acts listed in the RHPA. RCDSO has classified two of the DA’s national core competencies as controlled acts: the placing of treatment liners, and the placing of matrices and wedges. Thus, although DA students are taught these procedures, they are not authorized to perform them in practice in Ontario. All jurisdictions permit level II DAs to expose, process and/or mount radiographs. In New Brunswick, level I DAs can place and expose radiographs provided they have successfully completed a course approved by the New Brunswick Dental Society Board. Similarly, certified level I DAs in Ontario may be authorized to operate an X-ray machine provided they have completed HARPA-approved courses.

DAs work alongside of another dental professional — usually dentists or dental surgeons — but in some cases they may work with denturists or dental hygienists as well. According to HPRAC’s research, the level of supervision a DA receives varies; however, most jurisdictions, including Ontario, require the supervising professional to be physically on the premises and available to intervene if need be.

The Education and Training of Dental Assistants

In a number of the 19 jurisdictions reviewed, level I DAs require no formal training or education beyond a high school diploma. Rather, skills are generally taught on the job by the employing dental profession. Regulator-approved training modules and courses in various fields (e.g., orthodontics, periodontal care and radiography) are available as continuing education modules. Although many provinces had formal education programs for level I DAs at one time, level II DAs are now considered the national standard in Canada. As noted in Chapter II, level II DA programs in Ontario are available at both private career and publicly funded colleges.

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85 HPRAC jurisdictional review, 19.
86 ODAA application, 9.
87 CDAA, “Canadian Dental Assisting Legal Scope of Practice by Province.”
88 HPRAC jurisdictional review, 21.
89 Ibid., 19.
90 Ibid., 21.
How Ontario is Different

Ontario is unique in several ways. First, Ontario offers a formal certification process for both level I and level II DAs, unlike most other jurisdictions. Second, according to ODAA, Quebec and Ontario are the only provinces in Canada that allow non-accredited level II dental assisting program graduates to bypass the NDAEB’s CPE.  

Ontario offers level I DA programs in publicly funded colleges and private career colleges, and in a high school technical program. Ontario’s Ministry of Training, Colleges and Universities (MTCU) has separate approval processes for dental assisting programs for publicly funded colleges and private career colleges. According to MTCU, as part of the approval process for private career colleges, the educational institute is required to provide a positive third-party assessment of its DA program in order to obtain program approval. MTCU sets the criteria for the third-party assessor, as well as a list of pre-approved assessors.  

In publicly funded colleges, all DA programs must meet the provincial college program standards for dental assisting. All college’s board of governors comprise external community and publicly appointed members, a student representative, the college president by virtue of office, and academic and administrative staff members who approve all programs offered by the college. As well, program advisory committees advise on program design and academic matters, and the credentials validation service is the college’s quality assurance body that ensures that a program meets its requirements.  

Although accreditation for DA programs in general is voluntary, CDAC only accredits level II or level I and II combined DA programs. Ontario’s publicly funded community college level II DA programs are accredited by CDAC, but none of the private career colleges offering level II dental assisting programs are accredited. The lack of a legislated requirement for graduates from these unaccredited programs to complete the NDAEB’s CPE may put patient care at risk, according to ODAA.  

The curriculum taught in Ontario level II DA programs is based on national set of competencies. For accreditation, colleges offering DA programs are required to provide instruction on all aspects of the national competencies, even if DAs are not allowed to practise those skills. As previously mentioned, two of the DA’s national competencies (the placing of treatment liners

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92 O Reg 415/06, ss. 11(2).  
95 O Reg 34/03, s. 4.  
96 Personal communications with MTCU  
98 ODAA application, 15.
and of matrices and wedges) are considered controlled acts by RCDSO. Ontario DA students learn theory and practical skills at a pre-clinical level using manikins, and instructors who are practising dentists provide supervision and training.99 This enables Ontario DAs to meet the national competencies’ requirement for examination.

**Labour Mobility**

Ontario graduates of accredited dental assisting programs who have NDAEB certification possess portable mandatory skills that allow them to practise in other Canadian jurisdictions.100 Some jurisdictions, however, provide for a wider scope of practice for level II DAs. Ontario DAs who move to these jurisdictions would likely have to upgrade their skills in order to gain a similar scope of practice. In these places, graduates of accredited programs in Ontario may be given provisional registration or a licence to practise while they are working to obtain the additional education required. Ontario graduates of non-accredited programs have less recognition and portability. These graduates must write the NDAEB exam, take the NDAEB CPE or retrain at a CDAC-accredited institute, and complete additional education if required.101

**Existing Regulatory Oversight**

In Ontario, the regulation of health professionals under the RHPA is just one part of a system of regulation. Other pieces of legislation provide an added layer of regulatory oversight to the provision of certain health care procedures, such as taking X-rays. The RHPA, however, is an overarching regulatory framework for the regulation of health professions in Ontario. This framework supports other aspects of the system, including effective governance (on both a micro and macro level) of ethical health care practitioners (HCPs), and a mechanism by which the broader public can be assured of the qualifications of HCPs.

The RHPA is structured on a controlled acts model that assumes that some health care procedures have a more significant risk of harm than other procedures. The act lists 13 procedures102 that, if not performed correctly and by a competent practitioner, have a high element of risk. These procedures are known as controlled acts, and the model identifies the existence of risk in a particular act. The RHPA also makes it an offence for unregulated health professionals to perform these procedures unless they have been properly delegated by a regulated health professional or meet the exceptions under the act.

The controlled acts model restricts access to high-risk procedures without restricting the scope of practice of health professions. This allows health care professionals who share the performance of the same controlled acts to have overlapping scopes of practice. This sharing can help promote

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99 Ibid., 44.
101 ODAA application, 30; CDAA, “Mutual Recognition Agreement for Purposes of Labour Mobility — Dental Assisting.”
102 Regulated Health Professions Act, 1991 (RHPA), s. 27(2).
collaboration amongst health professionals. The use of orders, directives and delegation sanctions and enables the performance of a procedure not authorized to a health professional.\textsuperscript{103}

According to RCDSO, an order “means the authorization required by a member of the College of Dental Hygienists of Ontario or the College of Nurses pursuant to their professional specific acts to permit members of these Colleges to perform their own authorized acts.”\textsuperscript{104} For example, dental hygienists can only initiate orthodontic and restorative procedures upon the order of a dentist.\textsuperscript{105} As an unregulated health profession, DAs have no authorized acts; therefore, DAs do not receive orders from dentists with the exception of when a dentist orders X-rays as per requirements under HARPA.\textsuperscript{106}

A medical directive is a type of order that is set up in advance to allow the performance of an ordered procedure(s) under specific conditions without direct assessment by the authorizer of the directive at the time.\textsuperscript{107} It is documented with appropriate authorization from the health professional(s) with the authority to give the order for the procedure(s), and approved by appropriate administrators.\textsuperscript{108}

The RHPA also permits a process whereby a regulated health professional authorized to perform a controlled act confers that authority to someone else — a regulated or unregulated health professional who is not authorized to perform the act.\textsuperscript{109} This process is known as delegation. The act also authorizes regulatory colleges to make regulations governing or prohibiting delegation of controlled acts by or to its members.\textsuperscript{110}

The \textit{Dentistry Act, 1991}’s professional misconduct regulation states that “[t]he following are acts of professional misconduct…. Delegating an act set out in section 4 of the Act except as permitted by the regulations.”\textsuperscript{111} However, according to RCDSO, in its publication to its members (\textit{Dispatch}), “[Delegation] authorization requires regulatory authority and until such time as the appropriate regulation is in place, dentists cannot delegate any of their authorized or controlled acts to anyone.”\textsuperscript{5} Similarly, the policies and regulations of the dental hygienists’ and denturists’ regulatory colleges give their members the authority to delegate the performance of

\begin{thebibliography}{99}
\bibitem{105} \textit{Dental Hygiene Act, 1991}, s. 5(2).
\bibitem{106} \textit{Healing Arts Radiation Protection Act} (HARPA), RSO 1990, c H 2, s. 6(1)b.
\bibitem{107} FHRCO, “An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario.”
\bibitem{108} Ibid.
\bibitem{109} Ibid.
\bibitem{110} RCDSO, “Level II Dental Assistants Now a Reality,” 11.
\end{thebibliography}
an authorized controlled act for the purpose of training individuals who are becoming members of their respective professions.113

Within the context of dental assisting, when referring to the communication between dentists and DAs for the direction of intra-oral duties that are not controlled acts, DAs are assigned intra-oral duties.114 DAs do not perform any intra-oral duties involving controlled acts, because there is no mechanism to authorize their receipt of delegation to perform these acts.

Ontario’s DA curriculum models the national competencies and skills set by NDAEB. Although DAs may be taught the full scope of the national competencies, they are not authorized to practise their full scope because of the existing policies regarding delegation among dental health professions. The national competencies include the application of treatment liners with no pulpal involvement and the application/removal of matrices and wedges, competencies that RCDSO considers to be controlled acts.115 Currently Ontario DAs have no appropriate authority to perform these procedures.

**RCDSO Intra-Oral Activities’ Assignment Policy**

Under the professional misconduct regulation contained within the *Dentistry Act, 1991*, members of RCDSO have an obligation to ensure that those who perform intra-oral procedures are qualified.116 The regulation states that “[t]he following are acts of professional misconduct… Ordering a person to perform an intra-oral procedure or delegating or assigning such a procedure to a person without first ensuring that the person is qualified to perform the procedure safely and competently.”117

In 1999, the RCDSO Council passed (in principle) standards of practice for assigning intra-oral duties.118 The *Standards Relating to the Performance of Intra-Oral Procedures by Third Parties*119 provide a greater degree of oversight by specifying that a dentist who authorizes an intra-oral procedure is responsible for the performance of the procedure, and that the dentist must be in the office while the procedure is being performed and must ensure that it is performed safely and competently before the patient leaves the office. The standards also outline the types of intra-oral duties that can be assigned and who may be qualified to perform these duties,120 including only assigning intra-oral duties to level II DAs who have completed the NDAEB certification exam.

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115 Ibid.
116 O Reg 853/93.
117 Ibid., s. 2(4).
118 RCDSO, “Level II Dental Assistants Now a Reality.”
119 Ibid.
120 Ibid., 14.
In a 2001 memo\textsuperscript{121} sent to its members, RCDSO informed them about council-approved changes to this standard. According to the memo, RCDSO was also proposing to amend its regulation under the \textit{Dentistry Act, 1991}, in order to make the standard enforceable and to permit its members to delegate. Following such amendments, the revised standards would have allowed delegation by a member of RCDSO (in accordance to standards determined by the College) to DAs so that they could perform the two intra-oral activities that are considered controlled acts. However, according to the College, these amendments have not been made and as such its members remain unable to delegate controlled acts.

HPRAC contacted RCDSO to inquire about the oversight of assigning intra-oral activities to certified level II DAs. It is not clear if this oversight is enforced, because it is not listed as a standard of practice on RCDSO’s website. ODAA indicated in its application that it understands that RCDSO does not monitor or enforce this standard;\textsuperscript{122} however, HPRAC heard from ODA it has communicated to its members that they are expected to follow the standard:\textsuperscript{123} that the dentist in a dental office will supervise dental assistants.\textsuperscript{124} Moreover, if there is inadequate supervision, RCDSO should be made aware of such practice (by patients, DAs, office staff, etc.), but to date, it has received only a handful of complaints.\textsuperscript{125}

\section*{The Legislation of Radiographic Imaging}

Exposure from ionized radiation, such as X-rays, can be a risk factor for cancer. HPRAC’s conclusion from the literature review was that while there is risk of exposure to ionizing radiation from dental X-rays, the evidence reviewed showed that the level of exposure is still low compared to other sources of radiation exposures (e.g., medical exams involving radiation exposure, and natural sources). Nevertheless, HPRAC did further examine how radiographic imaging is regulated as it relates to the dental assisting practice.

\section*{The Regulation of X-Ray Use in Other Jurisdictions}

HPRAC reviewed other Canadian jurisdictions to compare how Ontario regulates DAs for X-ray taking. In other jurisdictions that have a similar omnibus\textsuperscript{126} legislation governing health professionals, most have listed, or are in the process of listing, X-ray application as a restricted/reserved activity under legislation. For example, in Alberta, the application of X-ray machines is a restricted act. This restricts the use of these machines to regulated health professionals and adds an additional layer of regulatory control to the process. DAs are a

\textsuperscript{121} Memorandum from RCDSO to Ontario dentists, dated January 31, 2001, “Re: Revised Standards Relating to the Performance of Intra-oral Procedures by Third Parties.”
\textsuperscript{122} ODAA application, 44.
\textsuperscript{123} ODA submission, 43.
\textsuperscript{124} Correspondence from RCDSO to HPRAC, December 3, 2012.
\textsuperscript{125} Ibid.
\textsuperscript{126} The term “omnibus legislation” is used in this and other HPRAC reports to refer to umbrella legislation, such as Ontario’s RHPA, 1991, that governs all regulated health professions in a jurisdiction and that provides general provisions that apply to everyone.
regulated health profession in Alberta, and therefore are allowed to perform this restricted act. B.C. has proposed including X-ray application as a restricted activity in legislation.\textsuperscript{127} Manitoba has passed a bill that will create a system of reserved activity in which the use of X-ray machines will be listed as a reserved activity; however, that section of the act has not yet been proclaimed enforced.\textsuperscript{128} DAs are regulated in both these provinces and therefore would be authorized to perform the restricted/reserved activity accordingly.

In Quebec, because DAs are unregulated, they are not members, “of a professional order whose members are empowered by law to use x-rays,”\textsuperscript{129} and thus they are not authorized to take X-rays. Radiography skills are not part of the legal scope of practice for DAs in Quebec at this time.\textsuperscript{130}

Other Canadian jurisdictions, including Saskatchewan, New Brunswick, Prince Edward Island (PEI) and Newfoundland and Labrador, have separate legislation that regulates the use of X-rays. For example, under PEI’s \textit{Public Health Act}’s Radiation Safety Regulations, DAs are permitted to use X-rays on human beings provided the DA is “acting under the supervision of a registered dentist, or an instructor approved to teach the dental assisting student.”\textsuperscript{131}

In Newfoundland and Labrador, X-rays are regulated by the Radiation Health and Safety Regulations under the \textit{Radiation Health and Safety Act}. These regulations provide a practitioner (as defined by the \textit{Dental Act}) the authority to use X-ray equipment for irradiation of human beings.\textsuperscript{132} The Dental Auxiliaries’ Regulations under the \textit{Dental Act, 2008}, authorize DAs to expose, process and mount dental radiographs provided the DAs are under the direct supervision of dentists.\textsuperscript{133}

In Saskatchewan, X-ray machine use is regulated through the \textit{Radiation Health and Safety Act, 1985} (RHSA).\textsuperscript{134} The RHSA prescribes the registration, licensing, operational and technical standards of compliance for the installation and use of X-ray machines.\textsuperscript{135} DAs in Saskatchewan are explicitly allowed to use X-ray equipment, since they are self-regulated in that province.

In Nova Scotia, DAs’ scope of practice is set out in the \textit{Dental Act’s Dental Assistant Regulations}.\textsuperscript{136} This scope includes “exposing dental radiographs,” which allows DAs to use X-rays on patients.\textsuperscript{137}

\begin{itemize}
\item \textsuperscript{127} Health Professions General Regulation Restricted Activities (Consultation Draft March 19, 2010), \url{http://www.health.gov.bc.ca/professional-regulation/pdfs/Consultation_Draft_Restricted_Activities_March_19_2010.pdf}.
\item \textsuperscript{128} The Regulated Health Professions Act, C.C.S.M., c. R117, \url{http://web2.gov.mb.ca/laws/statutes/ccsm/r117e.php}.
\item \textsuperscript{129} Règlement d'application de la Loi sur les laboratoires médicaux, la conservation des organes et des tissus et la disposition des cadavres, RRQ, c L-0.2, r 1, 171(a).
\item CDAA, “Canadian Dental Assisting Legal Scope of Practice by Province.”
\item \textsuperscript{131} Radiation Safety Regulations, PEI Reg EC547/84, s. 8(1)(e).
\item \textsuperscript{132} Radiation Health and Safety Regulations, CNLR 1154/96, s. 10(3)(b).
\item \textsuperscript{133} Dental Auxiliaries’ Regulations, 2012, NLR 49/12, s. 13 (1).
\item \textsuperscript{134} Radiation Health and Safety Act, 1985, SS 1984-85-86, c R-1.1.
\item \textsuperscript{135} Ibid., ss. 3-6.
\item \textsuperscript{136} Dental Assistants Regulations, NS Reg 92/94.
\end{itemize}
Ontario's *Healing Arts Radiation Protection Act*

In Ontario, the act of taking and processing radiographs is not a controlled act under the RHPA.\(^{138}\) The use of X-rays for the irradiation of human beings, including the application and ordering of X-rays, is instead regulated under the *Healing Arts Radiation Protection Act, R.S.O. 1990* (HARPA).\(^{139}\) This act and its regulations govern X-ray machines’ standards and operation, and the qualifications of individuals operating them.\(^{140}\) In addition, HARPA authorizes inspectors from MOHLTC to examine X-ray machines, their operation and the premises in which such machines are installed.\(^{141}\)

HARPA specifies the health professions that have authority to operate an X-ray machine in Ontario:

- A legally qualified medical practitioner
- A member of the Royal College of Dental Surgeons of Ontario
- A member of the College of Chiropodists of Ontario who has been continuously registered as a chiropodist under the *Chiropody Act* and the *Chiropody Act, 1991*, since before November 1, 1980, or who is a graduate of a four-year course of instruction in chiropody
- A member of the College of Chiropractors of Ontario
- A member of the College of Medical Radiation Technologists of Ontario
- A member of the College of Dental Hygienists of Ontario\(^{142}\)

Dental assistants are not listed among those authorized to operate an X-ray machine; however, the general regulation under HARPA provides that people who complete specified dental assisting programs or a course in dental radiation safety as approved by the former HARP Commission and the MOHLTC-appointed Director of X-Ray Safety\(^{143}\) can also use an X-ray machine to irradiate human beings.\(^{144}\) This regulation allows qualified DAs in Ontario to use dental X-ray machinery.\(^{145}\) To enable training, DA students are allowed to take X-rays when under the supervision of a dentist.\(^{146}\)

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\(^{137}\) Ibid., s. 5(1)(c).
\(^{138}\) Section 27(2) of the RHPA refers to applying or ordering the application of a form of energy prescribed by the regulation under the Act as a controlled act.
\(^{140}\) Ibid., 8.
\(^{141}\) Ibid.
\(^{142}\) HARPA, s. 5(2).
\(^{143}\) Since June 22, 2009, when the regulation was amended.
\(^{144}\) O Reg 543.
\(^{145}\) Ibid.
\(^{146}\) Ibid., s. 5(1).
The act also requires that X-rays be prescribed by qualified individuals (such as physicians, nurse practitioners, dentists, chiropractors and podiatrists\textsuperscript{147}) before they can be taken. DAs are not, therefore, authorized to independently take X-rays unless the X-rays have been prescribed by a dentist.\textsuperscript{148}

**Responsibility for Oversight**

The HARPA also states that the owner of an X-ray machine must assign the role of “radiation protection officer” (RPO) to an individual who is either a qualified medical practitioner, a member of RCDSO, a member of the College of Chiropodists of Ontario or a member of the College of Chiropractors of Ontario.\textsuperscript{149} In a dental practice, the dentist assumes this role. This means that the dentist is responsible for ensuring that the X-ray machine within her or his dental office is maintained and operated safely.\textsuperscript{150} The RPO is also responsible for ensuring that DAs using the equipment are properly trained.\textsuperscript{151}

To ensure compliance with HARPA, the Minister of Health and Long-Term Care appoints a Director of X-ray Safety and inspectors\textsuperscript{152} who administer/enforce the act, which includes random inspections of X-ray facilities in Ontario. The inspectors may enter a facility containing an X-ray machine in order to inspect the premises, operations, records and radiographs, and to see where an X-ray machine is installed or operated. An inspector may also require the production of proof that any person who operates an X-ray machine meets the qualifications and requirements specified in the act.\textsuperscript{153} X-ray inspectors, during their inspection of a facility with X-ray machine, review the credentials of all operators qualified to take an X-ray. In dental facilities, those operators could be dentists, dental hygienists, medical radiation technologists or DAs.

Although HARPA provides prosecutorial authority, X-ray inspectors can report non-compliance with HARPA to RCDSO, and in some circumstances CDHO may be involved if the dental practice belongs to a dental hygienist.\textsuperscript{154} The X-ray Inspection Service conducted 1,398 inspections during fiscal year 2011–12, and approximately 85% of the registrants audited were dentists. These inspections resulted in the issuance of 1,401 orders, mostly for administrative issues (e.g., documentation was not available on-site for the inspector’s review). Inspectors are required to follow up on the orders they issue for non-compliance and, once a facility achieves compliance, the inspector identifies the timing of the next visit based on the inspection and its

\textsuperscript{147} According to s. 6(1) of HARPA, only chiropodists registered since before November 1, 1980 or who are graduates of a four-year course of instruction of chiropody, are authorized to prescribe or operate X-ray machines. Ontario’s chiropody’s program is currently only three years long.

\textsuperscript{148} HARPA, s. 6(1)(b).

\textsuperscript{149} Ibid., s. 9(1).

\textsuperscript{150} Ibid., s. 9(4).

\textsuperscript{151} O Reg 543, s. 8(1).

\textsuperscript{152} X-ray Inspection Unit, Performance Improvement and Compliance Branch, MOHLTC, personal communication, January 22, 2013.

\textsuperscript{153} HARPA, s. 20(4).

\textsuperscript{154} Ibid., s. 21(3)
outcome. X-ray inspectors track all inspections and orders compliance as the end result of all inspections. This applies to all facilities under HARPA jurisdiction.\footnote{Leo Tse, Manager, X-ray Inspection Unit, Performance Improvement and Compliance Branch, MOHLTC, personal communication, January 22, 2013.}

## Dental X-Ray Safety Programs

In Ontario, when a HARPA inspector requests proof of credentials for DAs operating a dental X-ray machine, the act requires that the DA has graduated from an appropriate course or program.\footnote{HARPA, s. 20(4).} Dental assistants trained in Ontario at schools with approved program and courses are automatically qualified to operate an X-ray machine upon graduation; their diploma/certificate is proof of successful training. However, internationally trained dental professionals or DAs from other Canadian jurisdictions working in Ontario may not meet the current HARPA requirements.\footnote{O Reg 543, s. 4, specifies 10 components that must be met in order to meet HARPA’s requirements.} These individuals are referred to the list of approved programs/courses such as the Dental Office Radiography Certificate at George Brown College.\footnote{George Brown College, Continuing Education Health Sciences and Community Services: Dental Office Radiography Certificate, accessed March 8, 2013, http://coned.georgebrown.ca/owa_prod/cewskcrss_P_Certificate?area_code=PA0042&stream_code=PS0460&cert_code=CE0105.} This certificate program comprises three compulsory courses, each of which takes approximately two to four months to complete. The courses cover subjects such as orofacial anatomy and dental radiography I and II.\footnote{Ibid.}

RCDSO has advised its members that transcripts showing successful completion of an approved DA program or dental radiology course, or a current ODAA certificate with a HARP designation, constitute sufficient proof of qualifications.\footnote{RCDSO, “How do I know if a Current or Prospective Staff Member has HARP Qualifications,” Dispatch, Vol. 13, No. 2 (July 1999), 11.} However, there is no requirement for continuing competence, and X-ray program curricula in Ontario are not subject to regularly scheduled reviews for currency and update.

Before 2009, the HARP Commission was responsible for approving dental radiology programs and DA educational programs for the taking of X-rays. By July 1, 2009, the Commission had no sitting members, and subsequently, in May 2011, it was decommissioned (repealed from HARPA). Since June 2009, MOHLTC’s office of the Director of X-ray Safety has assumed management of the course/program review process. The office is considering options for the development and management of the educational program review and approval process. Based on the existing legislation, as well as its changing management, previously approved programs are not currently being monitored or overseen.\footnote{Leo Tse, Manager, X-ray Inspection Unit, Performance Improvement and Compliance Branch, MOHLTC, personal communication.}
Chapter Summary

As part of the dental team, DAs work under the supervision of other dental health professionals to provide chair-side assistance and intra-oral care. HPRAC’s review (which included literature, jurisprudence and jurisdictional reviews) examined the risk of harm arising from DAs’ duties. The review found little evidence of risk of harm arising from DAs performing their duties, separate from the inherent risk of the area of health care within which the profession operates.

HPRAC’s review also examined the scope of practice and training of DAs, and noted the consistently defined core activities and training for level II DAs. The activities and training of level I DAs, however, are less consistent.

The national certification process for level II DAs has been adopted by most provinces in Canada. As well, across the jurisdictions reviewed, most DAs are regulated under a variety of regulatory models, the most common being interprofessional regulatory bodies or regulation under the dental profession. In provinces such as Ontario, however, where DAs are not regulated, oversight protection falls under other legislation, the supervising dental profession and general provincial labour standards/laws.

HPRAC conducted additional research on how Ontario DAs are authorized to take X-rays, and compared that information to other Canadian jurisdictions. The information indicated that there are multiple levels of checks and balances before a DA is authorized to take a dental X-ray in Ontario. However, Ontario’s existing credential process for operating X-ray machines does not require that operators complete continuing education courses in order to stay up to date; instead, a credential check of the operator’s educational qualifications, and not an assessment of his or her competence, is all that is required. The supervising dentist still has the responsibility to ensure the competencies of individuals assigned to perform intra-oral care and of individuals authorized to take dental X-rays.
Chapter IV: What We Heard

For all referrals, HPRAC engages in a broad-based consultation with stakeholders to help develop its recommendations to the Minister of Health and Long-Term Care. At the start of the DA referral, HPRAC began determining relevant public interest concerns, questions and perspectives on the issue, including those of key health care practitioners, other affected health care professionals, clients, patients, advocates and regulators. The issue then proceeded through a multi-stage process in which information and responses were both requested from and shared with stakeholders.

The Consultation Program

HPRAC conducted an extensive public consultation program from December 2011 to February 2012. To ensure that the broader community of interest had the opportunity to participate in this referral, HPRAC asked a number of groups, organizations and individuals to comment on the issue, including:

- regulatory health colleges
- regulated health profession associations
- regulated health care professionals
- academics and subject matter experts with an interest and/or expertise in the regulation of health professions
- organizations/groups with an interest in the regulation of health professionals
- local health integration networks (LHINs)
- the public

HPRAC’s website was the main communications vehicle for the consultation process. Relevant background material was posted on its dental assistants’ referral page, and the public was invited to comment on a series of questions about the DA profession related to risk of harm and public interest concerns. Comments were posted for public review regularly. The survey questions were based on HPRAC’s process and criteria guide. Submissions to the site were reviewed regularly so that HPRAC could determine key themes and highlight potential issues vis-à-vis the regulation of the practice of DAs.

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164 HPRAC’s goal for the consultation process was to uncover both broad themes and unanticipated issues, not to create quantitative data of stakeholder interests or concerns.
It is important to note the expected outcomes from this consultation process. The information gathered is intended to crystallize broad themes as well as highlight unanticipated “outlier” issues. The data were not expected to indicate support for, or opposition to, a particular topic. By definition, respondents self-select to participate in the consultation process and, in so doing, present their own particular views and concerns on the subject matter.

HPRAC’s consultation program received 1,147 submissions. Sixteen submissions were from organizations, the majority of which were direct and indirect dental-community stakeholders. The remaining 1,131 submissions were from individuals, mostly dental assistants. Participants in the consultation process were asked, among other things, whether the applicant had demonstrated that the practice of dental assisting could pose a risk of harm to the health and safety of the public, and whether there was adequate evidence to support regulation.

Among the respondents that supported regulation, the most common reason was that regulation would ensure that individuals performing radiographs and infection control duties were adequately trained. Respondents also argued that DAs are regulated in most other Canadian jurisdictions, and thus Ontario is lagging behind by allowing DAs to remain unregulated in this province.

One respondent commented that while DAs from Ontario may meet NDAEB requirements, they do not meet the level of professionalism expected from other regulators in Canada. The respondent argued that regulating Ontario’s DAs would instil an expectation that DAs are a responsible profession that maintains registration, completes annual competency requirements and works within a defined scope of practice.

Another respondent indicated that the existing supervisory model is ineffective, because dental practices are large and direct supervision is often not possible. As well, concerns were expressed by some respondents over the possible conflict of interest that dentists may have as both owners of practices and as employers of DAs vis-à-vis upholding the public interest.

The respondents that opposed the regulation of DAs indicated that currently there is adequate oversight of the profession by dentists and that no evidence has been provided to indicate that the current system is ineffective. These respondents argued that there are sufficient checks and balances within the existing regulatory system to protect the public, and that issues brought up by ODAA can be adequately addressed within the current system.

Those who oppose regulating DAs believe that the profession does not possess a unique body of knowledge and that regulation will not change the existing DA practice of working under the

165 Submissions from the Denturist Association of Ontario (DAO), CDHO and CDAA.
166 Submission from the Saskatchewan Dental Assistants’ Association (SDAA).
167 Submission from the College of Alberta Dental Assistants (CADA).
168 Ibid.
169 Submission from SDAA.
170 Submission from the College of Chiropodists of Ontario with the Ontario Podiatric Medical Association (OPMA) and the Ontario Society of Chiropodists (OSC).
171 Submissions from the College of Nurses of Ontario (CNO) and ODA.
172 Submissions from ODHA and the College of Physicians and Surgeons of Ontario (CPSO).
supervision of another dental health professional. According to these respondents, dental assistants are not an autonomous profession; they do not practise independently. These respondents argued that regulation would not change the working relationship between DAs and dentists, nor would it address the issues ODAA has brought up regarding the inappropriate delegation of duties to DAs or to unscrupulous dental practitioners. The Ontario Dental Hygienists Association (ODHA) reported, for example, that, “Self-regulation for dental hygienists did not control the unscrupulous practices of these employers and it is very unlikely that regulation of dental assistants will accomplish it either. Unethical dentists must be reported to and held accountable by their own regulatory body.”

A number of organizational stakeholders commented on the inadequacy of Ontario’s existing HARPA legislation to protect patient safety in dental radiography. HPRAC heard the HARP Commission was once tasked with the responsibility to review and monitor radiograph programs in educational facilities. Since the Commission no longer exists, and because there are non-accredited DA programs in Ontario, regulators from other jurisdictions raised concerns about how thoroughly radiography safety is being taught. Those that support the regulation of DAs indicate that a regulatory college for DAs could provide an added layer of protection for the public vis-à-vis dental X-ray safety. Even those stakeholders who oppose the regulation of DAs support the notion that HARPA needs to be reviewed and updated.

Table 2 summarizes the key comments and themes gathered through the consultation process about the risk of harm posed by the DA profession.

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173 Submissions from ODA, ODHA, CNO and the Ontario Association of Medical Radiation Technologists (OAMRT).
174 Submissions from CNO and ODHA.
175 ODHA submission.
176 Submissions from the Board of Directors of Drugless Therapy – Naturopathy; OAMRT; the College of Chiropodists of Ontario with OPMA and OSC; CDHO; DAO; SDAA; CADA; OAMRT; and ODHA.
177 Submission from DAO.
178 Submission from CDAA.
179 Submissions from the Board of Directors of the Drugless Therapy – Naturopathy, DAO and OAMRT.
180 Submissions from OAMRT and ODHA.
### Table 2: Consultation Submissions — Key Themes

<table>
<thead>
<tr>
<th>Area of Risk: Primary Criterion</th>
<th>Summary of Comments Supporting Regulation</th>
<th>Summary of Comments Opposing Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The profession is engaged in duties, procedures, interventions and/or activities with potential risk of harm (i.e., infection control protocols)</td>
<td>There are no defined educational requirements for level I DAs, and without adequate supervision and appropriate training patients may be harmed by the inappropriate assignment of duties for complex and high-risk activities.</td>
<td>Existing occupational health and safety legislation and professional guidelines for infection control provide adequate protection. The dental health profession’s guidelines hold the dentist accountable for training staff adequately and having appropriate policies in place. The Ontario Dental Association (ODA) provides continuing education opportunities to all dental team members, including DAs on topics such as infection control.</td>
</tr>
<tr>
<td>The profession is engaged in duties, procedures, interventions and/or activities with potential risk of harm (i.e., ionizing radiation exposure from dental X-rays)</td>
<td>There is a risk of harm arising from DAs who are not adequately trained to perform this duty and are inadequately supervised. HARPA is outdated. A regulatory college for DAs will ensure adequate training and education in the area of dental X-ray safety.</td>
<td>Exposing dental radiographs is not a controlled act as currently defined in the RHPA; however, it is regulated under HARPA. HARPA requires dentists to undertake specific safety education, and specifies which dental professionals can be assigned X-ray duties. HARPA can be amended to strengthen existing oversight powers to ensure that competencies keep pace with technology and scope of practice advancements.</td>
</tr>
<tr>
<td>The profession is engaged in duties, procedures, interventions and/or activities with potential risk of harm (i.e., intra-oral duties)</td>
<td>Several risks arise from indirect supervision without appropriate training in this area:  - There may be inappropriate assessment or care when DAs do not possess appropriate educational requirements</td>
<td>Limited information regarding risks with adequate relevant and verifiable evidence; information is anecdotal with no qualitative research, randomized controlled trials, cohort studies or other verifiable evidence submitted.</td>
</tr>
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### Area of Risk: Primary Criterion

<table>
<thead>
<tr>
<th>Summary of Comments Supporting Regulation</th>
<th>Summary of Comments Opposing Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Level II educational programs teach that placing treatment liners, matrices and wedges are considered controlled acts&lt;br&gt;- 17% of responding members reported that they are often delegated certain activities that are considered controlled acts&lt;sup&gt;181&lt;/sup&gt;</td>
<td>Care is assigned by members of RCDSO via guidelines to certified assistants (i.e., from approved dental assisting programs and the NDAEB exam with ongoing ODAA membership and continuing education).</td>
</tr>
<tr>
<td>There is inadequate supervision of DAs</td>
<td>Dentists are providing inadequate supervision to DAs who have inadequate training. Dentists are also assigning duties to DAs that are outside of their appropriate boundaries to perform but DAs are unwilling to report concerns for fear of losing their job.</td>
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</tbody>
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## Other Comments

A number of stakeholders provided additional comments on the applicant’s readiness to comply with other aspects of self-regulation. There was some concern that the applicant was unable to

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<sup>181</sup> ODAA Application, 24.
distinguish between advancing the profession’s status and protecting the public.\textsuperscript{182} A number of submissions cited the need for regulation in order to advance professional recognition.\textsuperscript{183} Some stakeholders commented on the DAs’ lack of a distinct body of knowledge, and others commented on the applicant’s inadequate evaluation of other regulatory mechanisms and the lack of clarity on how the profession plans to regulate the different classes of DAs.\textsuperscript{184} They also noted that the application did not address the economic impact of regulation on existing practitioners.\textsuperscript{185}

A number of individual respondents commented on the potential impact on their practice if DAs become regulated. These respondents, who were primarily from remote regions of the province, stated that access to regulated DAs may be difficult where they live, because there may not be a DA training program nearby where existing DAs can upgrade their credentials.\textsuperscript{186} Some respondents expressed concern that the regulation of DAs could be detrimental for rural communities seeking to access appropriate dental assisting human resources.\textsuperscript{187} Finally, some respondents challenged ODAA’s notion that DAs trained by their supervising dentists are any less qualified and skilled than DAs who have undergone formal education.\textsuperscript{188}

**Key Informants**

As part of HPRAC’s process of gathering evidence to review for regulation, key informant interviews/or meetings with Council may be used. Contact with persons or organizations that have an identified expertise or stake in the issue were made by the HPRAC Secretariat as part of the information-gathering process. In considering the application for regulation of the DA profession, HPRAC conducted interviews with the following groups/organizations:

- X-ray Inspection Unit of the Performance and Compliance Branch at MOHLTC
- Ministry of Training, Colleges and Universities
- College of Dental Hygienists of Ontario
- Ontario Dental Hygienists Association
- Ontario Dental Association, and
- RCDSO

**Chapter Summary**

Many of the comments gathered through the consultation process that supported the regulation of DAs in Ontario cited issues with the lack of enforcement of both the training and the education of DAs. Many respondents support the argument that there is sufficient risk of harm to patients within the scope of DAs’ duties and that the lack of enforcement of training standards, coupled

\textsuperscript{182} Submissions from CNO and ODA.
\textsuperscript{183} Submissions from individuals.
\textsuperscript{184} Submissions from ODA, OAMRT, ODA.
\textsuperscript{185} Submissions from the CNO and ODA.
\textsuperscript{186} Submissions from individuals 963 and 996.
\textsuperscript{187} Submissions from individuals 36 and 963.
\textsuperscript{188} Submissions from individuals 34, 35 and 36.
with perceived inadequate supervision, puts patients at risk for harm. These respondents support regulation because they believe it is the best way to mitigate this risk. They also argue that there needs to be appropriate accountability for DAs’ actions.

Those organizations that oppose regulation believe that the responsibility for oversight lies ultimately with the dentist(s), and that regulation will not change the way in which DAs practise. These respondents argue that DAs do not perform any controlled acts and are not authorized to practise independent of another dental profession and therefore there is little risk inherent in the practice of the profession. These respondents acknowledged that while there may be weaknesses in current mechanisms of oversight, those weaknesses can be addressed without the need for self-regulation of the profession.
Chapter V: Rationale

In considering the referral question, HPRAC consulted a variety of sources of information, including the ODAA application; a legislation review for X-ray taking by DAs in Ontario and across the provinces; HPRAC’s literature, jurisprudence and jurisdictional reviews; comments submitted during the HPRAC consultation process; and key informant interviews.

Primary Criterion: Risk of Harm

As noted in Chapter II: HPRAC’s Criteria, HPRAC has developed a two-part assessment tool to determine if a health profession should be regulated. In fulfilling the primary criterion, applicants must demonstrate, using relevant, verifiable evidence, that the practice of the profession meets a risk of harm threshold before HPRAC applies the secondary criteria to the application.

HPRAC’s primary criterion is defined as follows:

The fundamental principle with respect to health profession regulation under the RHPA is the protection of the public from harm in the delivery of health care, premised on the fact that it is in the public interest to do so. As such, it is vital to demonstrate that the health profession seeking regulation under the RHPA poses a risk of harm to the health and safety of the public. The term risk of harm refers to actions where a substantial risk of physical or mental harm may result from the practice of the profession. This criterion is intended to provide a clear articulation of the degree of harm posed by the profession to the health and safety of the public. In addressing the risk of harm in this context, the applicant is asked to identify the risks associated with the practice of the profession concerned, as distinct from risks inherent in the area of health care within which the profession operates.\(^{189}\)

This primary criterion is intended to provide a clear articulation of the degree of harm posed by the profession to the health and safety of the public. In addressing the risk of harm, the applicant must identify the risks associated with the practice of the profession, not risks inherent in the area of health care within which the profession operates.

An Evidence-Based Approach

As part of HPRAC’s deliberations and processes, and in keeping with the Minister of Health and Long-Term Care’s requirements on decision-making, HPRAC uses an evidence-based approach when formulating its recommendations for the minister’s review. Applicants for regulation under the RHPA must provide different types of evidence to inform the decision-making process. The type of evidence required will differ based on which criteria the proposal is addressing. To help

applicants fulfill this requirement, HPRAC’s criteria and process document\(^{190}\) groups the types of evidence needed into a number of subject areas: research, knowledge/information and economics. Examples are provided for each area, and include empirical evidence from randomized control trials and other trials; analytic studies, such as cohort or case control studies; time series analyses; anecdotal evidence; qualitative evidence; before and after studies; surveys; the results of consultation processes with networks/groups; expert knowledge; grey literature; and financial sustainability studies.

Different study types comprise different degrees of structural rigour and address different aspects of a general scientific enquiry. A well-conducted randomized controlled trial, for example, offers compelling evidence of “whether a cause-effect relationship exists between treatment and outcome and for assessing the cost effectiveness of a treatment.”\(^{191}\) These studies are appropriately used in investigating some unknowns but cannot be used in all cases. Many other types of studies, when well conducted, are also important to help HPRAC understand as many aspects as possible regarding the profession’s risk of harm. HPRAC also considers factors such as the quality of experimental design, scientific enquiries and study areas; the ability to generalize the results; and other potential research limitations, because poor study design can produce inaccurate outcomes. HPRAC thoroughly considers and weighs all the evidence presented.

**HPRAC’s Rationale**

HPRAC considered ODAA’s reasons to request the regulation of DAs in Ontario as they relate to the risk of harm that unregulated DAs pose to patients.

As part of HPRAC’s deliberation, HPRAC reflected on how ODAA has provided effective governance and certification procedures for its members for more than 50 years. During this time, ODAA has established good stakeholder relationships with other regulatory bodies in Canada and with other dental professionals. As the profession’s certifying body, ODAA has followed the Canadian standard for certifying level II DAs via the NDAEB examination and the CPE process. ODAA has established a Code of Ethics that its members abide by, and has supported members’ efforts to participate in professional development opportunities through the annual submission of continuing education credits. ODAA has recently approved a complaints and discipline policy in order to create a transparent process in which to deal with complaints about the professional activities of certified DAs.

**Infection Control**

HPRAC considered the potential risk of harm to the public from improper infection control procedures in the dental office. HPRAC’s literature review showed that the risk of disease transmission in the dental care setting is small. The evidence does, however, support the

\(^{190}\) Ibid.

importance of proper infection control procedures in the dental office to ensure consistent sterile instrumentation and operatories. The evidence reviewed indicated that it is the collective responsibility of the dental team to understand each of their roles in the infection control process; it is not the sole responsibility of any one profession.  

HPRAC is also aware of RCDSO’s guidelines for infection control, which stipulate that all oral health care workers must “receive office-specific training in infection prevention and control as part of their orientation, and whenever new tasks, procedures or equipment are introduced. This training should be supplemented whenever necessary and reviewed at least annually by means of staff meetings, attendance at continuing education courses and through self-learning programs.” The guidelines specifically state that the dentist’s role is to ensure that all staff are adequately trained in infection prevention and control procedures; as well, dentists are responsible for ensuring that the necessary supplies and equipment are operational, up to date and routinely monitored for efficacy. Without additional evidence to show that these guidelines are ineffective or that RCDSO members are noncompliant with them, HPRAC cannot fully assess the magnitude of risk to patient care in the absence of quantitative evidence.

Dental Radiography

HPRAC also considered the potential risk of harm from dental radiography. ODAA noted that X-ray taking is a restricted act in other Canadian jurisdictions and suggested that Ontario should consider adding it as a controlled act under the RHPA. HPRAC reviewed the regulation of X-ray taking across Canadian jurisdictions and found that some jurisdictions have legislation similar to Ontario’s HARPA to regulate the use and operation of X-ray machines.

HPRAC is not in a position to comment on the appropriateness of how X-ray taking is currently regulated because it is beyond the scope of this current review and because HPRAC’s review of HARPA focused primarily on its application to dental assistants. HPRAC does acknowledge hearing from a number of stakeholders that commented on the currency of the legislation, however. Although a profession’s regulatory body would provide additional oversight to ensure the training and qualifications of individuals who operate X-ray machines, the evidence that HPRAC reviewed does not indicate that the risk from dental X-ray exposure is comparable to other sources of ionizing radiation exposure such that this additional oversight is needed.

Furthermore, HARPA does provide additional accountability for how dental radiography is authorized. First, DAs are not authorized to take X-rays if a dentist does not prescribe them. Second, the dentist is the “radiation protection officer,” and as such must ensure the training and qualifications of the individual taking the dental X-rays within his or her office. Third, HARPA stipulates that only individuals who can demonstrate they have completed an approved X-ray safety course can operate an X-ray machine. Fourth, MOHLTC conducts regular inspections of

194 Ibid., 3.
dental offices to check the credentials of DAs who operate X-ray machines. There are, therefore, multiple layers of oversight of the DAs who take dental X-rays in Ontario.

HPRAC did hear from stakeholders during the consultation process — those that both supported and those that did not support the regulation of DAs — that HARPA is in need of review and updating. HPRAC’s review of HARPA as it relates to dental X-rays provided an understanding of stakeholders’ concerns about how dental radiography curricula are approved in Ontario. The basis of a DA’s credential check by the provincial X-ray safety inspector is to ensure that the individual has completed a course in dental X-ray safety that meets HARPA’s requirements. Hence, developing a robust procedure to approve and review dental X-ray safety curricula would provide assurance that a DA’s training in this area is adequate.

**Intra-Oral Care**

HPRAC also reviewed DAs’ practice setting and scope of practice. HPRAC is aware that currently there are two duties within DAs’ national skill set that are considered controlled acts by RCDSO. HPRAC is also aware that currently there is no mechanism that can be used to delegate authority to DAs to perform these specific acts. The performance of a controlled act generally identifies the existence of risk in a particular act. Based on the information HPRAC has reviewed and that has been confirmed by ODAA, Ontario DAs are currently not authorized to perform any controlled acts.

HPRAC reflected on the term “risk of harm” when considering the evidence about DAs’ duties. According to HPRAC’s primary criterion, 196 risk of harm refers to situations in which a substantial risk of physical or mental harm may result from the practise of a profession. Because HPRAC found no evidence to indicate that DAs practise outside of the supervision of the dental profession or that DAs can be authorized to independently perform intra-oral duties involving a controlled act, risk of harm is mitigated to a significant extent by the supervising dental profession.

HPRAC heard from stakeholders that noted that present-day dental practices preclude the hands-on supervision that once existed to monitor the performance of DA duties. The supervision of DAs is indirect at best — i.e., the dentist is in the dental office, but not directly supervising the DA’s duties. ODAA believes that this indirect supervision is appropriate when a DA’s training, qualifications and accountability are sufficient. HPRAC’s jurisprudence review noted, however, that when DAs committed errors, the supervising dentist was still held accountable. 197 The supervising dentist does not, therefore, escape his or her responsibility for providing proper oversight of the DAs in the dental practice.

RCDSO’s Council approved, in principle, a standard of practice (see Chapter III for more information) outlining the types of intra-oral duties that can be assigned and the qualifications required to perform intra-oral duties. The standard noted the dentist’s responsibility to provide adequate supervision of the performance of these duties by ensuring they were “safely and

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competently performed.” HPRAC notes that the enforcement of this standard may be unclear among the different stakeholders and proposes that the standard, or a similar standard, needs to be revisited and its enforcement assured.

In its application, ODAA noted that its members have reportedly notified the organization about dentists who inappropriately assign intra-oral duties or delegated controlled acts to DAs. In accordance with the professional misconduct regulation under the *Dentistry Act*, dentists are prohibited from assigning intra-oral duties without ensuring the qualification of the individual to appropriately perform those duties. Dentists are also prohibited from delegating controlled acts. Practitioners who contravene this regulation should be held accountable for their actions and brought to the attention of their regulatory college for sanctions.

HPRAC has taken note of ODAA’s assertion of the need to enforce the education and training of DAs in order to provide greater oversight and accountability of the dental assisting practice. HPRAC has also taken note of ODAA’s concern about the potential risk of having non-accredited DA programs in Ontario and the interim changes in the administration of HARPA regarding the assessment of dental X-ray curricula. HPRAC’s review of the evidence has not, however, revealed that sufficient evidence exists for the risk of harm in these activities such that existing oversight mechanisms cannot be adjusted to ensure adequate accountability and public protection.

HPRAC’s review of the evidence regarding the risk of harm that unregulated DAs pose does not, at this time, support regulation of the profession under the RHPA. Existing legislative requirements within the *Dentistry Act, 1991*, and HARPA are sufficient to protect the public. Further accountability can be established through the review and enforcement of existing policies for the supervision of DAs, the assignment of intra-oral duties and the approval of a dental X-ray safety course. As well, ODAA should continue to provide leadership in certifying DAs in Ontario and supporting continuing education opportunities for its members.

**Secondary Criteria**

In order for HPRAC to consider the secondary criteria, the applicant must first demonstrate, with evidence, that there is a risk of harm. The purpose of the secondary criteria is to measure the appropriateness of regulation under the RHPA for professions that HPRAC has determined pose a risk of harm to the public. The risk of harm threshold was not met for the application regarding dental assistants in Ontario. As a result, a discussion of the secondary criteria has not been included in this report.

**Chapter Summary**

HPRAC’s criteria and process examined the evidence regarding whether the applicant meets the risk of harm threshold and whether it is otherwise in the public interest that the profession be regulated under the RHPA. HPRAC’s review process does not include an assessment of the

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199 Ibid., 13.
merit of the profession seeking regulation. The evidence submitted by ODAA has not met the risk of harm threshold. The duties that DAs perform have not been verifiably demonstrated to pose a risk of harm that is distinct from the risks that are inherent in the area of health care within which the profession operates. Additionally, because DAs perform their duties under the supervision of dental professionals, and because there are existing regulation structures that provide oversight, the applicant has not shown at this time that the practise of the DA profession poses a substantive risk of harm to the health and safety of the people of Ontario.
Chapter VI: Other Considerations

HPRAC applied its criteria and process to assess ODAA’s application for regulation under the RHPA and found it has not met the risk of harm threshold. HPRAC reflected on the minister’s referral and considered other information on how to strengthen existing accountability for dental health professionals who are responsible for supervising DAs.

Delegation of Controlled Acts

As examined in Chapter III, the professional misconduct regulation under the Dentistry Act, 1991, states that, “The following are acts of professional misconduct…. Delegating an act set out in section 4 of the Act except as permitted by the regulations.” However, according to RCDSO, in its publication to its members (Dispatch), “[Delegation] authorization requires regulatory authority and until such time as the appropriate regulation is in place, dentists cannot delegate any of their authorized or controlled acts to anyone.” For the practice of level II DAs, RCDSO further stated, “Because two of the core ‘Level II’ procedures, namely the ‘application of treatment liners with no pulpal involvement’ and the ‘application/removal of matrices and wedges’ are considered by the RCDSO to be ‘controlled acts’, these cannot be performed in Ontario by Level II dental assistants until the appropriate regulation is in place.”

HPRAC heard from ODAA that its members have reported that dentists have delegated them to perform controlled acts. HPRAC reviewed the existing delegation policies among regulated dental professions and found that the existing policies do not allow DAs to practise within their full set of national skills’ competencies. NDAEB has identified 13 duties that all level II DAs must be competent to perform if they want to achieve certification. The two procedures identified by RCDSO as “controlled acts” are part of the level II DAs’ national competency skill set. Ontario DAs are trained to perform these skills on manikins but are not permitted to perform these duties on patients in a clinical setting.

HPRAC was told about a memorandum that was sent from RCDSO to its members informing them of the detailed changes approved by council in the revised Standard of Practice Relating to the Performance of Intra-Oral Procedures by Third Parties. This revised standard would allow dentists to delegate the two controlled act duties to DAs. According to the memo, in order for the standards to be enforceable, amendments to regulations under the Dentistry Act, 1991, were necessary. One of these amendments, for example, gives RCDSO members the authority to delegate controlled acts in accordance with standards published by the College. To HPRAC’s

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200 O Reg 853/93, s. 2(3).
202 Ibid.
203 ODAA application, 24.
204 ODAA application, Appendices: NDAEB National Skill Set Table.
205 RCDSO Memorandum to Ontario Dentists, January 2001.
206 Ibid.
knowledge, however, these amendments have not been made and the enforcement of the revised standard remains unclear.

Although ODAA asserts that dentists are delegating controlled acts to DAs, RCDSO has not identified a similar concern, due to the lack of complaints received on this issue. Delegation policies amongst regulated dental professions need to be reconciled in order to ensure that appropriate authority can be conferred and strict standards and guidelines are in place to provide appropriate accountability for the delegator (i.e., the dentist) and responsibility for the recipient of delegation (the DA).

For these reasons, HPRAC recommends that MOHLTC collaborate with RCDSO to place a priority review to existing regulations and policies as they relate to the delegation of controlled acts, specifically conferring the authority to certified level II DAs to practise its full set of national skills competencies. This collaboration should include convening a working group amongst the dental professions (but also includes a representative from MOHLTC) to review existing delegation policies for dental care in Ontario. Where applicable, these policies should be consistent across the different dental colleges, whose members may often work with DAs.

**Interprofessional Collaboration**

Interprofessional collaboration (IPC) is central to the efficient delivery of care in Ontario’s health care system. Although there are varying definitions of the terms “interprofessional care” and “interprofessional collaboration,” HPRAC accepts HealthForceOntario’s definition for interprofessional care: “the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.”

In recent years, HPRAC has examined the concept of IPC and its impact on Ontario’s health care system. In 2007, the Minister of Health and Long-Term Care asked HPRAC to recommend mechanisms that facilitate and support IPC amongst health colleges, beginning with the development of standards of practice and professional practice guidelines where regulated professions share the same or similar controlled acts. In 2008 and 2009, HPRAC delivered two interim reports and a final report, respectively, to the minister.

Previous HPRAC reports have recommended regulatory reform as the key way to enhance collaboration amongst some health professions. It is possible that these policy recommendations could have wider applicability to health care providers, regardless of their regulatory status. One of HPRAC’s key recommendations was for health professions to create common standards where possible, particularly when professions have shared scopes of practice.

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In the field of dentistry, for example, HPRAC heard from ODAA that there was considerable overlap in the duties assigned to the different members of the dental team. According to ODAA, “[a]ll of the duties performed by Level 1 dental assistants may also be performed by Level 2 dental assistants. All [of the DAs’] duties may be performed by hygienists and all dental assisting and hygiene duties can be performed by dentists.”210 However, HPRAC also heard from ODA that dentists see the DA’s role as assisting dentists and that therefore there is no overlap in scope of practice.211 Nevertheless, creating shared guidelines amongst dental professionals in areas of common practices would help to clarify the duties and responsibilities of each member of the dental team.

The applicant’s proposal for regulation noted that, as a profession, DAs are committed to providing patient-centred care. Dental assistants work with many other dental professions (including dentists, dental hygienists, denturists and dental technicians) to facilitate their work.212 ODAA also noted that its members have collegial working relationships with the other dental regulatory organizations and dental professional associations.

During the consultation process, HPRAC heard concerns about the difficulty of multiple regulated health professionals in the small practice setting of a dental office being independently accountable for infection control and subject to different standards and expectations.213 ODAA responded to these concerns by noting that regulatory colleges for dental hygienists and dentists in British Columbia, for example, were able to work together in a joint session with DAs to create an agreed-upon set of standards that met the requirements of all professions.214 HPRAC believes that a similar approach should be attempted in Ontario — that the dental professions should work together to create both infection control guidelines and guidelines that govern the assignment of dental assisting duties or any other shared dental practices.

HARPA

As described in Chapters III and V, the operation of X-ray machinery in Ontario is not a controlled act regulated under the RHPA. Instead, it is regulated through its own legislation, HARPA. HPRAC heard from different stakeholders about the currency of this legislation, and ODAA expressed its concerns about how the X-ray safety curriculum for dental assisting programs is approved in Ontario. For example, HPRAC heard that HARPA qualifications are not recognized in Saskatchewan, although no specific details were provided as to why.

During the consultation process, HPRAC received a submission from the Ontario Association of Medical Radiation Technologists (OAMRT), which also expressed concerns about DAs’ training in X-ray safety in this province. OAMRT noted that although HARPA and its regulations mitigate the potential risk of harm to patients undergoing X-rays, it is no longer effective in the dental field because of concerns over DAs not being educated and trained to a common standard

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210 ODAA application, 8.
211 ODA submission.
212 ODAA application, 57.
213 ODHA submission, 24.
214 ODAA response to submission, 7.
in dental radiography. According to OAMRT, “There is no HARP Commission any more and, therefore, there is an issue about the qualification of Dental Assistants in terms of meeting the educational requirements regarding exposing patients to dental X-rays from any dental X-ray source.”

OAMRT also noted that HARPA is not only outdated vis-à-vis the educational facilities that can train DAs but that the regulation about educational facility is obsolete and unenforceable. OAMRT concluded in its submission that changes in HARPA regulation could resolve any deficiency and re-establish public safety without the need for the DA profession to become regulated.

HPRAC also learned that MOHLTC’s X-ray safety inspectors focus on checking the credentials of the DA responsible for taking dental X-rays when they inspect dental offices. Dental assistants must provide proof of having taken a HARPA-approved course; however, there is currently no requirement under HARPA for DAs to maintain the currency of their training through any continuing education program. Completion of a HARPA-approved course appears to be the only requirement for taking X-rays in Ontario. These courses therefore need to be kept up to date and subject to strict, regular oversight to ensure that their subject matter reflects current technology and safety requirements.

Chapter Summary

HPRAC considered some of the wider issues related to the practice of dental assisting. Specifically, HPRAC examined the concerns raised about the existing policies governing delegation amongst regulated dental professions. HPRAC believes that these polices create barriers for Ontario DAs vis-à-vis their ability to practise to their full national skill set. As well, HPRAC believes that the creation and strict enforcement of common standards, guidelines and policies should be considered among the regulated dental professionals whose members work with DAs, especially as they relate to the delegation of duties, the assigning of intra-oral duties and performing infection control duties.

HPRAC also acknowledges the issues expressed by stakeholders about the current process to review and approve dental X-ray safety courses; however, once this review and necessary changes are in place, the deficiency will be adequately resolved. HPRAC has made these additional recommendations in order to further strengthen the existing accountability and oversight of the duties performed by DAs.

215 OAMRT submission, 95.
216 OAMRT submission, 94.
217 Ibid., 95.
Chapter VII: Summary

Safe, effective and patient-centred health care is the primary goal of regulatory oversight. Regulatory regimes must promote these goals, clearly and simply, for both health care practitioners and patients. Ultimately, regulatory oversight should be proportionate to risk. Professional regulation under the RHPA is a significant part of the regulatory framework for the delivery of health care, but it is not the only way to effectively protect the public.

HPRAC carried out its published process in assessing the application for regulation of the DA profession in Ontario. This process included an extensive consultation program; consideration of the evidence provided by the applicant; literature, jurisdictional and jurisprudence reviews; and conducting more detailed research in several key areas. HPRAC noted the lack of relevant available research about the risk of harm aspects of the DA profession, and the existence of existing regulatory mechanisms to provide adequate oversight of the practice of the profession. Consultation comments noted that the scope of practice of the DA profession would not change even if the profession were regulated, because DAs would continue to facilitate the work of other dental professionals, chiefly dentists and dental hygienists.

HPRAC also considered the nature of the profession’s supervisory structure and the duties for which DAs are responsible in a dental practice. The lack of performance of controlled acts by the DA profession effectively reduces the element of risk inherent in the practice of the profession. Furthermore, DAs do not practise independent of dentists and thus responsibility remains with the supervising dentist.

HPRAC’s review process did not include an assessment of the merits of the profession seeking regulation. The value to the health care system associated with the DA practice is not the focus of HPRAC’s risk of harm assessment. Rather, HPRAC’s criteria and process examine whether the applicant meets the risk of harm threshold and whether it is otherwise in the public interest that the profession be regulated under the RHPA.

The outcome of the HPRAC assessment process is that the applicant did not meet the risk of harm threshold: there is insufficient evidence to require regulation under the RHPA as a means of managing existing weaknesses in policies concerning the DA scope of practice. Public safety and quality of care are sufficiently upheld at this time through the regulations contained within HARPA and the Dentistry Act, 1991, and under ODAA’s certification process. Further clarification of RCDSO’s standards for assigning intra-oral duties to certified level II DAs should be made in order to provide clarity to the expectation and assurance that the policy is being enforced.

HPRAC also conducted additional research to determine the existing oversight mechanism and the process for DAs to be authorized to take and expose dental radiographs. Aside from the general concerns noted by stakeholders about the currency of HARPA and the existing process to approve dental radiography programs, HPRAC is satisfied with the multiple layers of oversight that enable DAs to take dental X-rays. However, developing a more robust curriculum-approval method, along with reinforcing responsibility of the radiation protection officer, would serve to strengthen public protection.
HPRAC recommends that dental regulatory colleges work to revise delegation policy in order to determine how DAs can be authorized to perform the two specific duties that are within their national skills set. HPRAC also supports ODAA’s continued efforts to certify level II DAs in accordance with NDAEB standards and to support its members in professional development activities such as continuing education.
Appendix A: List of Acronyms

CADA  College of Alberta Dental Assistants
CCPA  Canadian Centre for Policy Alternatives
CDAA  Canadian Dental Assistants Association
CDAC  Commission on Dental Accreditation of Canada
CDHO  College of Dental Hygienists of Ontario
CHMS  Canada Health Measures Survey
CIHI  Canadian Institute for Health Information
CNO  College of Nurses of Ontario
CPE  Clinical Practical Evaluation
CPSO  College of Physicians and Surgeons of Ontario
DA  Dental assistant
DAO  Denturist Association of Ontario
FHRCO  Federation of Health Regulatory Colleges of Ontario
HARPA  *Healing Arts Radiation Protection Act*
HCP  Health care practitioner
HPRAC  Health Professions Regulatory Advisory Council
IPC  Interprofessional care
LHIN  Local Health Integration Network
MOHLTC  Ministry of Health and Long-Term Care
MTCU  Ministry of Training, Colleges and Universities
NDAEB  National Dental Assisting Examining Board
OAHPP  Ontario Agency for Health Protection and Promotion (Public Health Ontario)
OAMRT  Ontario Association of Medical Radiation Technologists
ODA  Ontario Dental Association
ODAA  Ontario Dental Assistants Association
ODHA  Ontario Dental Hygienists’ Association
OPMA  Ontario Podiatric Medical Association
OSC  Ontario Society of Chiropodists
PDA  Preventative dental assistant
RCDSO  Royal College of Dental Surgeons of Ontario
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<th>Acronym</th>
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<td><em>Regulated Health Professions Act, 1991</em></td>
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<td>RHSA</td>
<td><em>Radiation Health and Safety Act, 1985</em> (Saskatchewan)</td>
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<td>Radiation protection officer</td>
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<td>SDAA</td>
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Appendix B: About HPRAC

HPRAC was established under the *Regulated Health Professions Act, 1991* (RHPA), with a statutory duty to advise the Minister of Health and Long-Term Care on matters related to the regulation of health professions in Ontario. This duty includes providing advice to the minister on:

- whether unregulated health professions should be regulated;
- whether regulated health professions should no longer be regulated;
- amendments to the RHPA;
- amendments to a health profession’s act or a regulation under any of those acts;
- matters concerning the quality assurance programs and patient relations programs undertaken by health colleges; and
- any matter the minister refers to HPRAC relating to the regulation of the health professions.

The minister relies on recommendations from HPRAC as a key source of evidence-informed advice when formulating policy vis-à-vis health professions’ regulation in Ontario. In providing its advice and preparing its recommendations, HPRAC is independent of the Minister of Health and Long-Term Care, the Ministry of Health and Long-Term Care (MOHLTC), the regulated health colleges, regulated health professional and provider associations, and stakeholders that have an interest in issues on which it provides advice. This ensures that HPRAC is free from constraining alliances and conflict of interest and that it is able to carry out its activities in a fair and unbiased manner.

HPRAC presents its recommendations in a report to the minister for consideration. Recommendations are advisory only and the minister is not bound to accept HPRAC’s advice. The report is confidential, although the minister may choose to publicly release an HPRAC report. Any follow-up action is at the discretion of the minister. Should the minister choose to accept HPRAC’s advice, MOHLTC is responsible for implementation based on the direction of the government.

In developing its advice to the minister, HPRAC strives to ensure that its processes are thorough, timely and efficient, and built on a foundation of fairness, transparency and evidence-based decision-making. HPRAC undertakes research to provide the evidence for its conclusions, drawing on organizations and individuals with relevant expertise, both in Ontario and elsewhere, and adjusts its consultation process for each profession it considers.
Appendix C: Dental Assistant Consultation Program

HPRAC’s Consultation Approach

When a referral is received from the minister, HPRAC determines relevant public interest concerns and questions and tries to understand all perspectives on an issue, including those of key health professionals, other affected health professionals, clients, patients, advocates and regulators. Each issue proceeds through a multi-stage process in which information and responses are requested from and shared with stakeholders. HPRAC also conducts literature, jurisdictional and jurisprudence reviews, and engages in key informant interviews. Its analysis of the issues helps HPRAC determine whether additional information is required, and the appropriate processes to be used.

HPRAC used two mechanisms to obtain broad stakeholder input into this referral process:

1. Written submissions through an online survey, and
2. A feedback form that could be submitted via fax or by mail.

Overview of the Consultation Process

Stakeholder input informs HPRAC when developing its recommendations to the minister. As noted above, as part of its consultation process, HPRAC notifies and consults with stakeholders whom HPRAC believes could potentially be affected by its recommendations. Stakeholders and interested parties include regulatory health colleges, health profession associations, health care providers and the public. In general, the following key principles are used to develop the consultation program:

- The inclusion of interested stakeholders and members of the public at a level of involvement that reflects their needs and interests.
- The flexibility to respond to unanticipated issues and stakeholder input throughout the referral period.
- An expectation that the consultation process will crystallize broad themes as well as highlight unanticipated “outlier” issues. The data are not expected to indicate support for, or opposition to, a particular topic. By definition, respondents self-select to participate in the consultation process and, in so doing, present their own particular views on the subject matter.
- The incorporation of issues, concerns, comments and perspectives into the recommendation-making process.
- Ensuring that all consultation material is available in both official languages (on request, HPRAC will provide information on accessible formats).

Within its mandate, HPRAC may consult with selected individuals and organizations if it needs additional information to complete the review of the minister’s referral. Persons or organizations
with identified expertise or a stake in the issue may be invited, at HPRAC’s discretion, to make presentations, reports or submissions. These individuals and groups may include hard-to-reach groups as well as those who may not have the resources to participate in standard processes and methods. (See Table 1 for a list of organizations consulted for this referral.)

Risk of Harm

The risk of harm concept is fundamental to the protection of the public and thus this principle is woven into the fabric of RHPA. Section 30 (1) notes that risk of harm is a “serious bodily harm [which] may result from the treatment or advice or from an omission...”

The Supreme Court of Canada, in the leading case concerning the interpretation of the phrase, defined “serious bodily harm” as “any hurt or injury, whether physical or psychological, that interferes in a substantial way with the physical or psychological integrity, health or well-being of a complainant.”

For this referral, HPRAC followed the following approach to risk of harm in its evaluation of whether the dental assistant profession should be regulated, either independently or in conjunction with an existing profession under the RHPA:

- The term risk of harm refers to actions where a substantial risk of physical or mental harm may result from the practice of the profession. This criterion is intended to provide a clear articulation of the degree of harm posed by the profession to the health and safety of the public. In addressing the risk of harm in this context, the applicant is asked to identify the risks associated with the practice of the profession concerned, as distinct from risks inherent in the area of health care within which the profession operates.

Public Interest

Again, as part of the RHPA, public interest is stated as being within the minister’s duty to ensure “that appropriate standards of practice are developed and maintained and that individuals have access to services provided by the health professions of their choice and that they are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board.”

Within the context of this definition, HPRAC used the following principles to evaluate whether the profession of dental assistants should be regulated under RHPA. Regulation would:

- Protect the public from unqualified, incompetent and unfit health care providers, to the fullest extent possible.
- Establish mechanisms to encourage the provision of high-quality care.
- Provide the public with freedom of choice within a range of safe health care options.

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219 HPRAC, Regulation of a New Health Profession under the Regulated Health Professions Act (RHPA) 1991: Criteria and Process.
220 RHPA, 1991, s. 3.
- Establish a scope of evolution in the roles played by individual professions and flexibility in how individual professionals can be utilized, to ensure maximum system efficiency.
- Ensure that regulation is proportionate to risk to patients and the public.
- Ensure that regulation is efficient, by minimizing duplication and avoiding delays in taking action to protect the public.

Table 1. Dental Assistants’ Referral Stakeholders

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<tr>
<td>Academic/Expert</td>
<td>Dr. Sandra Bennett, Program &amp; Standards Advisor (Dentistry), Ministry of Health Promotion and Sport (Ontario), and Assistant Lecturer (Dentistry), University of Toronto</td>
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<tr>
<td>Academic/Expert</td>
<td>Dr. Walter R. Teteruck, Chair, Continuing Dental Education, University of Western Ontario</td>
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<tr>
<td>Education</td>
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SUBMISSION FOR REGULATION UNDER THE REGULATED HEALTH PROFESSIONS ACT

A Report Prepared for the Health Professions Regulatory Advisory Council (HPRAC)

Nov 11, 2011
ODAA – HPRAC Proposal

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By signing below I agree to the above statement.

[Signature]

[Date]

November 3, 2011
Introduction

The Ontario Dental Assistants Association (ODAA) has been an incorporated, not-for-profit professional membership Association for Ontario dental assistants since 1934 and the certifying body for Ontario dental assistants since 1961. In the interest of public safety and accountability, ODAA submits this application for self-regulation of the profession of dental assisting under the Regulated Health Professions Act 1991.

ODAA is the largest dental assisting member services organization in Canada. Representing close to 8,500 members, ODAA is the voice for Ontario dental assistants, certifying and promoting the profession, advocating on behalf of its members and providing membership support and benefits.

The profession of dental assisting in Canada is regulated in all provinces with the exception of Ontario and Quebec. Alberta and Saskatchewan dental assistants are self-regulated, while dental assistants in the remaining jurisdictions are regulated under dental regulatory authorities.

The Royal College of Dental Surgeons of Ontario (RCDSO) has guidelines/policies which state that dentists may delegate intra-oral dental assisting duties to Level 2 dental assistants who have graduated from a government approved dental assisting program and who have passed the National Dental Assisting Examining Board (NDAEB) examination. Though many dentists/employers adhere to these guidelines there are also many employees who are performing dental assisting duties without the appropriate education and examination.

Outside of the RCDSO directive to Ontario dentists, regarding the delegation of intra-oral duties, there are no restrictions or regulations in place regarding the delegation of duties to Level 1 or chairside dental assistants. Ontario dentists can and do employ individuals who have received no formal education in dental assisting to perform the duties of a dental assistant.

To address this void in regulation and provide some measurable means of quality assurance, ODAA certifies Ontario dental assistants. This voluntary certification requires the applicant to have graduated from a government approved dental assisting program and successfully complete an entry to practice examination. To maintain certification each year, members must pay the professional membership dues and submit proof of continuing education courses.

Level 1 (chairside assistants) and Level 2 (intra-oral) assistants are frontline oral healthcare workers assuming responsibility for established infection control protocols, exposing radiographs and numerous other extra-oral and intra-oral clinical tasks.

Dental assistants work in many different types of settings including private practices for general dentists and specialists, public health units, dental hygiene clinics, denture clinics, dental labs, community and private colleges, industry-related companies and insurance companies.

ODAA is requesting that all clinical dental assistants become regulated in the interest of public safety.
Primary Criteria:
Primary Criterion: Risk of Harm

1. Provide a general description of services provided by the practitioners of the profession.

Dental assistants are frontline healthcare practitioners who are an integral team member in the delivery of dental care. Dental assistants provide both clinical and administrative support in a dental office through direct patient care as well as working alongside dentists, dental hygienists, dental technicians and denturists.

In Ontario, there are both Level 1 and Level 2 dental assistants.

Level 1 Duties:

- sanitizing and disinfecting dental operatories, radiography rooms and dispensary areas
- sterilizing instruments
- performing biological monitoring
- transferring instruments to the dentist/hygienist
- recording medical, dental and nutritional data on patient charts
- recording services rendered on patient records
- oral irrigation and suctioning of the oral cavity
- manipulation of restorative materials including: cavity liners/bases; amalgam; temporary and intermediate restorative materials; bonding systems etc.
- exposing, processing, self-evaluating and mounting of radiographs and photographs as specified by HARP
- performing laboratory procedures including the pouring and trimming of study models, and the fabrication of custom impression and bleaching trays
- instructing in care and maintenance of pre-fitted appliances
- retracting a surgical flap that has been prepared and reflected by a dentist
- presenting community oral health education on oral health (extra-oral)
- performing other extra-oral duties as delegated

Level 2 Duties:

- all chairside duties listed above
- dental radiography as outlined in Level 1
- performing intra and extra oral assessments within scope of practice
- polishing (mechanical) of the coronal portion of the teeth
• placing and removing of dental dam
• obtaining preliminary impressions of teeth for study models
• providing intra-oral hygiene instruction
• providing dietary counseling relative to oral health
• applying topical anesthetics
• applying pit and fissure sealants
• applying desensitizing agents
• whitening of the coronal portion of the teeth
• polishing restorations

As frontline workers, dental assistants are responsible for infection control protocols within the dental office. These responsibilities include sanitization and disinfection of dental operatories and radiography rooms, sterilization of instruments, biological monitoring and management of infectious and hazardous waste with a goal to eliminate any cross contamination. With the increased risk of transmission through blood and saliva of highly infectious diseases and emerging diseases and the possibility of pandemics, infection control could not be more paramount than it is today.

Three major routes of disease transmission can occur in the dental environment; and these include: the patient to health care practitioner; the healthcare practitioner to patient and patient to patient. Anything, including hands, instruments, handpieces, water lines syringe tips, anesthetic syringes, temporary crowns, impression trays, fluoride trays, needles, cotton rolls and disposable sundries which have come in contact with patient blood and/or saliva has the potential of transmitting disease. Even surfaces that have been touched during patient care with contaminated gloves, instruments or products can become fomites supporting the indirect spread of microbes.

The public expects their health and well being to be protected while receiving dental care. It is likely that a dental patient would assume, unless informed otherwise, that the enormity and complexity of infection control procedures and protocols would only be delegated by the dentist to a qualified individual. As long as dentists in Ontario are able to delegate infection control responsibilities to uneducated and unregulated personnel, the risk of harm to the public will remain.
2. Specify and describe the diagnostic modalities employed by the practitioners of the profession.

Dental assistants do not diagnose but can make assessments to assist the dentist/dental hygienist with their examinations. Charting dentition may be one such assessment which is then validated by the dentist/dental hygienist. Dental assistants do take radiographs when prescribed by the dentist. These radiographs are used as a diagnostic tool.

Dental assistants are taught to employ a high level of self-assessment skills. For example they perform intra and extra-oral assessments that link oral hygiene instruction, dental dam punching and placement. They are also taught to self-assess their work, questioning whether the radiographs are of diagnostic quality and whether the impression captured all of the teeth and gingival margins.

3. Specify areas of practice, diagnosis, treatment, interventions, modalities and services:

   a.) Performed exclusively by practitioners of the profession

Dental offices and/or clinics are unique and private businesses. Dental health care delivery systems encompass solo and group practices. Depending on the number of dentists and operatories, type of dentistry and oral healthcare provided and the philosophy of the dentist(s), Level 1 or Level 2 dental assistants or a combination of Level 1 and Level 2 dental assistants may be employed. Additionally dental receptionists and dental hygienists may also be part of the team compliment changing the delegation of duties to the dental assistants.

The different delivery modalities and uniqueness of each dental office make it difficult to specify in all cases what duties are exclusively performed by dental assistants. Generally, level 1 dental assistants are primarily responsible for infection control, exposing radiographs and assisting for restorative procedures while Level 2 dental assistants assume these duties as well as other intra-oral duties as delegated by the dentist.

   b.) Also performed by other regulated health professions

All of the duties performed by Level 1 dental assistants may also be performed by Level 2 dental assistants. All dental assisting duties may be performed by hygienists and all dental assisting and hygiene duties can be performed by dentists. However, in a busy dental practice the roles of each practitioner are likely to be very clearly defined by the practitioner’s education and expertise.

   c.) Also performed by other unregulated health professions

Currently, there are no restrictions or regulations in place in Ontario regarding the hiring of Level 1 dental assistants and though the RCDSO has a guideline in place regarding the delegation of intra-oral duties, dentists can and do employ individuals who have received no formal education in dental assisting to perform the duties of a dental assistant. Essentially, that means all infection control protocols and procedures may be performed by people who are not formally trained in disease transmission and asepsis. This is a potentially harmful practice.
All other chairside duties including sterilization of instruments, suctioning of the oral cavity, charting, preparation of filling materials and simple laboratory procedures can be done by people who are trained on the job.

While on-the-job training may have once been an acceptable practice, the employment of laypersons trained by the dentist, no longer serves the public interest. The duties of dental assistants and the care they are expected to provide for dental patients today far exceeds this model.

Level 1 dental assistants are granted a high degree of responsibility, independence and autonomy and public safety suffers when laypeople are hired to do this work. No curriculum or standards exist to ensure on the job training meets a recognized level of instruction. Furthermore outcomes are not measured through any calibrated testing/evaluation mechanism. Dentists, put simply, are not professional educators.

Additionally, on the job training does not provide any education with respect to professional practice standards including the value and need for continuing education. Ethics and accountability of a health care professional are not disseminated in this training model and therefore in no way prepares the dental assistant to face ethical dilemmas they will encounter in practice.

No independent monitoring body exists for dental assistants in the province of Ontario. While the Royal College of Dental Surgeons of Ontario (RCDSO) has guidelines/policies that state that dentists may delegate intra-oral dental assisting duties to those who have graduated from an approved dental assisting program and who have passed the National Dental Assisting Examining Board (NDAEB) examination, no regulation or accountability exists. Though many dentists /employers adhere to these guidelines, there are also many employees at both levels performing duties without the appropriate education and examination.

d.) Performed in conjunction with other regulated health professions...

There is considerable overlap within the full scope of dentistry. To utilize dental assistants in this area, dental education is based on a hierarchical model with the educational designation above subsuming the education of the credential below. This allows level 2 dental assistants to perform the duties of a level 1 dental assistant, the hygienist to perform the duties of a level 1 and 2 dental assistant and the dentists to perform the full spectrum of duties.

In provinces where dental assistants (level 2) are regulated, dental assistants are able to perform many other duties such as orthodontic and prosthodontic duties and limited scaling. The orthodontic and prosthodontic modules are post level 2 graduation modules and are not subsumed into dental hygiene practice. The scaling module is also an after Level 2 graduation module, but is subsumed in dental hygiene and dentist scope of practice.

There is also education overlap with the professions of denturists and dental technology.

All healthcare professionals working in dentistry are ultimately responsible for infection control, but in most dental clinics/offices, dental assistants are primarily responsible and delegated this task. Strict adherence to infection control protocols is time consuming making it an issue of economics and thus the utilization of dental assistants in this area.

Dental assistants assist in the delivery of dental care as an integral team member. They facilitate the work of dentists, hygienists, denturists and dental technicians. How they do this is often unique to each dental setting.

Whatever their expected duties are in each dental setting, dental assistants always work collaboratively with other dental professionals.
4. Specify which diagnoses/assessments, interventions, substances, treatment modalities, and services provided by the profession entail a risk of harm to patient/clients. Include references to, and copies of, scientific literature and other published information.

Infection Control:

The 2003 SARS outbreak in Ontario demonstrated the importance of healthcare workers having a sound understanding and formal education of disease transmission and control. Dental assistants are primarily responsible for infection control within the dental setting. Knowledge of disease transmission, asepsis, sterilization and cross contamination is imperative.

Chairside asepsis involves the infection control procedures performed at chairside just before, during and immediately following patient treatments. Since patients' mouths are the primary sources of potential pathogens in the office, these chairside procedures take on a special meaning. At this point, three major routes of microbial spread can occur and these include patient-to-practitioner; practitioner to patient; and patient to patient. There are numerous ways that microbes can escape from patient's mouths, so anything that is placed within the mouth and removed is contaminated and must be discarded or properly managed before reuse. These include hands, instruments, hand pieces, water lines, syringe tips, anesthetic syringes, temporary crowns, impression trays, fluoride trays, needles, cotton rolls and other disposables.

Direct transmission of pathogens occurs through person-to-person contact such as through sneezing or coughing or spatter produced through dental instruments. Direct transmission can also occur through unprotected contact with an infectious lesion or infected body fluids, such as blood and saliva. Since dental treatment often involves contact with blood and always with saliva, which can be contaminated with blood even if it's not visible, this is a major source of concern for the dental clinic. Diseases such as hepatitis, herpes infection, HIV infection and tuberculosis are spread through direct contact.

Indirect transmission of disease is no less of a concern. This occurs when microorganisms are first transmitted to an object or surface and then transferred to another person who touches those objects or surfaces. In dental offices telephones, work surfaces, charts, use of bar soap and cloth towels are all examples of where indirect cross contamination can occur. Lack of biological monitoring resulting in unsterilized instruments is also a source of indirect disease transmission.

Certain pathogens referred to as blood-borne, are carried in the blood and body fluids of infected individuals and can be transmitted to others through direct or indirect contact. Common blood-borne microorganisms of concern in dentistry include HCV, HBV and HIV/AIDS.\(^1\)

Dental offices produce three types of infectious waste: blood and blood-soaked materials; pathologic waste like soft tissue and extracted teeth; and sharps, which include contaminated sharp objects used for patient care. Dental assistants are responsible for bio-medical waste management and though patients may not be at risk, the community at large can be if the waste materials are not disposed of properly. Infectious waste should never be disposed of in the same manner as general waste. It requires special handling and disposal, which cannot be guaranteed when untrained people are responsible for managing hazardous waste from a health care setting.

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   Infection Control in Practice, Organization for Safety, Asepsis and Prevention (OSAP)
   Infection Prevention and Control in the Dental Office Guidelines, RCDSO, November 2009
The continuance of the status quo, allowing the delegation of infection control procedures and protocols to personnel with no formalized education is asepsis, with little or no knowledge of the potential gravity of an error or omission is both unfair and nothing short of dangerous for patients.

Radiography:

According to the Healing Arts Radiation Protection (HARP) Act dentists in Ontario can delegate the exposing, mounting and processing of radiographs to dental assistants who have graduated from a HARP approved radiography program. For formal dental assisting programs, the radiography component is approved by HARP and HARP has also approved stand alone radiography programs.

Most provinces in Canada regard the exposing of radiographs as a controlled act as any exposure to radioactive components poses a harmful risk to patients. However, this is not the case in Ontario. Radiographic exposure is delegated to dental assistants, some of whom are not formally educated.

Many Ontario dental assisting educational programs are not accredited and thus there are unknown standards with respect to the faculty hired to teach radiography at many of these facilities. Though these programs may be HARP approved, the HARP Commission no longer exists and Ministry of Health and Long Term Care personnel do not regularly monitor the program, review the curriculum or review the credentials of the teaching staff. At the core of this issue is a lack of standardization and an unbiased agency to approve radiography education and this poses an inherent risk for patients.

The study of radiography in all other health related disciplines is formalized and rigorous. Dental radiography must also meet this standard and be taught by qualified educators in accredited facilities. Without this, the potential for patients to be over exposed to ionizing radiation exists. Patients have the right to expect that radiographs are exposed by formally educated and qualified professionals who have met competency at a specified standard.

ODAA is aware that radiographs are being exposed by individuals without formal education. There are hundreds, perhaps even thousands of people working as dental assistants who have been “trained on the job”. This situation must be addressed and is of grave concern.

Intra-oral Skills:

Many intra-oral duties that dental assistants perform can cause injury to a patient if not done correctly. Level 2 assistants apply pit and fissure sealants, desensitizing agents, topical anesthetics and acid etch, perform coronal polishing, whiten the coronal portion of the tooth, apply and remove a dental dam, perform fluoride treatments and obtain alginate impressions. If these delegated skills are not performed according to accepted practice standards, the patient may, at a minimum experience discomfort. More serious injury or over-exposure to potentially harmful substances such as fluoride or acid etching gels cannot be underestimated.

The lack of accreditation of private career colleges and the knowledge that dentists are delegating these duties to employees who may not be formally educated contribute to risk of harm.
5. Explain the extent to which public safety is at risk because the profession remains unregulated.

Presently, dentists can and do hire staff who are not formally educated to work as dental assistants. The public expects their health and well being to be protected while receiving dental care. It is likely that a dental patient would assume that the enormity and complexity of infection control protocols would be performed by those who are formally educated. As long as dentists in Ontario are able to delegate infection control responsibilities to uneducated and unregulated personnel, the risk of harm is real. The reality is that dentists attempt to save money in salaries by hiring uneducated personnel to perform infection control procedures and though these may meet the interest of the dentist, this practice is certainly not in the public’s interest.

In 1999, Level 2 or intra-oral assistants were initiated. The RCDSO advised Ontario dentists they could delegate specific duties to dental assistants who had passed the National Dental Assisting Examining Board (NDAEB) examination. In 1999, the scope of practice included 9 intra-oral duties whereas now it encompasses 13 intra-oral duties. This framework of one profession “checking” the NDAEB credential of another is unofficial, ineffective, antiquated and patriarchal.

The RCDSO’s mandate relates only to dentists. There is no language pertaining to dental assistants or about the profession of dental assisting. Ontario dental assistants have no voice and no vote. They have no opportunity or ability to comment, influence or change educational requirements, standards of practice, continuing competency for their profession. In the current climate, dental assistants are completely marginalized. Without self regulation they will remain invisible.

Other than this single guideline, the RCDSO doesn’t regularly disseminate information to their members regarding the profession of dental assisting. As the monitoring body of dentists, the RCDSO has not accepted any responsibility for or to dental assistants.

As the certifying body, ODAA regularly communicates with our membership. However we estimate that there are several more thousands of dental assistants working in Ontario who are not our members.

ODAA has long recognized the void and necessity of regulation for dental assistants. In an effort to fill this void and with the public’s best interest in mind, as a membership organization, ODAA became the certifying body for dental assistants—however, this is on a voluntary basis and does not replace regulation.

ODAA provides guidance to members regarding our scope of practice. We derived this scope of practice from the guidelines of RCDSO. There remains a great deal of confusion among dental assistants, dentists and dental hygienists with respect to the scope of practice for dental assistants resulting in the performance of illegal duties and mis-delegation of duties.

ODAA has conducted membership surveys regarding duties performed by dental assistants and responses indicate that a significant number of ODAA certified dental assistants are performing skills outside what is deemed to be our legal scope of practice. There are level 1 assistants performing intra-oral duties without the appropriate education and there are level 2 intra-oral assistants performing duties for which only hygienists/dentists are educated and qualified.
Many dentists report that as employers and business owners, they have the right to determine what duties dental assistants can perform. Responses to ODAA membership surveys indicate many members are requested to perform duties outside of the acceptable scope of practice. These duties are often performed under duress. With no official regulatory framework and no representation or support of any kind through the monitoring process of RCDSO, dental assistants are ultimately alone with no recourse and may feel the threat of job loss if the delegation by the dentist is not accepted.

ODAA can only play an advisory role in these situations—we have no authority. We suggest our members when faced with mis-delegation of duty dilemmas; educate their employers about the Level 2 duties. To aid and support dental assistants in this delicate discussion, ODAA publishes a Skills Chart. However, ODAA members continue to report that they are simply expected to do as they are asked.

ODAA has received complaints regarding dental assistants. The College of Dental Hygienists (CDHO) has frequently contacted us to inquire if certain individuals are members of ODAA. These individuals are suspected of performing duties that are restricted to the practice of hygiene. With the exception of two individuals, the dental assistants in question have not been members of ODAA. In 1999, ODAA removed the certification status of one of our members as this person was found guilty of posing as a dental hygienist. However, due to the lack of regulatory status, we cannot assure the public that this person is not still working as a dental assistant.

In the past year, we have also had several anonymous complaints regarding some of our members who were accused of performing duties associated with the practice of dental hygienists. We were unable to investigate these complaints due to the anonymous nature.

Additionally, we have received 2 complaints from employers who wanted the certification status of their employees removed due to concerns within their dental practice. One such complaint involved a dental assistant who had left a patient unattended after this patient was sedated. Another complaint was of a professional misconduct nature. We requested that the complaints be put in writing and to date, ODAA is not in receipt of any written documentation.

Members of the public have contacted us with concerns about the educational level of various dental assistants. Many of these dental assistants were not our members or an investigation was hindered because the patient couldn’t identify the individual by full name and refused to give us the name of the dentist where the member worked.

In May 2009, ODAA revoked the certification from a member who had been convicted of possession of child pornography. This member was advised that he had lost his certification for a period of 2 years. Reinstatement will only be considered if the member can show proof of remedial counseling. To date, ODAA has had no further contact with him.

In January 2011, again, responding to a lack of provincial regulation and bridging a gap, ODAA formalized a complaints and discipline policy. This new policy was circulated to our entire membership advising them of this new addition to our certification program. A copy of this policy is included in the appendix.

Our process however, does not have the inherent power to investigate and discipline through a governance model with set practice standards and accountability requirements. At best, even in the most serious cases of misconduct or incompetency, our membership organization could only revoke membership and certification. With a revoked ODAA membership and certification, the dental assistant in question could continue to work and provide patient care as usual.
Educational requirements and disparity are of paramount concern. With the exception of Quebec, Ontario is the only province in Canada which allows non-accredited dental assisting program graduates to bypass the NDAEB Clinical Practice Evaluation. In every other province, Quebec notwithstanding, graduates of non-accredited dental assisting programs must successfully complete the NDAEB written examination and the NDAEB clinical practice evaluation (CPE) in order to be registered/licensed. Through lack of any provincial regulation or initiation through the RCDSO, Ontario stands alone in the country, allowing dentists to delegate the same level 2 intra-oral skills to non-accredited dental assisting program graduates and accredited dental assisting graduates. This not only is a concern for patient care, but non-accredited dental assisting graduates have great difficulty with portability without the dual NDAEB certificate.

The standards, requirements and rigor of accreditation is an evidence based process. Programs must provide the Commission on Dental Accreditation of Canada extensive documentation and evidence to demonstrate that educational standards, educated faculty, adequate budget, equipment and supplies are in place. This documentation is confirmed at an onsite survey visit.

Non-accredited programs have not been measured against any standardized criteria. Recognizing this, all jurisdictions with the exception of Ontario and Quebec, require that in lieu of a program successfully garnering accreditation status, non-accredited program graduates must prove not only their clinical competency and skill but their ability to practice these skills safely through the NDAEB administered CPE.

This lack of accountability and oversight of non-accredited programs is highlighted by the two separate phone calls received by ODAA in the summer of 2011. These phone calls from private career colleges were enquiring whether a dentist had to authorize and be present when students were practicing their intra-oral duties on patients. Anecdotal evidence suggests unclear is the requirement of dental assisting programs to have a dentist authorize, specifically prescribe and diagnose radiographs in the school setting. Without a regulatory body, questions such as these are often posed to ODAA.

Upon investigation, ODAA learned that there are no actual guidelines for dentist supervision of dental assisting while working on patients; according to the staff person we spoke with at the Ministry of Colleges, Training and Universities. The RCDSO has no jurisdiction over dental assisting educational programs and neither does ODAA.
6. Explain the anticipated effect of regulation on the current risk of harm presented by the profession.

Regulating the profession of dental assistants would thereby create an administrative foundation and framework with appropriate bylaws for governance. These bylaws would set out and assure an entry to practice standard, quality assurance, duty to report, continuing competency through required hours of practice and mandatory continuing education credits. Additionally, accountability, code of ethics and practice standards violations would be dealt with through a structured complaints, investigation and discipline model in line with other healthcare professionals. Through these mechanisms, all decisions and requirements of the profession shift, to centre and focus on the best interest and protection of the public.

Regulating dental assistants will result in an agreed upon scope of practice, practice standards and quality assurance. Regulation rather than the dentist employer, will then set the standard of practice for dental assistants.

Furthermore, dentists will no longer be able to hire people without formal education and delegate complex and highly critical tasks such as infection control to them. This would be of tremendous benefit in terms of risk management and public safety.

With self-regulation, dental assistants will have autonomy. The current conflict of interest allowing dentists as the employers of dental assistant to monitor or “regulate” dental assistants will be removed.

Regulation will decrease illegal practice and empower dental assistants. With governance for dental assistants, the current ambiguity about their role and their respective scope of practice will be removed. Dentists, as delegators, will have a better understanding of what can be delegated and to whom. Furthermore, with professional accountability in place, practice standards clearly articulated and scope of practice defined, dental assistants will have a solid platform from which to speak to dentists/employers who demand they perform procedures they have not been formally educated for and are outside of the approved scope of practice. Public safety will benefit with the oversight of a regulatory body.

Regulation will ensure that all dental assistants make a commitment to continuing competency and continuing education. Continuing competency assures the public the practitioner is technically competent, while continuing education assures patients the practitioner is up to date with current trends, techniques and materials.

Regulation of the profession of dental assisting will improve the quality of our educational programs. Presently, only the publically funded community college programs are accredited by the Commission on Dental Accreditation of Canada (CDAC). There are many private career colleges in Ontario offering dental assisting educational programs. These programs are non-accredited. This non-accredited status with no requirement for the graduates to successfully complete the NDAEB clinical practice evaluation makes the patients of these graduates vulnerable to less than optimal care. Accreditation with successful completion of the NDAEB written examination or no accreditation, but mandatory completion of the written as well as the CPE will provide the assurance to both the dentist employers and the public that programs and graduates have been held to a high and national standard. This is good for the public, the profession and the future of dental assisting.

Lastly, regulation could reveal opportunities for Level 2 dental assistants to provide, within their scope of practice, dental services to the public, outside of the traditional dental office. Preventive services to marginalized populations including the homeless, seniors in long term care, First Nations and new immigrants would have a positive impact on both oral health and general health. These populations have extensive oral needs, some of which could be more economically and rapidly addressed through the utilization of level 2 dental assisting skills.
Bylaws govern the profession of dental hygiene and dentistry. It would seem reasonable then, that a governance model should be in place for all of the same reasons for the profession of dental assisting. Although there is overlap of skills and education with other professions, dental assistants possess a distinct body of knowledge and play a unique and vital role within the dental team. Through these mechanisms, all decisions and requirements of the profession shift, to centre and focus on the best interest and protection of the public.

Regulating dental assistants will result in an agreed upon scope of practice. This will empower dental assistants to speak up to employers/dentists who demand that they perform procedures for which they have not been formally trained and that are outside of the approved scope of practice. Public safety will benefit as the regulatory body would be able to monitor who is doing what with respect to skills/duties.

Furthermore, regulation will ensure that all dental assistants make a commitment to continuing education, keeping them up to date with current trends and issues that impact their career and affect the well-being of patients. Best practices within infection control issues are constantly changing and the more knowledgeable people are, the better they are at protecting the public.

Regulation of the profession of dental assisting will improve the quality of our educational programs. Presently, only the community college programs are accredited by the Commission of Dental Accreditation of Canada (CDAC). There are many private career colleges in Ontario offering dental assisting educational programs. There will be some pressure exerted to ensure that they will become accredited and so we can be more comfortable knowing that the facilities, faculty and curriculum are operating at the national standard. This is good for the public, the profession and the future of dental assisting.

7. Where the profession is supervised by regulated and/or unregulated health professionals, what direct and indirect mechanisms are in place to ensure the delivery of safe care, including quality of work performance?

and

8. What proportion of practitioners in the profession concerned perform duties without direct and indirect supervision?

There is a common perception that both level 1 and level 2 dental assistants are directly supervised by their dentist/employer. ODAA’s surveys and interaction with its members reflect exactly the contrary. Our feedback suggests while dentists may be on the premises, their supervision of dental assistants is very indirect.

Indirect supervision works well if three key elements are in place – education, qualification and accountability. With formal education, the practitioner not only understands the “how” of a procedure, but the “why”. They are able to integrate their knowledge with clinical practice, problem solving based on a foundation of education and self-evaluate. Most importantly, the educated individual understands the clear parameters of their scope of practice and knows when to seek consultation from someone with more education and expertise. When these key elements are not in place and if critical tasks are delegated, direct supervision and monitoring mechanisms must be implemented to guarantee quality assurance and well being of the patient.
When dentists hire people without formal education, these assistants are either trained by the dentist or another staff
member who may or may not be formally educated themselves in dental assisting. Without formal education, these
dental assistants then have little or no cognitive understanding of disease transmission, cross contamination and other
important infection control procedures.

With an on the job training model in conjunction with indirect supervision being the norm in dental offices, the
delegation and responsibility for the infection control and protection of all of the staff and patients is risky at best.
Furthermore, many of the infection control procedures are likely wholly unsupervised as they take place at the
beginning and end of the day, before and after the dentist is on the premises.

Some dentists and organized dentistry may take exception to the view that the work of dental assistants is largely
unsupervised. Those in opposition of this notion, state dentists are responsible for the entire operational procedure of
their dental office. While it is true that the dentist owns the practice and therefore, oversees the overall operation of
it, it would be rare to find a dentist directly supervising the sanitization and disinfection of operatories, the sterilization
of instruments and the biological monitoring procedures. Most often, the dentist is treating a patient while this type of
work is being done.

The delegation of infection control procedures to those lacking formal education may be a cost savings to the dentist.
However, unknowing patients who are entrusting their health and well-being to this unacceptable practice may pay in
the end by contracting a serious illness.

In addition to the misguided delegation of infection control procedures, ODAA has been advised by dental assistants,
hygienists and dentists that some dentists are training assistants without formal education to expose radiographs,
place and remove dental dams, perform whitening procedures and other intra-oral duties, all with little or no monitoring.
There is most assuredly not enough time in the day for a dentist to directly supervise these practices. Furthermore,
even with direct supervision, these duties are outside of the recognized scope of practice and the guidelines
established by the RCDSO. Level 1 assistants do not have the requisite education or demonstrated competency to
safely perform these skills.

Furthermore, supervision is not sufficient when the dentist/employer performs duties that are outside of the recognized
scope of practice and the guidelines established by RCDSO, and for which dental assistants do not have the requisite
education or training.

The current situation clearly illustrates and underscores the need for regulation of the profession and adherence to the
regulation by the professionals themselves and those who delegate to them.

In an effort to protect the public, in recent years, ODAA has been very vocal about the urgent need for dental assisting
to be a regulated health profession. In addition, ODAA has advised the public that some dentists are delegating the
responsibilities of infection control within the dental office to uneducated and unqualified level 1 dental assistants.
However, even though the ODAA has sounded the alarm in the name of patient protection, the RCDSO continues to
endorse the delegation to uneducated, unqualified, unregulated, unlicensed and often unsupervised personnel.

Dental assistants do work under direct supervision when they assist the dentist at chairside for various procedures.
However, some skills that take place before, during and after the procedure, such as the exposure of radiographs,
applications of topical anesthetic, placement and removal of dental dam, may be delegated. Delegating these
procedures facilitates the dentist treating more than one patient at a time. While the dentist is examining or
anesthetizing another patient, the level 2 dental assistant becomes the operator providing direct patient care.
Level 2 dental assistants are also delegated many of the preventive procedures such as application of densensitizing agents, selective rubber cup polishing, fluoride and fissure sealant application. In these treatment scenarios, the level 2 dental assistant will work as the operator assessing. Within their scope of practice, the dental assistant will assess the patient and make a decision about the grit of the polishing agent based on the amount and tenacity of the stain, what type of fluoride based on patient dental history and patient management and type of isolation for the fissure sealant.

The assessments and decisions level 2 assistants make are based on their education. Accredited programs ensure their students have a thorough understanding of the assessment process and the decisions required based on the patient’s dental and medical history, current oral conditions, age and manageability of the patient. Competency is based on many factors including treatment planning within the scope of a dental assistant, performance of the procedures on many patients of different ages, strict adherence to safety and infection control and post treatment self-analysis.

Dentists are highly respected healthcare practitioners educated in dentistry. However, they receive little or no training about how to supervise and manage staff. ODAA members advise our association that regular performance reviews of their work is very rare.

The hiring and delegation of tasks and skills to uneducated personnel that could be injurious to patients must be terminated. Coupled with the present supervisory relationship, it very clearly does not put the interests of the public first. Additionally, Level 2 skills, in the best interest of the public should only be delegated to someone who has either graduated from an accredited program or in lieu, has successfully completed a Clinical Practical Evaluation. Furthermore, if a task is within the scope of practice of a dental assistant; if the dental assistant is formally educated, registered and licensed and if the the task has been properly delegated, the issue and need for supervision may be moot.

With regulation and standards of practice in place, the public is assured dental healthcare professionals are accountable for their work and they only perform duties within a recognized scope of practice.

9. How do recent advances in treatment and technology contribute to potential risks of harm posed by the profession?

Formally educated dental assistants at all levels are taught how to expose intra-oral radiographs. However, many dentists, particularly orthodontists and oral surgeons, in addition to intra-oral radiographs now expose panoramic and cephalometric radiographs. The panoramic technique is used to produce extraoral radiographs of the entire dentition and related supportive structures of the lower half of the face, while a cephalometric radiograph is a lateral projection that provides a right-angle view of the side of the skull superimposed on tissues including the opposite side of the skull.

Extra oral radiographs require higher doses of radiation. Dental assistants are taught only theory around these types of radiographs. They do not practice the exposing of these types of radiographs while in their college program. Without practice and competency evaluations, patient safety may be compromised due to operator error and the necessity for retake exposure. Similar concerns may arise with digital radiography as many college programs may only teach theory around these types of radiographs.
With the advent of tooth whitening products more and more patients are requesting this dental procedure. Though level 2 assistants are taught how to whiten teeth with products that are readily available to the public, many in office whitening products have a very high level of hydrogen peroxide. With increased peroxide is an increased risk of gingival burning. Often, dental sales personnel may advise prospective purchasers of these products, that this duty can be delegated to dental assistants. With a lack of clarity around the scope of practice of dental assistants, dentists and dental assistants may take the word of dental sales personnel, further compromising patient safety.

Dentistry is a health science. Like all health sciences, the field of dentistry is constantly undergoing technological change. New techniques and materials are constantly emerging. Recognizing this, provincial licensing bodies require all dentists, dental hygienists and dental assistants to have continuing practice hours and mandatory continuing education. Without these two requirements in place for all Ontario dental assistants, the best interest of the patient is not addressed.

10. Explain the profession’s experience with liability insurance protection, including the current percentage of practitioners of the profession who carry liability insurance coverage. What is the position of professional association and related organizations on this matter?

ODAA members are able to purchase malpractice insurance through the Canadian Dental Assistants Association (CDAA). Presently .01% of our members purchase this insurance. The RCDSO provides insurance coverage to dentists through their Professional Liability Program and ODAA has been advised that dental assistants, employed by dentists, are covered under this insurance. The malpractice insurance presently offered by CDAA has a clause that stipulates if the person is covered under any other insurance, that insurance would take a precedent in the event of a claim. For this reason, ODAA does not actively promote the CDAA malpractice insurance.

11. Describe any process undertaken to determine the public need for regulation and the response/results achieved.

Over the past 6 years, ODAA has had a dozen media campaigns designed to bring attention to the need for regulation of dental assistants in Ontario. Advertising in 10 major and 12 smaller newspapers, ODAA has advised the public that dental assisting is not yet a regulated health profession and dentists continue to hire untrained staff to do the work of dental assistants. We have had a very positive response to this media campaign and our Executive Director has spoken on several radio talk shows regarding this. The public is much more savvy and has a heightened concern about the need for stringent infection control procedures in health care settings. With this in mind, there is support from the public to regulate dental assistants. Frankly, we have heard time and time again, how shocked the public is to learn that dentists can and do delegate infection control protocols to those without formal education. In the name of public trust, the interests of the public are best served with the regulation of the profession of dental assisting.

12. What professional titles should be restricted to members of the profession? Why?

ODAA has been the voluntary certifying body for dental assistants for more than 40 years. It has and continues to bestow the title and credentials of Certified Dental Assistant (CDA) to those who join and meet the required criteria. The title CDA has been and continues to be a recognized title and ODAA believes that this title should continue.
13. Identify any known circumstance(s) under which a member of the profession should be required to refer a person to another health profession.

If a dental assistant, working in direct patient care position and noticed a lesion or something untoward/abnormal, they would need to refer the patient back to the dentist who would then refer the patient to another health care practitioner. However, in cases of child abuse, the dental assistant would have an obligation to report this to the proper authorities.
Secondary Criteria:
**Criterion: Professional Autonomy**

**Questions 1-4:**

Dental assistants both facilitate the work of dentists and dental hygienists and provide direct patient care. All duties are initiated through delegation by the dentist. Dental assistants do not have the authority or education to diagnose nor do they communicate any diagnosis to the patient.

Level 1 and level 2 dental assistants are delegated the responsibilities and duties of infection control. These duties are almost always completed with little or no supervision by the dentist. The level of autonomy is acceptable if the delegation is given to a dental assistant who has been formally educated. Of grave concern, is the delegation of infection control to the non-educated person working as a dental assistant. The high degree of independence and autonomy puts patients and the entire dental staff as considerable risk. It is irresponsible, unfair and potentially dangerous to task procedures to uneducated personnel as these procedures require judgment and assessments.

Level 2 dental assistants may also be delegated the task of intra-oral hygiene instruction. These patient care procedures are delivered autonomously by the dental assistants. Dental assisting programs, accredited by the Commission on Dental Accreditation of Canada (CDAC), have had this unbiased organization assess the objectives, learning tasks and assessments for these topics. Dentists who delegate these duties to non-accredited graduates without direct supervision cannot be certain of quality assurance. Level 2 dental assistants perform many intra-oral duties very autonomously. To do so, they must be formally educated to assess and treatment plan for their patient within their scope of practice. These assessments and the subsequent treatment plan requires foundational knowledge and judgement.

Many of our ODAA certified dental assistants adhere strongly to our Skills Chart. Many members report they are and want to be accountable to the ODAA. However, without regulation and with the power differential between dental assistants and dentists, there is a great deal of pressure on the dental assistants to do what their employer delegates them. Without regulation of the profession of dental assisting, Ontario dental assistants are positioned at the bottom of the hierarchy with no voice, and no recourse for reporting, intervention and support.
5. How would self-regulation affect the current model of accountability? How would the public interest be served by this change?

Regulatory bodies exist to protect the public and accountability is inherent in regulation. Accountability begins by requiring applicants meet certain education standards at the onset. This is likely graduation from an accredited program with successful completion of the NDAEB written examination or graduation from a non-accredited program with successful completion of the NDAEB written and clinical examinations. Other requirements may be in place such as mandatory CPR and a criminal records search. This initial process ensures the applicant has demonstrated competency and is safe to practice at an entry level.

Once the applicants become registrants of the regulatory body, their obligations continue through the language of the bylaws. The bylaws require the member to adhere to more and ethical standards of practice. Competency is maintained and enhanced through mandatory continuing practice hours and mandatory continuing education. A compulsive reporting mechanism, monitoring are in place to ensure the members’ adherence to the bylaws. Additionally, annual licensing/membership fees are imposed and renewal is required to practice.

Consequences for violation of the bylaws will be clearly delineated and it will be the responsibility of the individual to know, understand and adhere to the bylaws of their profession.

With self-regulation, a new model of daily practice will emerge, not only for dental assistants but also for the other members of the dental team. Regulation will flatten some of the hierarchy and enable dental assistants to be professional partners with dental technicians, denturists, dental hygienists and dentists.

This “partnership” model will require the other team members who are regulated themselves, to recognize and respect the scope of practice of Ontario dental assistants. Duties and skills of each of the profession will be clearly defined and articulated and intra-professional collaboration with the interest of patient in mind will be realized. This will result in less misdelegation and therefore less illegal practice.

Self-regulation will empower dental assistants. The regulatory framework will provide dental assistants with a legitimate process to address their concerns with their dentist employer or any member of the dental team.

Recognizing dental assistants work in a team environment and under a delegation model, the regulatory bylaws for dental assistants will define the delegation and supervisory (direct, indirect or authorization) conditions under which a patient can receive dental services by a dental assistant. This information will aid the dentist and the dental assistant, thus strengthening their partnership and ensuring both professions are working within the parameters of their regulatory authorities.

The current “management” of Level 2 assistants through the RCDSO guideline regarding the delegation of intra-oral duties, both restricts and marginalizes these health care professionals. Dental assistants have no voice, no vote and no involvement in the decisions directly related to their education, their regulation and their professional practice. With no influence, or any sort of self-determination, Ontario dental assistants are denied the responsibility and accountability of their profession.

Self-regulation of Ontario dental assistants will hold its registrants accountable. This accountability will elevate and inspire the profession of dental assisting. In turn, it will most assuredly provide enhanced clinical services and ultimately will foster best practice standards for patient safety.
6. Are members of the profession currently performing controlled acts under the delegation of regulated professionals? How would the public interest be served by this change?

In most Canadian provinces, exposing radiographs is considered to be a controlled act and yet in Ontario dentists may delegate this duty to a dental assistant who has graduated from a HARP approved dental assisting program or a HARP approved dental radiography program. The HARP approval process in dental assisting educational programs is based on a one-time approval review of curriculum and equipment.

Dental assistants enrolled in a level 2 educational program are taught skills that include the placing of treatment liners and matrices and wedges and these are considered to be controlled acts. ODAA advises our members not to perform these duties and this is also included in the RCDSO guideline regarding the delegation of intra-oral duties.

In a recent ODAA survey, 17% of the members responding, reported they are often delegated the fabrication and intra-oral placement of temporary restorations and temporary crowns and 15% reported that they had performed or were performing through delegation orthodontic duties such as placement of arch wires, elastics and bands. These duties are considered controlled acts under the Regulated Health Professions Act, 1991. Level 2 dental assistants in most Canadian provinces are permitted to place temporary restorations, fabricate and place temporary crowns and various orthodontic procedures, only after the successful completion of a post graduate module in prosthodontics and orthodontics. Ontario doesn’t offer these modules and therefore these controlled acts are being misdelegated to Ontario dental assistants.

Furthermore, 9% of ODAA members who responded to our survey stated they have performed whitening of the coronal portion of the teeth using products with concentration levels of hydrogen peroxide as high as 40%. Health Canada recommends that whitening products made available to the public should have a 5-8% maximum concentration of hydrogen peroxide. Further, the RCDSO’s own delegation guidelines for Ontario dentists state that the delegation of this skill be restricted to “whitening of the coronal portion of the teeth with products readily available to the public”. Ontario dental assistants are not educated, nor skilled to use these potentially dangerous products. Lack of education and skill by the clinician could result in gingival burning.

Level 2 dental assistants are able to take preliminary impressions for the purpose of study models. However, ODAA is aware of delegation of the controlled acts (RHPA 1991, Controlled Acts) such as the construction, repair and alteration of dental prosthetics, restorative and orthodontic devices. These services should not be provided by any level of Ontario dental assistant as they are in the scope of practice for only dentists, dental technicians and denturists.

Controlled acts are controlled to protect the public. These acts restrict the delivery of specified procedures to practitioners who have met a level of competency through formal education. With regulation in place, the standard of such education will be determined; ensuring only those with the prescribed credential shall deliver controlled procedures.
Criterion: Educational Requirements for Entry to Practice

1. Describe the educational and clinical/practical training programs available in Ontario. Specify theoretical and clinical/practical experiences.

   a.) Describe how the professions body of knowledge and approach to diagnostic/treatment modalities and services are taught in this program.

   b) Relate the education and training to the diagnostic/assessment abilities, treatment modalities and service.

Although many provinces had Level 1 formally educated dental assistants at one time, Level 2 intra-oral dental assisting is now considered the national standard in Canada. Dental assisting programs teaching this program teach at a minimum, thirteen core competencies. Graduation is followed by mandatory successful completion of the National Dental Assisting Examining Board (NDAEB) written examination for all graduates. In regulated Canadian provinces, a Clinical Practical Evaluation (CPE) administered by the NDAEB is required for graduates of a non-accredited program.

Ontario is unique in two ways. Firstly, we still offer formal educational programs for both Level 1 and Level 2 dental assistants and secondly, Ontario (through the RCDSO guideline) doesn't require the CPE for non-accredited graduates.

Level 1 chairside dental assisting programs are offered in private career colleges and in one high school technical program. These level 1 programs are not recognized in other parts of Canada and so provides no portability to the graduate.

The goal of Level 1 is to prepare the graduate to assist the dentist at chairside. These programs place the emphasis on didactic education with very little clinical education. Clinical education is limited to the use of DXTRS (manikins) as patients. Clinical competencies include mock restorative assisting, and the placement, exposure and processing of dental radiographs on DXTRS.

To complete a level 1 program, there is a required clinical placement of 80 hours in a dental office and the student must expose a full set of radiographs within that placement on a patient under the supervision of a dentist.

Radiography competency testing by the dentist is a flawed process. The supervising dentist doesn’t know the standard expected by the program. Placement dentists are also not calibrated as an evaluator group. Thus the program has no way to reliably state their graduates are competent against a prescribed measure.

Conversely, Level 2 accredited programs are required to evaluate their students’ radiography competency on both manikins and patients in the school setting before they expose patients on practicum rotations. This is a critical step to deem them both safe and competent to expose radiographs on the public.

The Commission on Dental Accreditation of Canada doesn’t accredit level 1 programs. As such, no “arms length” analysis of their curriculum, learning outcomes, evaluation procedures has ever been undertaken.

In Level I or chairside programs, the focus is on theory. Course content includes:

- Infection control protocols
- Orientation to dentistry
• Oral facial science
• Dental materials/environmental health and safety, WHMIS
• Clinical dentistry
• Preventive dentistry and nutrition
• Oral pathology
• Diagnostic records
• Dental pharmacology
• Medical emergencies, First Aid, CPR
• Clinical practical procedures
• Dental Radiography
• Practice Management
• Dental Specialties
• Dental Jurisprudence

Although level 2 intra oral dental assisting education has been offered in eight other provinces (with the exception of Quebec) since the early 1970’s, Ontario did not introduce a level 2 program until 1999. Level 2 dental assisting educational programs vary in length from nine to eighteen months across the country. The majority offer ten month programs of study. Level 2 programs in Ontario, the same as many other provinces, are offered in both publicly funded community colleges as well as private, for profit, career colleges. Community colleges only offer a level 2 certificate as they integrate the level 1 and level 2 skills into one flow through program while some private colleges offer a discreet level 1 and level 2 program, requiring the student to complete the level 1 program first and then enroll in the level 2 program.

The curriculum of Ontario private career colleges is approved by the Ministry of Colleges, Training and Universities and the NDAEB regularly require non-accredited programs to have their curriculum assessed on a regular basis by an outside agency in order for their graduates to qualify to write the NDAEB written examination. Presently no Ontario private career colleges offering dental assisting educational programs are accredited by the Commission on Dental Accreditation of Canada (CDAC).

Accredited programs use a building block model, providing the student with the foundational knowledge required to safely and competently perform the clinical skills. This is followed by the introduction and acquisition of the skill on manikins, student partners as patients and finally public patients.

In Level 2 accredited programs, theory is fully integrated with clinical practice. Clinical competency is the combination of professionalism, integration of knowledge and problem solving, procedural accuracy, adherence to safety and infection control protocols and self-evaluation. In each of the areas, the student is assessed against established critical criteria. This “amalgamation assessment” emphasizes responsibility and accountability in every phase of patient treatment and prepares the student for their role as a health care practitioner.
Accredited programs must ensure continued competency by setting requirement numbers that students must achieve. Students are assigned a variety and number of patients over a specified period of time. They must be able to demonstrate continued competency in all intra-oral skills sets.

Level II curriculum course content includes:

- Orofacial anatomy
- English for health sciences
- Dental Radiography
- Dental business and computer concepts
- Dental biomaterials
- Chairside principals and infection control
- Dental pharmacology
- Communication
- Oral ecology
- Dental assisting professionalism
- Intra-oral principles and skill development
- Nutrition and diet counselling
- Dental Jurisprudence

In Ontario Level 2 programs there are approximately 574 hours of academics and 172 hours of pre-clinical and clinical practice. Students’ complete an 80-hour placement as part of the curriculum.

With the absence of regulation for Level 2 dental assistants in Ontario, the only policy/guideline that presently exists is through the RCDSO. They advise their members that only level 2 assistants who have passed the NDAEB examination may be delegated and perform intra-oral duties on patients in a dental office. As a result of this policy, level 2 dental assisting students from all colleges cannot perform their intra oral procedures on patients (with the exception of radiographs) while on practicum. In regulated jurisdictions, students are permitted to perform intra-oral procedures, delegated by the supervising dentist on patients, during clinical placements.

c) What percentage of the practitioners of the profession is educated and trained in Ontario?

ODAA has no definitive knowledge of how many dental assistants there are in Ontario. It is estimated that there could be 13,000 to 15,000 dental assistants. Of that number, close to 50% are ODAA certified dental assistants. The ODAA does know that dentists continue to employ people who have no formal education in dental assisting to do the work of dental assistants.
d) What percentage of the members of the professional Association is educated and trained in Ontario?

ODAA has a membership base of close to 8,500 and 7,700 are certified dental assistants. Data collected by our organization suggests that 94% of ODAA certified members have been educated in Ontario.

2. Identify and describe the Ontario and Canadian academic education and clinical/practical training programs available to persons seeking to enter this profession. Specify theoretical and clinical/practical training programs.

The registrars of the College of Dental Assistants of Alberta and the Saskatchewan Dental Assistants Association and the registrars of dental colleges representing regulated Level 2 programs, form the Dental Assisting Regulatory Authorities (DARA). Quebec and Ontario (the ODAA) are invited to these meetings but with a non-regulating status, do not have a vote. Meeting annually, the DARAs discuss trends, issues and challenges for Level 2 dental Assistants. Their decisions impact the core curriculum for Level 2 dental assisting programs in Canada.

The DARA has agreed and set the national competency for Level 2 assistants. The written examination is delivered by the National Dental Assisting Examining Board (NDAEB). The national skill set includes the following mandatory competencies:

- chairside dental assisting
- exposing of radiographs
- oral hygiene instruction
- dietary counseling relative to oral health
- obtains preliminary impressions for study casts
- performs selective coronal polishing
- placement and removal of the dental dam
- application of fluoride treatments
- application of treatment liners (no pulpal involvement)
- application and removal of matrices and wedges
- application of pit and fissure sealant
- application of desensitizing agents
- application of topical anesthetic
- use, care and maintenance of coronal whitening bleaching trays
The 200 question case based written examination is blueprinted and is determined by a national occupational analysis and eight domains:

- conduct appropriate to the professional setting (5-10%)
- dental sciences (7-12%)
- clinical support procedures (5-10%)
- client records (5-10%)
- client care procedures (45-50%)
- practice management procedures (5-10%)
- laboratory procedures (5-10%)
- preventive procedures (18-22%)

The DARA also agreed that for purpose of initial licensure, level 2 dental assistants graduating from non-accredited programs, additionally, be required to successfully complete the NDAEB Clinical Practical Evaluation (CPE) as an entry to practice standard. The CPE consists of nine intra-oral skills.

- exposes dental radiographs
- obtains preliminary impressions for study casts
- applies and removes dental dam
- performs selective coronal polishing
- applies and removes matrix and wedge
- applies fluoride
- applies topical anesthetic
- applies pit and fissure sealant

The CPE is performed on a manikin. In addition to assessing the candidate’s skill competency, safety and infection control are critical criteria for all skills. This process ensures not only, that the candidate is able to demonstrate their knowledge and practice of a technical skill, but additionally, and just as importantly, that the delegated procedure is delivered in a safe and aseptic manner, with no harm to the client.

All regulated jurisdictions utilize the NDAEB written and/or CPE as a re-entry to practice assessment for applicants who have let their registration/licensure lapse. This ensures competency and safe practice for the public.

Provincial scopes of practice determine which of the thirteen skills level 2 dental assistants in their jurisdiction can practice. However, all examination candidates (written and clinical) must have been educated to perform all thirteen skills as an operator in the education program. Provincial scopes of practice may also include additional skills and post graduate modules which may or may not be practiced outside their home jurisdiction.

All provincial jurisdictions offer level 2 dental assisting educational programs, meeting the national standard with the exception of Quebec. In addition, Ontario also offers some Level 1 dental assisting programs.
Students from accredited dental assisting programs apply directly to the NDAEB for the written examination. Eligibility requires an application form along with a letter of successful completion from their dental assisting program.

Non-accredited dental assisting programs must have their program content assessed every three years by the NDAEB. If the program receives approval, candidates, like their counterparts from accredited programs, apply with an application form and letter of successful completion, from their dental assisting program.

All of the dental assisting programs in Quebec are non-accredited. None of the programs have applied to have their curriculum assessed by the NDAEB for exam eligibility. It is understood their curriculum does not currently meet the national entry level standard for dental assisting.

All publicly funded and many private, for profit Level 2 dental assisting programs in Canada are accredited by the Commission on Dental Accreditation of Canada. Through the rigor and continued monitoring of the accreditation process, these programs demonstrate adherence, accountability and achievement of an educational framework delivering all required competencies with college and program policies supporting the learner.

Programs vary in length across the country and many programs offer multiple intakes. Many Ontario community colleges offer accredited upgrade programs for level 1 dental assistants who want to upgrade to level 2. Ontario Private Career colleges may also offer these upgrade programs, however these are not accredited programs.

Ontario graduates of accredited dental assisting programs with the NDAEB certificate have direct portability of their mandatory skills in other Canadian jurisdictions. However, some jurisdictions provide for a larger scope of practice for level 2 dental assistants. In these provinces, the Ontario accredited graduate with the NDAEB certificate may be afforded a provisional registration/license to practice while obtaining the additional education required. Ontario graduates of non-accredited programs have less recognition and portability. These graduates are required by all other regulated Canadian jurisdictions to write the NDAEB exam, sit the NDAEB Clinical Practical Evaluation and complete additional skills education if required.

There is no credit, recognition or portability to any Canadian jurisdiction for Ontario level 1 graduates, with the exception of Quebec.

Ontario is only partially compliant when measured against the national standard. While it does require all level 2 dental assistants successfully complete the NDAEB written exam as a prerequisite to perform intra-oral skills, no mechanism is in place to monitor whether this is truly the case. Further, graduates from non-accredited programs are not required to complete the NDAEB Clinical Practice Evaluation, unlike any other province (except Quebec) in the country.

Foreign trained dental professionals (including the US) must have their credentials assessed prior to the NDAEB deciding on their exam eligibility. If deemed eligible, all foreign trained dental professionals must do both the written examination and the CPE administered by the NDAEB.
3. Identify and explain the major differences between programs in different jurisdictions.

All level 2 programs must offer at a minimum chairside assisting and the additional thirteen mandatory skills. Provincial jurisdictions may also require for registration/licensure, the inclusion of additional skills taught within the core education. These additional competencies may include any or all of the following:

- removal of sutures
- removal of periodontal dressings
- removal of retraction cord
- performing pulp vitality testing
- obtaining plaque indices
- adjustment of fissure sealants with a hand instrument or slow speed rotary handpiece
- fabrication of temporary crowns
- cementation and removal of temporary crowns

Additionally, post graduate modules depending on jurisdiction include:

- preventive dentistry module (limited scaling)
- orthodontic module
- prosthodontic module
- polishing amalgam restorations
- amalgam insertion and carving
- placing provisional restorations
- restorative implant assisting technology.

Quebec’s dental assisting programs do not meet the national standard. As such, the graduates do not qualify to write the NDAEB examination. Additionally, they do not have a well defined scope of practice nor can they expose dental radiographs. Quebec did try to regulate dental assisting in 2010 but the legislation did not pass. There was little in the way of public consultation and there was opposition from various stakeholders. The regulation of the profession of dental assistants in Quebec is currently under review.

The recognized and accepted Canadian national standard for dental assisting in all provinces, with the exception of Ontario and Quebec, is either a credential from an accredited program with the NDAEB written certificate or a level 2 credential from a non-accredited program with both the NDAEB written and clinical certificates.

Ontario’s level 2 education programs do offer chairside assisting and the additional thirteen mandatory skills. However, graduates of our programs cannot apply and remove matrices and wedges or apply treatment liners in private practice. Lack of regulation, also precludes expanded duty post-graduate modules.
American dental assisting educational and registration/licensure requirements fall under state regulations. Each state has different requirements—some states have no regulation for dental assisting. Many states do offer dental assisting educational programs similar to our Level 2 program. Other American states have the equivalent of Ontario’s level 1 or chairside assisting. However, unlike Ontario’s level 1 assistants, to expose radiographs, the American level 1 assistants must be licensed.

The United States has its own counterpart to the NDAEB. Their examining board, known as the Dental Assisting National Board (DANB) provides a written examination leading to a certification credential. DANB, however, does not offer a clinical examination.

Dental Assistants are regulated in Britain and the educational level is equivalent to Ontario’s Level I programs. Germany has formal educational programs very similar to Canada’s Level II programs.

4. What academic credentials are required by the following organizations:

   a) The Professional Association, as a condition of membership;

ODAA is both the professional membership association and the certifying body for Ontario clinical dental assistants. Any person working in the dental field or student in a dental assisting/reception educational program can join the Association. However to become a certified dental assistant, members must demonstrate that they have graduated from a government and HARP approved dental assisting educational program. Level 1 candidates must write ODAA’s entry to practice certification examination and Level 2 dental assistants must provide the NDAEB certificate. Level 1 certified dental assistants hold the CDA credential while Level 2 certified individuals are given the CDA II credential. On occasion, candidates without formal education may be permitted to challenge the level 1 certification examination as long as they have graduated from an approved stand alone HARP radiography program.

Certified dental assistants must abide by the ODAA Code of Ethics and commit to maintaining their certification through continuing education courses/seminars/workshops etc. They must achieve 15 continuing education credits each year.

   a) Employers:

Many Ontario dentists hire only ODAA certified dental assistants. The ODAA certification status assures employers, their employee has met both an educational and certification standard. Additionally, many dentists place a very high value on continuing education for themselves and their team. Thus, they fully embrace and endorse ODAA’s requirements for members to provide proof of mandatory continuing education.

Those dentists who do not make certification with ODAA an employment requirement must themselves ensure that their dental assistants have graduated from a HARP-approved program allowing them the delegation of radiographs. As RCDSO members, dentists hiring level 2 intra-oral assistants are advised to hire those employees holding the NDAEB certificate.

Although, this is the current protocol, ODAA has anecdotal evidence which suggests that Ontario dentists continue to hire people without formal education to do the work of clinical dental assistants.
b) Canadian Jurisdictions:

The Dental Assisting Regulatory Authorities (DARA’s) have agreed upon protocols to address candidates moving from an unregulated jurisdiction to a regulated one. As Level 2 dental assisting programs are considered to be the national standard, these protocols speak to Level 2 Canadian dental assistants and equivalent to level 2 (as determined by NDAEB) formally educated dental professionals.

The NDAEB exam is required by all regulated provinces as well as Ontario, as an entry to practice standard. The examination is imposed on candidates graduating from CDAC accredited programs, non-accredited programs or those possessing a level 2 equivalent credential from outside of Canada. Regulated jurisdictions, excluding Ontario, additionally require successful completion of the CPE for non-accredited level 2 graduates and foreign trained equivalents.

Depending on the candidate’s status and the jurisdiction, the applicant is granted full registration/licensure. Jurisdictions with a larger scope of practice than the originating jurisdiction may only provide a temporary/restricted/provisional practicing status until the applicant has completed additional education, thereby meeting the jurisdictions entry to practice standard.

5. What need, if any, has been identified for varying levels of registration?

Given Ontario has three categories of dental assistants, initially; a system of registration and licensure will need to be implemented to address and determine standards and scopes of practice for each. Eventually, as a regulated province, Ontario would align itself with the rest of the regulated jurisdictions and only register and license level 2 dental assistants.

Currently, there are three distinct categories of dental assistants working in Ontario. These include:

Level 1 Chairside Assistants:

This is a formally educated dental assistant who has graduated from a Level 1 or chairside dental assisting program. These programs have been approved by the Ministry of Training, Colleges and Universities and are HARP approved, allowing the graduates of these programs to expose radiographs. The number of private colleges in Ontario teaching these programs is diminishing but there are at least six such programs (some have several campuses).

ODAA is encouraging these colleges to move to teach Level 2 programs as the market need for Level 1 assistants is decreasing as more dentists recognize the value of Level 2 intra-oral dental assistants. In 2011, we had approximately 76 new level 1 graduates write our certification examination.

ODAA has 2,025 certified dental assistant members who are Level 1 assistants. We have been encouraging our members to upgrade to a level 2 assistant and thousands have done so over the past nine years. We anticipate that many more will upgrade once we become regulated.

ODAA does have certified Level 1 assistants who may have not been formally educated but have successfully challenged our Level 1 certification examination. Many of these members have taken a stand alone HARP approved radiography course and are able to expose radiographs. It is our belief that these level 1 dental assistants qualify for a certificate of registration and licensure as they are certified and have made a commitment to continuing education.
Preventive Dental Assistants (PDA):

Commencing in the early 1990’s prior to Level 2 dental assisting being approved in Ontario in 1999; dental assisting programs taught five intra-oral duties. Graduates of these programs are known as Preventive Dental Assistants (PDAs). In order to perform any or all of the five intra-oral procedures, these dental assistants were “listed” by RCDSO.

There are likely several hundred PDAs practicing in Ontario. ODAA currently has 297 members. PDA certified members of ODAA are known as Certified Preventive Dental Assistants (CPDA). Many PDAs have upgraded to a level 2 status but a few hundred have not. Because of this, a level of registration and licensure is required for this group of dental assistants.

Level 2 Intra-Oral assistant:

Canada is considered an international leader with respect to the profession of dental assisting. With eight provinces regulated and many of the dental assisting educational programs being accredited, it is clear the interest of the public is protected within most parts of Canada.

Ultimately, Ontario along with its regulated counterparts will only recognize one standard of dental assisting—level 2, intra-oral dental assistants. Graduates of accredited programs will continue to write the NDAEB exam and be exempt from the CPE. Non-accredited Canadian graduate and foreign trained dental professionals with level 2 equivalency will be required to complete both the NDAEB written and clinical examinations.

However, there are currently “categories” of level 2 dental assistants in Ontario that will need to be addressed when regulation is implemented. The original NDAEB examination encompassed chairside assisting and only nine (now thirteen) intra-oral skills. Additionally, non-accredited graduates have never been examined clinically by the CPE. Restriction activity licenses or “grandfathering” in some cases will need to be assessed in the best interest of the public. ODAA currently has close to 5,114 certified level 2 dental assistant members.

In most provinces, Level 2 assistants can perform expanded duties either offered through their core education program or through additional modular education. ODAA envisions the inclusion of additional skills within the level 2 programs as well as expanded function modules. As such, registration and licensure mechanisms will be in place reflecting the member’s scope of practice to ensure competent and safe practice in the public’s interest.
1. Describe the core body of knowledge of the profession.

Dental Assisting educational programs are taught at both Community Colleges and Private Career Colleges. For level 2 accredited dental assisting programs the curriculum of dental assisting programs must include foundation knowledge in the following areas:

- Behavioral Sciences
- Biomedical Sciences
- Oral Health Sciences
- Dental assisting theory and practice

The following elements address dental assisting practice:

- Professional conduct;
- Safe, ethical and professional practice environment;
- Communication;
- Collaborative practice/teamwork;
- Problem-solving and critical thinking;
- Dental assisting process of care (including the dental assistant’s assessment, the dental assisting plan for delivering procedures, their implementation and the evaluation of dental assisting procedures);
- Provision of dental office administration skills; and
- Health Promotion and education for individuals and communities

**Behavioral Sciences:**

Dental assistants need a solid foundation in oral and written communications, psychology, sociology, health promotion and community programming and education. Dental assistants must be able to apply this knowledge when providing dental assisting procedures and patient care procedures. Of particular importance is the ability to communicate well in a diverse work environment. Course curriculum must include the knowledge required to develop critical thinking and problem-solving skills.

**Biomedical Sciences:**

Graduates of dental assisting programs must have sufficient knowledge in anatomy, physiology, chemistry, biology, microbiology and infection control, pathology, nutrition, pharmacology and medical emergencies to be able to apply this knowledge to dental assisting and patient care procedures.

Curriculum content must facilitate graduates to apply advances in biology to clinical and community practice and to integrate new knowledge and therapies relevant to oral healthcare and health promotion.
Oral Health Sciences:

Dental assistants must be knowledgeable in tooth morphology, head, neck and oral anatomy, oral pathology, radiography, preventive dentistry, the dental specialties and dental materials. They must be able to apply this knowledge to implement dental assisting procedures and patient care procedures.

Dental Assisting Theory and Practice:

Dental assisting educational programs must provide sufficient knowledge that dental assistants can apply the principles to dental assisting patient care procedures. Dental assisting theory must ensure the integration of theory and practice in the following areas:

- Foundational knowledge to anticipate the operator’s needs for various dental procedures to develop chairside dental assisting skills
- Foundational knowledge in the properties and manipulations of commonly used dental materials
- Foundational knowledge for assisting at the pre-clinical level for dental and dental specialty procedures performed within a general dental practice
- Foundational knowledge of laboratory skills
- Foundational knowledge of office administration procedures
- Foundational knowledge required to develop skills to assess, plan, implement and evaluate dental assisting procedures and patient care procedures
- Foundational knowledge related to the methodology of literature review relevant to dental assisting

Dental assistants facilitate dentists, dental hygienists and other dental professionals in providing services to patients. Primarily dental assistants provide chairside assistance during dental procedures as well as performing intra-oral duties. The knowledge that they receive during the course of study allows them to perform the following recognized duties:

Level 1 Chairside Duties include:

- Preparing the work area, ensuring that all operatories are disinfected, sanitized and instruments ready for the procedure
- Sterilizing of all instruments
- Selecting and transferring instruments to the dentist/ hygienist using either the two-or-four handed dentistry technique
- Suctioning of the oral cavity
- Preparing restorative materials including cavity liners/bases, amalgam, temporary and intermediate restorative materials, bonding systems etc.
• Exposing, processing, evaluating and mounting of radiographs
• Performing laboratory procedures including the pouring and trimming of study models, the fabrication of custom impression and bleaching trays etc.
• Charting of data on patient’s record or chart
• Preparing and holding curing light
• Retracting a surgical flap
• Instructing patients in the care and maintenance of pre-fitted appliances
• Holding a surgical flap that has been prepared and reflected by a dentist

**Level 2 Intra-oral Duties:**

- Mechanical polishing of the coronal portion of the teeth
- Placement and removal of the dental dam
- Taking of preliminary impressions of teeth for study models
- Topical application of anti-cariogenic agents
- Oral hygiene instruction with an intra-oral component
- Dietary counselling relative to dentistry
- Application of treatment liners
- Application of pit and fissure sealants
- Application of desensitizing agents
- Whitening of the coronal portion of the teeth
- Polishing restorations
- Oral irrigation

**Patient Relations:**

Dental assistants are frontline health care workers and as such perform key roles in patient relations. Dental assistants may welcome the patient to the office, escort them into the operatory and prepare them for the procedure. Patients look to dental assistants for clarification regarding the dentist’s instruction. Dental assistants monitor the patient’s condition and vital signs during procedure and provide comfort and reassurance. Level II assistants often perform intra-oral duties without direct supervision. Nutritional counselling as it relates to oral health is often done by dental assistants.
Infection Control:

Clinical dental assistants are the staff members primarily responsible for infection control within the dental office. Infection control is the discipline concerned with preventing the spread of infections within the health care setting. This is a practical sub-discipline of epidemiology.

One area of infection control concerns itself with the prevention (hand hygiene/hand-washing, cleaning/disinfection/sterilization) of disease transmission. All healthcare professionals must be cognizant of infection control protocols but practically speaking, it is often the dental assistant who does the duties associated with infection control. Dental assistants clean and sterilize instruments, and sanitize and disinfect equipment and operatories and monitor the effectiveness of sterilization equipment by performing regular biological testing.

The dental assistant ensures that the operatory is disinfected between patients and at the end of the day. Knowledge of chemicals and their efficacy is essential and most often it is the responsibility of the dental assistant to learn about the preparation and use of the chemicals, as well as ordering and adequate supply. High-level disinfection results in the killing of microorganisms (with the exception of high levels of bacterial spores) so that disease is not transmitted.

Instruments must be cleaned prior to sterilizing ensuring that all human tissue and debris have been properly removed. Sterilization is a process intended to kill all microorganisms and the cleaned instruments are then placed in the autoclave for sterilizing. The efficiency and effectiveness of the sterilizer must be monitored regularly.

Infection control is essential to all healthcare settings but its importance is often under-recognized and under-supported in the dental practice setting.

Though the Ministry of Colleges, Training and Universities must approve dental assisting educational programs, the Ministry is not regarded as the accrediting body. The Commission on Dental Accreditation of Canada accredits the Canadian educational programs for dentistry, dental hygiene and dental assisting. Presently all Ontario Community College dental assisting programs are accredited to the established national standards. At this time, there are no accredited private career colleges in Ontario.

2. Are there professions currently regulated with whom the applicant occupation’s body of knowledge overlaps? Include evidence to support your answer.

Dentistry is built on a hierarchical model with education overlap among all of the formally educated disciplines. Many of the topics such as behavioral sciences, microbiology, anatomy, pharmacology, anesthesia and pain control, pathology, radiography, and the dental specialties are included in every dental discipline to the level required to support the duties and intra-oral procedures that dental professionals will perform on patients.

As such, a dentist may perform all of the duties of a dental hygienist and a dental hygienist may perform all of the duties of a clinical dental assistant. Due to the depth and breadth of knowledge and skills in specific areas, scopes of practice are usually defined within the practice of dentistry allowing the dental professional to practice their knowledge and highest technical skills.

However, without regulation, scopes of practice parameters are not always sharp. Without a regulating body for dental assistants, misdelegation frequently occurs. Anecdotal evidence through surveys and inquiries received by the ODAA suggests that both level 1 and level 2 dental assistants are asked to work outside their knowledge base and scope of practice.
3. Does the profession concerned subscribe to evidence-based practice?

The education and practice of the dental disciplines is evidence based. Accredited level 2 dental assisting programs must demonstrate the delivery of up to date and evidence based education. Additionally, learning objectives, learning outcomes and assignments for students must articulate how evidenced based research and decision making is integrated into the curriculum.

ODAA and its members support and subscribe to evidence based research, decision making and practice. Certified dental assistants are encouraged to base their own practice on scientific and evidence based body of knowledge.

ODAA members are encouraged to keep up to date with changes in the profession through their continuing education requirements. Within our Journal, we have regular columns on infection control wherein we educate our members about the latest information and knowledge that comes from the Centre for Disease Control and the OSAP (Organization for Safety, Asepsis, and Prevention) which is considered to be dentistry’s global resource for infection control. Our organization recently endorsed RCDSO’s updated infection control guidelines as another model for best practices.

The tenets of evidence research, decision making and practice is precisely why it must be only formally educated level 1 dental assistants who are delegated infection control procedures and level 2 dental assistants who are delegated intra-oral procedures.

4. Does the profession concerned practice based on evidence of efficacy? If so, please provide examples of how treatment strategies, interventions, modalities and service are based on efficacy.

The world of dentistry is a constantly evolving health care profession. The entire profession strives to provide best practice and patient-centered treatment which is effective, efficient, pain free and is not cost prohibitive. Products, materials used within dentistry, techniques and treatments are constantly progressing to ensure patient care is showcasing best practices in all modalities.

The profession of dental assisting is no different than its counterparts. Over the years the materials and services level 1 and level 2 dental assistants provide has dramatically changed. Infection control products as well as a plethora of sterilizers are the norm. Level 1 dental assistants who were once assisting for amalgam and chemical cure composite restorations are now assisting for bonded amalgams and light cured composite restorations.

Level 2 dental assistants have seen lining and fissure sealant materials evolving from chemical cure to light cure. The newest fissure sealant materials on the market do not require a dry environment, decreasing patient discomfort and patient management issues. Concentrations and duration of treatment for fluoride applications have changed along with the introduction of desensitizing and whitening agents. Digital radiograph exposure is rapidly overtaking conventional exposures and computer technology is allowing patients to view their own intra-oral structures, providing them with a better sense of their oral health and dental needs.

Ontario dental assistants even though not required to, recognize and embrace change and the need to remain current in their profession. This is evidenced by the 7,700 members who voluntarily maintain their ODAA certification through continuing education.
5. Provide a proposed scope of practice for the profession. Explain how the scope of practice related to the body of knowledge described above.

ODAA proposes that the scope of practice for Ontario dental assistants eventually be the same as it is for all other regulated jurisdictions—a level 2 credential with the NDAEB certificate (written) for all graduates and additionally, the CPE for non-accredited and level 2 equivalent foreign educated personnel.

The national standard recognizes, restricts and clearly articulates the minimum scope of practice for level 2 dental assistants. Currently, education programs offering level 2 programs must deliver the theory and clinical competencies which encompass chairside assisting and the mandatory thirteen intra-oral skills approved by the DARAS and examined by NDAEB. The core programming is also required, at a minimum for a program to be eligible for a site survey and subsequent accreditation by CDAC.

Though Ontario level 2 dental assisting students are taught thirteen intra-oral duties, they cannot legally practice the application of matrices and wedges or liners because these skills are considered controlled acts. ODAA envisions Ontario level 2 dental assistants will, with regulation be able to perform these duties. Additionally, it is expected that Ontario education institutions will offer expanded function post graduate modules for level 2 dental assistants. These modules could include, but not necessarily be limited to the Orthodontic, Prosthodontic and/ Preventive (Scaling) Dentistry module.

Enclosed is the Canadian Dental Assistants Association Scope of Practice chart. This chart clearly delineates the duties level 2 assistant can perform in each jurisdiction in Canada. SEE APPENDIX

The Ontario level 2 programs provide graduates with the necessary knowledge and skills to practice at the national entry to practice standard. Therefore, ODAA proposes that Ontario Level 2 accredited graduates with the NDAEB certificate and non-accredited graduates completing the NDAEB written and clinical examinations be regulated to perform the following nationally recognized thirteen skills.

- chairside dental assisting
- oral hygiene instruction
- dietary counseling relative to oral health
- exposes dental radiographs
- obtains preliminary impressions for study casts
- applies and removes dental dam
- performs selective coronal polishing
- applies treatment liners (no pulpal involvement)
- applies and removes matrices and wedges
- applies fluoride
- applies topical anesthetic
• applies pit and fissure sealant
• applies desensitizing agents
• use, care and maintenance of coronal whitening bleaching trays

The Ontario level 2 dental assisting programs assess additional competencies. As such ODAA recommends Ontario level 2 accredited graduates with the NDAEB certificate and non-accredited graduates with the written and clinical examinations be regulated to perform additional skills to include:
• fabrication and insertion of bleaching trays
• removal of sutures
• removal of periodontal dressings
• acid etch prepared cavities
• pulp vitality testing
• take and record gingival plaque indices
• application of anti-microbial agents
• face bow transfer
• periodontal screening and recording
• public health screening

It is anticipated that post graduate education course or multi day modules will eventually be available for qualified Ontario level 2 graduates. The following courses and modules will require formal education:
• placement and removal of retraction cord
• placement of temporary restorations
• place and finish amalgam restorations
• fabricate, cement and removal of provisional crowns
• orthodontic module
• preventive dentistry module (limited scaling)
• restorative implant assisting module
In Ontario, there are both level 1 or chairside dental assistants who have been on the job trained and level 1 chairside graduates of formal education programs. Programs offering level 1 education are HARP approved. In the rest of Canada (with the exception of Quebec) there are no formal education programs for level 1 assistants. Ontario level 1 educational programs are declining and it is expected and hoped that they cease to exist. In the near future, it is expected that only level 2 programs will be offered.

Many level 1 dental assistants have upgraded their education to level 2, but there remains a significant number of ODAA certified members (2,025) who have not yet upgraded and who many not want to. It is our intention to regulate these members in the public’s best interest, but we do not intend to regulate any new on the job trained or formally educated level 1 dental assistants after regulation passes. The regulated scope of practice for Level 1 dental assistants who are regulated at the time of legislation will be:

- all duties associated with chairside (extra-oral)
- radiography

It is believed that there are still several hundred Preventive Dental Assistants (PDAs) practicing in Ontario. ODAA presently certifies 297 PDAs. This program of study ceased to be offered in 1996, when Level 2 programs were introduced to the province. There are a limited number of these individuals in the province as many have upgraded to Level 2 and some have retired from the profession. However, there will be a need to regulate both member and non-member PDAs. The regulated scope of practice will be:

- chairside duties
- radiography
- obtains preliminary impressions for study casts
- selective coronal polishing
- application and removal of rubber dam
- oral hygiene instruction with an intra-oral component
- application of fluoride treatment

6. To what extend does the professional association or other organizations set standards of practice for diagnostic/ treatment modalities and services based on the identified body of knowledge? How are these standards enforced?

ODAA is both a professional membership association and a certifying body. As the certifying body, we expect our members to abide by the ODAA Skills Chart and our Code of Ethics. The Skills chart is made available to all ODAA members. This chart clearly outlines the legal duties or skills of each category of Ontario dental assistant. Personal responsibility and accountability form our organization’s foundation and philosophy. Still many ODAA members are requested to perform duties they have no education for. Sometimes, fearing the loss of their employment and with no “real” regulation in place to support them, they perform these duties under duress. Even though our organization has great empathy for dental assistants in these situations, it cannot endorse illegal practice under any circumstances.
In the absence of regulation, recently ODAA developed a Complaints and Discipline policy. As the only professional organization for dental assistants, we believe we must uphold our policies and ensure our members are compliant. As such, we are prepared to investigate with due diligence and discipline our certified members when necessary.

The profession of dental assisting in Ontario itself has overwhelmingly demonstrated the value and need for regulation by voluntarily joining and adhering to the policies of ODAA. Without the existence of ODAA’s Certifying program, Skills chart, and mandatory continuing education, the Ontario dental assisting profession would have even less recognition and less respect and Ontario dental patients would be at higher risk.

The national membership association, CDAA, undertakes an occupational analysis every five to seven years. The data garnered from surveys and focus groups provide a national snap shot of the scope of practice in each jurisdiction as well as post graduate modules offered for level 2 dental assistants.

The Dental Assisting Regulatory Authorities agreed upon the previous (chairside duties plus nine mandatory skills) and now the current (chairside duties plus thirteen mandatory skills) national entry to practice standard for level 2 regulated jurisdictions. In addition, regulators agreed the NDAEB written examination is required for all graduates. Additionally, a CPE is imposed on all non-accredited and level 2 equivalent foreign educated dental professionals.

The National Dental Assisting Examining Board develops and publishes a Domain Description for level 2 dental assistants, updated every five years, based on the occupational analysis. From the domain description, the NDAEB written exam committee in conjunction with the Division of Studies in Medical Education at the University of Alberta, prepares a blueprinted, valid and reliable written examination offered four times per year. The Clinical Practice Evaluation committee develops the criteria for the nine skills evaluated on the CPE and also calibrates session facilitators and evaluators to ensure inter-rater reliability across the country.

The NDAEBs mission is to assure individuals have met the current national baseline standard in the knowledge and skills required by Canadian provincial or territorial regulatory authorities for recognition of an intra-oral dental assistant.

The Commission on Dental Accreditation of Canada (CDAC) set the national minimum standards of education for dentistry, dental hygiene and level 2 dental assisting. Publically funded programs prepare extensive documentation every seven years, while private colleges prepare the same every three years, which is validated at a two day site survey.

Outcomes of the site survey are discussed at the annual CDAC meeting. Programs receive by transmittal letter, their accreditation status. These statuses include accreditation without reporting requirements, accreditation with reporting requirements, accredited with intent to withdraw or accreditation denied. Programs receiving status of accreditation with reporting requirement or intent to withdraw will both have recommendations which must be addressed—the latter of a more serious nature.

The accreditation status assures students, the regulator and the public the program/s curriculum and funding, administration, faculty, student support mechanisms and alike, have been reviewed in detail by a non-biased and arms length body.

The RCDSO developed a guideline in 1999 and published this in a 1999 RCDSO Dispatch. This guideline advises dentists which intra-oral duties can be delegated to graduate of level 2 dental assisting programs who have passed the NDAEB examination.
However, it is our understanding the RCDSO does not monitor or enforce their own 1999 delegation guideline. RCDSO has been very clear in their messaging. They do not regulate dental assistants and have no authority over dental assistants.

Regulation for dental assisting professionals is urgent. Without a monitoring process or enforcement, this already flawed, loose “system” is unheard of in the rest of the regulated provinces and is clearly an issue of concern for public safety.

7. Does the applicant's profession require commitment to continuous professional development? If so, please provide written details of existing continuous professional development programs.

ODAA requires that our certified dental assistants attain 15 continuing education credits each year. Courses must be approved by ODAA and must be in some way related to the profession and practice of dentistry. Members who have not completed the required CE credits receive notification that should they not attain this requirement; their certification will be considered lapsed. Those on maternity leave have a lower number of required credits to attain and should certification be lapsed for more than three years, the candidates must re-write the level 1 certification program or with respect to level 2, complete a major project.

8. With respect to the proposed scope of practice statement:

   a) What controlled acts if any should be authorized to the members of the profession?

According to the RHPA 1991 controlled acts include “Performing a procedure on tissue below the dermis……., or in or below the surfaces of the teeth, including the scaling of teeth.” Furthermore, a controlled act is “fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning”.

From this definition, controlled acts for Ontario dental assistants includes exposure of radiographs, placement and removal of matrices and wedges and placement of treatment liners. HARP qualified dental assistants, level 1 and level 2, when delegated by a dentist are able to expose dental radiographs. However, even though level 2 dental assistants are taught and assed to manikin competency in their education programs to place and remove matrices and wedge and place treatment liners and other regulated jurisdictions allow it, Ontario does not.

These skills are part of the thirteen skills meeting the national entry to practice standard. The education and accreditation processes, and the NDAEB examinations provide for competent and safe practice of these procedures. As such, they have included in our proposed skills list for Ontario level 2 dental assistants.

ODAA supports and promotes expanded skills for level 2 dental assistants if the appropriate level of didactic and competency education is undertaken. We have proposed many of the same post graduated courses and multi-day modules, as offered in other Canadian jurisdictions, for level 2 dental assistants.

   b) What specific acts (if any) should practitioners be authorized to delegate to others?

ODAA does not support the notion of level 1, level 2 or preventive dental assistants delegating acts to others. All work delegated to and performed by dental assistants should be done only by those with formal education from a government approved dental assisting educational program.
c) **What diagnostic/treatment modalities and services should members of the profession be authorized to perform?**

With formal education, an approved and clear scope of practice and regulation, dental assistants are positioned to provide competent and safe practice. At a minimum, Ontario dental assistants should be permitted to perform the national entry to practice skill set. Additionally with post graduate education and the requisite scope of practice parameters, level 2 dental assistants can provide safe, effective and valuable services for patients.

**d) What limitations of practice, if any, should be imposed on members of the profession? Which acts, if any, related to the field of care of the profession should not be authorized to the profession? What diagnostic/assessment abilities, treatment modalities and services are not part of the scope of practice for members of the profession?**

All dental assistants should be restricted from performing any duties for which they are not formally educated. Regulated level 1 assistants will be permitted to do only chairside duties and radiography.

Level 2 assistants graduating from an accredited program with the NDAEB certificate and level 2 assistants graduating from non-accredited programs with the successful completion of the NDAEB written and clinical examinations, should be permitted to perform at a minimum the national entry to practice 13 intra-oral duties and all chairside duties.

Skill sets aligning with post graduate courses and modules should allow expanded function level 2 dental assistants a larger scope of practice.

On the job trained laypersons should not be permitted to perform any duties related to direct patient care, including infection control.

e) **If a new controlled act is being requested, describe the degree to which this act would be exclusive to the profession. To what extent may the proposed act be shared with other professions? Where opportunities for sharing exist, please describe any consultation that has occurred with the affected stakeholders.**

ODAA is proposing that Ontario level 2 dental assistants be permitted to perform duties presently being performed by level 2 dental assistants in other provinces.

The controlled acts will require additional didactic and competency education. As outlined earlier in this document, ODAA proposes several additional skills and modules which will expand the scope of practice for the graduates.

In all regulated jurisdictions and in Ontario, dental hygienists can perform all of the skills a dental assistant can perform. Furthermore, all duties associated with expanded courses or modules are legally performed by dentists. For dental hygienists to perform duties associated with orthodontics, and prosthodontics and implant modules, additional education must be taken following graduation.

For many years, Ontario orthodontists have been advocating and lobbying to have the orthodontic expanded duties be included in the scope of practice for Ontario level 2 dental assistants. ODAA and the Ontario Association of Orthodontists developed an Orthodontic Module and offered a pilot program in 2007, when we believed that the regulation of dental assistants was imminent. The program of study included the application and removal of arch wires, bands and elastics. We have ceased to offer this program due to the delays of the HPRAC review.
The RCDSO approached ODAA in 2008 regarding the delegation of these orthodontic duties. ODAA’s position at that time was these duties were a controlled act and only regulated level 2 dental assistants with the completion of a module should be permitted to perform these duties.

ODAA has communicated to both the College of Dental Hygienists of Ontario and RCDSO our wishes to include the Preventive Dentistry Module (limited scaling) into our scope of practice when we become regulated.

The Prosthodontic module which includes the fabricating, cementing and removal of provisional crowns/bridges and the placing and removing of gingival retraction cords is part of the scope of practice in Alberta, British Columbia and Saskatchewan. ODAA has communicated to RCDSO and CDHO the desire to have this incorporated into our scope of practice.

f) Please explain how the proposed scope of practice serves the public interest and provides adequate public protection without unduly restricting the public’s choice of health.

Dentistry is considered a health discipline. The public expects, deserves and trusts only educated, competent and safe practitioners are providing their care and care for their loved ones. Without regulation for dental assistants in Ontario, there is no framework in place to ensure this.

The interest of the public is best served by ensuring regulated dental assistants are performing the only skill set associated with their formal education within the profession of dental assisting.

With regulation and bylaws focused on matters of public protection, entry to practice standards, scopes of practice, continuing practice hours and continuing education requirements for the profession of dental assisting will be established and monitored for compliance. These will form the pillars of public protection.

g) Are there currently regulated health professions with who the proposed scope of practice overlaps?

Yes, the proposed scope of practice overlaps with dentists, dental hygienists, dental technicians and denturists.
ODAA is proposing that all clinical dental assistants, working in Ontario be regulated under the RHPA 1991. There are approximately 13,000 -15,000 dental assistants working in various dental clinics, offices, public health units, hospitals, college educational programs, children’s aids societies, and other social services agencies that may provide dental care to clients.

Approximately 1,600 Ontario students are enrolled each year in Ontario dental assisting educational programs offered at 10 CDAC accredited community colleges and several non-accredited private career colleges throughout Ontario. Though Level 2 courses are taught in most programs there are 3 Private career colleges that offer only level 1 educational programs and Everest College, with 12 campuses, which offers both level 1 and level 2 programs.

ODAA is both the professional membership association and the certifying body for 8,500 members, 7,700 of whom are certified dental assistants and receptionists. With respect to clinical assistants, ODAA certifies 2,025 chairside assistants, 297 preventive dental assistants and 5,114 Level 2 dental assistants.

There may be approximately 5-6,000 additional clinical assistants working in Ontario who are not members of our Association. Some of these assistants are graduates of formally educated programs while others have been trained on the job.

The job market appears to be good for dental assistants. Some of our newer graduates report difficulty in finding employment, and claim that the lack of experience seems to be the overriding concern.

ODAA is aware that there is a surplus of dental hygienists and that some hygienists are seeking employment as dental assistants. We also are aware that some dentists are reluctant to hire dental hygienists to do the work of dental assistants.

ODAA has approached the RCDSO to discuss inter-professional collaboration with respect to the regulation of Ontario dental assistants. We believe a mentorship service model would be a viable collaboration. RCDSO is very experienced in regulating and we believe that with their business acumen and knowledge regarding regulation, this mentorship role would facilitate the profession of dental assisting in achieving our goals. This model would offer both a cost-effective and time-efficient option to the development of a regulatory body for dental assistants.

Within preliminary discussions, RCDSO has suggested that the regulatory body could share space, renting offices from RCDSO. The staff of RCDSO could work with the staff of our regulatory body, assisting in the development of a registration system, development of bylaws, quality assurance and in patient relations. With respect to the Council structure, chairs of the RCDSO could mentor our council members, assisting in policy advice and infrastructure.

ODAA believes that we would adopt a collaborative yet independent type of relationship with RCDSO. ODAA would pay consulting fees to the RCDSO at an agreed upon rate.
Business Location:
RCDSO has suggested that the regulatory body for dental assistants could rent office space from them. This is certainly a viable option as the sharing of space would lend itself to on-site assistance from RCDSO staff and Council. Due to the preliminary nature of our discussions, we haven’t discussed concrete financial details. However, sharing resources does present some cost-effective options.

Human Resource Plan:
Key personnel would include but not be limited to: Registrar, Registration Coordinator, Quality Assurance Coordinator, Practice Advisors (2), Communications Coordinator and administrative personnel (3).

Employment policies and procedures would have to be developed.

Action Plan:
1. To continue to communicate with ODAA members and non-members about the importance of certification and the ODAA plans for self-regulation.
2. To work with the Ontario government to ensure that the profession of dental assisting become a regulated health profession.
3. To develop a communication/marketing plan; ensuring as seamless a transition to regulatory status as possible. This could be funded by the seed funding provided by ODAA
4. To hire a registrar for the new college
5. To develop scope of practice, bylaws and regulations for the profession of dental assisting, using the seed funding from ODAA
6. To launch the college regulating dental assistants.
**Financial Plan: Draft Budget: (based on 14,000 registrants at $175.00 registration fee)**

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**SECONDARY CRITERIA: Economic Impact of Regulation**
Executive Summary

ODAA is proposing that the profession of dental assisting become a self-regulated health profession in the best interests of the public. ODAA is proposing that all clinical dental assistants providing direct service care to dental patients be regulated.

ODAA has been an incorporated professional membership association since 1934 and the certifying body for dental assistants since 1961. ODAA is a proactive organization in a strong financial position. The goal of becoming a regulated health profession has been a goal within our Strategic Plan for many years. ODAA has been deferring annual revenue for the past several years to ensure that a regulatory body governing Ontario dental assistants can be developed. ODAA plans to provide seed funding to the self-regulatory body in the realm of $250,000 - $400,000. We envision this money could be used in the development of bylaws, regulations, scope of practice and within the communications plan.

The profession of dental assisting is regulated in eight Canadian provinces with the exceptions being Ontario and Quebec. Dental assisting is self-regulated in the provinces of Alberta and Saskatchewan and the remaining provinces regulate dental assistants under the Dental Regulatory Colleges.

ODAA members want to be regulated. They believe that regulating the profession will ensure patient safety and is in the best interests of the public. ODAA undertook a survey of our membership in 2002 and at that time 87% of the respondents stated they wanted to be regulated. In 2011, another survey demonstrated a 90% level of support for this goal.

In provinces that presently regulate dental assistants, Level 2 or intra-oral dental assistants are regulated. In Ontario we have formal educational programs offering courses for both Level 1 chairside assistants and Level 2 intra-oral assistants. Level 2 intra-oral dental assistants are considered the national standard.

ODAA presently certifies approximately 2,100 Level 1 dental assistants, 295 Preventive Dental Assistants and over 5,000 Level 2 dental assistants. We believe that Level 1 education programs need to be phased out as Level 2 dental assistants are the national standard. We are proposing levels of licensure initially, but at some point, Ontario would only regulate level 2 intra-oral dental assistants; aligning Ontario with the rest of Canada.

Though most Canadian provinces regulate level 2 assistants, dentists can still hire people without formal training to do chairside assisting in many provinces. That means that lay individuals in other provinces may be responsible for infection control. We believe this is no longer acceptable, given the complexity associated with infection control. Therefore, we are proposing that to work as a clinical dental assistant in Ontario, you must be formally educated, licensed and held accountable for the work done.
Criterion: Regulatory Mechanisms

1. Are Practitioners of this profession subject to another regulatory mechanism?

No, there is no other regulatory mechanism. ODAA has been the certifying body since 1961; however certification is voluntary. ODAA has over 7,700 members who commit to certification. Our requirements to become certified are similar to many provincial licensure requirements. However, ODAA has little legal recourse available to us.

The RCDSO does have a guideline which advises dentists to delegate intra-oral duties to Level 2 assistants who have passed the NDAEB examination. Dental assistants work collaboratively with their dentist/employer and therefore ODAA encourages our members to have knowledge of RCDSO regulations/guidelines regarding record keeping, waste management, patient care and best practices for infection control guidelines. The relationship between dental professionals must be patient-centred and collegial to ensure that service delivery is providing optimal oral care.

2. Does the profession believe that it should be regulated under its own College? If so, describe the reasons why the applicant prefers a self-regulatory model over other models.

ODAA has been the certifying body for close to 50 years and as such we have 7,700 members who voluntarily make the commitment to certification. However, we know that there could be at least that many more people working as dental assistants in Ontario. Some of these people may be formally educated but many are not. Furthermore, we know that many assistants are performing duties outside the approved scope of practice for dental assistants and this is certainly an issue of public safety. There are dentists who continue to hire people without formal education to do the work of dental assistants. Ontario has graduates of dental assisting programs who cannot find work.

In the absence of being regulated, the ODAA Certification program has served the profession of dental assisting and dentistry well. However, we strongly believe that the public is best served by regulating the profession of dental assisting, ensuring the public that all dental assistants are formally educated, have a clearly defined scope of practice; have passed all entry to practice requirements and commit to continuing education.

Dental assistants are self-regulated in Alberta and Saskatchewan and it works well in those provinces. They have very good working relations with other dental professions and each respect one another. In other provinces, where dental assistants are regulated under the Dental College, dental assistants believe that their voices are not heard with respect to what they do and how they do it. Though dental assistants may be represented on the Council, they may have only 1 or 2 positions. ODAA believes that it is a conflict of interest to be regulated by one’s employer.

With estimates of close to 15,000 dental assistants in the province, ODAA believes that we can have a self-sustaining College. Ontario dental assistants want to be recognized and respected for the work that we do and we want to be self-determining with respect to our scope of practice, our regulations and the complaint and discipline process.

To date, we have had absolutely no problems in recruiting Board Directors for our Association and in fact often have many candidates vying for open positions. ODAA members long to have the voice of dental assistants heard.
3. Has the profession considered seeking regulation within an existing regulatory college? Describe the conclusions and outcomes of this discussion.

ODAA has discussed partnering with both the College of Dental Hygienists of Ontario and the RCDSO. As mentioned earlier, we believe that there are inherent conflicts with being regulated by one’s employer. Most dental assistants work for dentists but since hygienists are now able to self-initiate, employment opportunities for dental assistants will soon exist in these dental hygiene clinics.

Initially, discussions with CDHO appeared to be promising. However, since most dental assistants are employed by dentists in small business settings, we are concerned about the working environment and the effect on that environment if dental assistants and hygienists were to be regulated under the same college. Furthermore, we are also concerned about our scope of practice as there is some overlap, particularly in the expanded duties that we are seeking and we certainly do not want to have “turf” issues within our own regulatory body.

In January 2010, CDHO made a proposal to our Board of Directors that they take over our certification program. They did say at that time that they supported our request for self-regulation but thought that they could provide a better service model for our certification program, as they had the infrastructure for complaints and discipline. The Board of Directors of ODAA viewed this proposal with some wariness and believed that were CDHO to take over our certification program, we would never be self-regulated as the infrastructure for CDHO to regulate dental assistants would be in place within their college. Furthermore, we became concerned that our desire for a full scope of practice may be at risk.

ODAA has observed the Canadian dental assisting regulatory structure over the years. British Columbia dental assistants enjoy a very wide scope of practice and yet the leaders of organized dental assisting want to be self-regulated as they want more self-determination within their profession. The Atlantic Provinces do not have the numbers of dental assistants to sustain a self-regulation model but they too long for more say within their profession. Alberta and Saskatchewan are self-regulated and enjoy very collaborative relationships with other dental professionals.

Conversations with RCDSO have been ongoing and in the last few years have focused on how we can be self-regulated but enjoy a creative collaboration with RCDSO. We discussed many scenarios but the one that resonates with both organizations is one of a mentorship model wherein we would be self-regulated but would share some resources with RCDSO. We have discussed renting space from RCDSO and having their staff members assist our staff in the development of the registration process, the quality assurance program, and many other facets involved within the regulatory process.

4. Has the profession considered partnering with likeminded unregulated professions working in a similar field and who may be seeking regulation?

No, we are not aware of likeminded unregulated professions.

5. Should statutory self-regulation not be found to be appropriate for the profession, what alternate forms of regulation or governance may be considered?

ODAA is presently the certifying body for dental assistants and to that end we have approximately 7,700 certified dental assistants within our program. However, there are thousands of additional dental assistants working in Ontario who are not ODAA certified. Furthermore, dentists continue to hire those lacking formal training to do the work of dental assistants.

ODAA would consider partnering with an existing college, should that be deemed more appropriate. The Association would like to have solid representation on an existing council to ensure that the scope of practice would be equal to what exists in other provinces. Furthermore, we strongly believe that the voice of Ontario dental assistants must be heard.
Criterion: Leadership’s Ability to Favour the Public Interest and Membership Support and Willingness of the Profession to be regulated.

1. Provide evidence of the profession’s commitment to the public interest (e.g. communications, policies/protocols of the professional Association.

Certification Program:

ODAA has been the Certifying Body for Ontario dental assistants for close to 50 years and an incorporated Professional Membership Association since 1934. In the absence of being a regulated health profession, ODAA actively promotes certification to all Ontario dental assistants. ODAA became the certification body after collaborating with both the RCDSO and the Ontario Dental Association (ODA) in the early 1960’s.

The ODAA certification program resembles what is generally required for regulated health professions. We require that dental assistants be formally educated; pass an entry to practice examination; abide by our Code of Ethics and provide proof of continuing education credits each year.

ODAA’s Certification policies address lapsed certification and how to reinstate one’s certification. ODAA actively advises members against performing duties outside our scope of practice and has on occasion disciplined members who have violated that scope of practice and/or our Code of Ethics.

ODAA’s membership has grown over the years, with more dental assistants joining the Association and we do attribute that growth due to our goal of becoming a regulated health profession.

Website:

ODAA has a website that the public may access at www.odaa.org. The website offers information about the Association and the benefits of membership. It clearly explains certification and outlines the expectations around achieving and maintaining certification. The website provides details regarding ODAA’s application for regulation and why it is important to public safety issues.

The Journal:

ODAA publishes a 4-colour magazine called “The Journal” three times a year and welcomes subscriptions. The Journal celebrates the profession of dental assisting. We feature regular columns on Infection Control, Nutrition, Dental Assisting Duties; FAQ’s and trends regarding the work associated with dental assistants. We also have provided our members with information pertaining to the regulation of dental assistants. For many years, we had a regular column “Regulation Update” and within this column we discussed issues, updates with respect to regulation and our progress in achieving this goal.
Media Campaign:

For the past six years, ODAA has run a media campaign. Twice a year, advertisements are placed in Ontario newspapers. These advertisements promote certification of dental assistants and also advise the public about our goal of becoming a regulated health profession. We targeted 5 audiences within this campaign and they included ODAA members, potential members, dentists and other dental professionals, the government and the public. Furthermore, ODAA has spoken on several radio talk shows about our goals and we believe that the public supports our goal of becoming a regulated health profession. In fact, we often hear about how shocked consumers are upon learning that dentists can and do still hire people without formal dental assisting training.

Facebook:

ODAA launched a facebook page in late 2010 and within a few days had over 1,000 members. We use this facebook page to communicate with our members and to outline our goals. Regulation of dental assisting is a regular topic of communication. To date, we have over 2200 members who regularly access our facebook page.

Questions 2-4: Does a complaints and disciplinary procedure currently exist for the profession?

ODAA's Board of Directors approved a complaints and discipline policy in January 2011. We advised our members of this policy in our Spring 2011 Journal and through various other communication outlets. Though we had disciplined members prior to developing this policy, this policy was developed as one more tool to demonstrate that ODAA values the input of the public and public safety. Our policy speaks to how complaints must be submitted in writing to the Executive Director. Within 30 days of receiving the complaint, the Executive Director must seek some resolution between the parties involved, decide to conduct an investigation; dismiss the complaint and/or assess incapacity. Should an investigation result and enough evidence collected, the complaint will be forwarded to a complaints committee comprised of members of the Board of Directors.

Members can be proactive and self-initiate a complaint process. A copy of the complaints policy is included with this document.

5. Do the members of the profession/Association want self-regulation, and are they willing to provide financial resources, time, and effort required for self-regulation. Please describe any consultation process undertaken and the response/results achieved.

ODAA members want to be regulated. In 2002, discussions around this goal began within our Association. The Board of Directors established this as a goal within the Strategic Plan after conducting a survey among our members. At that time, the survey demonstrated that 87% of the respondents indicated their support.

Since then ODAA has spent considerable energy and resources to discuss what regulation will mean to dental assistants. A regular column in the ODAA Journal provided regular updates regarding regulation, information about the RHIPA and details on what it means to be a regulated health profession. When the HPRAC review was delayed, several hundred of our members sent letters to the Health Minister, expressing their disappointment.
ODAA has been the certifying body for dental assistants since the 1960’s and many of our members strongly believe in the value of certification. To be certified with the ODAA demands a personal commitment from the members as candidates must pass an entry to practice examination, abide by a Code of Ethics and earn 15 continuing education credits each year. The fact that the association has 7,700 certified dental assistants and receptionists speaks well of members’ commitment to their patients and to their profession. The fact that many dentists will only hire certified dental assistants demonstrates that the ODAA has set the standard in Ontario and that ODAA members are living up to it.

Over the past few years, members have expressed high enthusiasm for regulation and want it to happen as quickly as possible. In fact they believe that it is long overdue. Membership has grown over the last few years and we believe that this speaks strongly to our goal of becoming a regulated health profession.

In September, 2011, ODAA conducted a survey regarding the regulation of dental assistants. In this survey, we advised our members of some of the costs associated with the regulatory process and asked if their level of support remained. Close to 3,000 of our members responded to this survey and 90% agree with our goal of becoming a regulated health profession. ODAA has the capability of surveying our members through our membership database and the results were tabulated by this program and are included with this document.

In the fall of 2011, ODAA hosted 18 Information sessions throughout the province regarding what it means to be a regulated health profession. Within the session, the costs associated with regulating were discussed and our members continue to be very supportive of this goal. Though they recognize that the cost of licensing is a concern, they recognize the value to patient safety.

6. Do related organizations (e.g. associations and regulatory colleges representing practitioners in similar or related areas of health care) agree with the need for regulation of this profession? Document the discussions and outcomes from any consultation process undertaken on this topic.

All Canadian organizations associated with the profession of dental assisting support our request for regulation and in fact many have sent letters of support to both HPRAC and the Minister of Health and Long-Term Care. The Dental Assisting Regulatory Authorities (DARA) of Canada wrote a letter of support, as did the Canadian Dental Assistants Association, the Dental Assisting Educators of Canada, the Saskatchewan Dental Assistants Association and the College of Alberta Dental Assistants.

In discussions with the College of Dental Hygienists of Ontario they acknowledged that the regulation of dental assistants is the national standard. The Ontario Dental Association (ODA) has been reluctant to advise ODAA of their position, however ODA and ODAA are presently meeting on a regular basis and our goals have been discussed. ODAA made a presentation on why we want to be regulated to the ODA Health Policy and Government Relations Core committee in 2010. The RCDSO has been supportive and in fact has offered to assist us with our regulatory infrastructure. ODAA has not had any official conversations with the Ontario Dental Hygienists Association but we have shared a position paper with them and so we believe that they are familiar with what we are proposing.
7. How many persons practice this profession in Ontario? How many practitioners belong to an association? Please provide independently assessed and verified figures.

ODAA estimates that there are approximately 13,000 to 15,000 dental assistants working in Ontario. ODAA has 8,500 members including student members with close to 7,700 of our members being certified. According to Statistics Canada data from 2006, there were approximately 11,200 dental assistants working in Ontario at that time.

8. Are practitioners who do not belong to the professional body or bodies also supportive of the application? Where possible provide independently assessed and verified figures.

Membership in ODAA has grown the last few years and we do attribute that to our goal of becoming a regulated health profession. ODAA has received the occasional email or voice mail from non-members expressing some concerns with this goal. Other than that, we have no conclusive information regarding the level of support from other dental assistants.

9. What actions have been taken to align the profession with an established health profession regulatory College?

ODAA has undertaken conversations with the RCDSO regarding a creative collaboration. RCDSO has stated that they do not want to regulate dental assistants and is open to establishing a mentorship model once we become self-regulated. RCDSO has suggested that we could rent space within their facility and that they would provide assistance to our organization at both the administrative and committee levels. ODAA is open to this type of collaboration as we have enjoyed a collaborative relationship for many years with RCDSO and they have respected expertise within health regulation.

10. Explain the proposed fee structure for College members.

The salaries of Ontario dental assistants vary from $14.00 per hour to $32.00 per hour with the average salary being $21.00 per hour. This is based on the results of a National Salary Survey conducted by the Canadian Dental Assistants Association in 2011.

Being mindful of salaries, ODAA is proposing that the annual licensing fee be somewhere in the vicinity of $175.00 per year. We believe that with approximately 14,000 clinical dental assistants working in Ontario that this fee would pay for the annual operational costs associated with the College.
Criterion: Health System Impact

a.) Interprofessional Collaboration:

Questions 1-2.

Dental assistants are committed to providing patient-centred care. Dental assistants facilitate the work of other dental health professionals including dentists, dental hygienists, denturists and dental technicians and as facilitators they continually collaborate with these other health care professions.

ODAA has openly supported the RCDSO guidelines with respect to the delegation of duties by dentists to intra-oral dental assistants. Our scope of practice follows these guidelines and we regularly disseminate the guidelines to both dental assistants and dentists. ODAA actively promotes the RCDSO’s Infection Control Guidelines and have disseminated information on these best practices within our Journal. These best practices are also posted on our website under Professional Advisories.

Furthermore, ODAA approached RCDSO in the hopes of establishing a creative collaboration around our request to become a regulated health profession. Though we want to be self-determining and self-regulating, we have discussed with RCDSO having a mentorship relationship wherein RCDSO would assist/support us in the development of our regulatory infrastructure.

RCDSO requested that ODAA become part of an initiative to provide improved access to dental care to First Nations communities in the far north. As well, ODAA encourages our members to participate in the (ODA) Ontario Dental Association’s Remote Area’s Program. This program invites certified dental assistants to volunteer their services to northern communities. Dental assistants volunteer with dentists in providing dental care to these populations.

ODAA and the ODA have a long history of working well together. Both the ODA and the RCDSO worked with us to establish our certification program in the early 1960’s. To date, many dentists will only hire certified dental assistants. The ODA and ODAA collaborate with respect to the ODA’s Annual Spring Meeting (ASM). The ODA generously provides revenue to the ODAA by giving us money for every ODAA member who attends the Spring Meeting. In turn, we promote the Convention to our members at no cost to the ODA.

Dental assistants want to work within a collaborative, collegial work environment and dental assistants respect all oral health care professions. Both hygienists and dentists employ dental assistants and ODAA supports positive, healthy and proactive workplaces.

Dental assistants most often work alongside dentists and dental hygienists and within that team there is constant collaboration in order to provide optimal patient care.

ODAA endorses RCDSO regulations, guidelines and best practices. ODAA often has dentists calling us for clarification regarding record keeping, regulations around the administration of sedation, and questions regarding the duties of dental assistants. We endorse the regulations, policies and guidelines of RCDSO as our members work with and for dentists and we often disseminate information to our members and dentists from the RCDSO website.

Dentists and dental hygienists have often been guest speakers at the continuing education meetings that we host. We respect their commitment to providing the best patient care.
ODAA collaborates with other Canadian Dental Assistants Regulatory Authorities (DARA). Though we are not yet regulated, we are invited to all DARA meetings and though we cannot vote; our opinions and thoughts are welcome. We collaborated with the DARA in the development of the Mutual Recognition Agreement (MRA).

Our certification requirements for level 2 certification require that candidates must successfully pass the National Dental Assisting Examination Board examination and some of our dental assisting educator members are actively involved within many of the NDAEB’s committees.

ODAA regularly attends Council meetings of both the College of Dental Hygienists of Ontario and the RCDSO. We feel welcomed and enjoy a positive relationship with both of these organizations.

The self-regulation of dental assistants will enhance the relationships with other professions. We are eager to become more a part of decision making processes that will result from becoming regulated.

b.) Labour Mobility:

The regulation of Ontario dental assistants will improve labour mobility as currently, most of our members encounter barriers when moving from province to province. The national standard for the profession of dental assisting is regulation and accreditation of dental assisting educational programs. As mentioned previously, all Ontario community college dental assisting educational programs are now accredited, with most becoming accredited between 2005-2010. Presently, no private career colleges are accredited by the Commission on Dental Accreditation of Canada. When an Ontario Level 2 dental assistant wants to move to another province and they graduated from a non-accredited program, they are required to do a Clinical Practical Evaluation (CPE) which evaluates 9 intra-oral duties.

If an Ontario dental assistant moves to British Columbia and has either graduated from an accredited program or successfully completes both the NDAEB written examination or from a non-accredited program and have successfully completed both the written and clinical examination administered by the NDAEB; they will be issued a provisional license and be required to return to school within 1 year to upgrade to British Columbia standards.

Canadian provinces, with the exception of Quebec, require level 2 dental assistants to write the National Dental Assisting Examining Board (NDAEB) examination. The Dental Assisting Regulatory Authorities have agreed to have similar licensing requirements and they recognize licensure between provinces and so labour mobility is quite fluid for regulated provinces. When Ontario becomes regulated, we have agreed to abide by the DARA’s licensing requirements as we are a signatory to the Mutual Recognition Agreement (MRA).

Once we are regulated, dental assistants from other provinces will have few barriers in becoming part of the Ontario regulatory process.

The regulation of Ontario dental assistants would have little or no impact on formally educated dental assistants graduating from an accredited formal education program. For those graduates who graduate from a non-accredited program, they would have to successfully complete the Clinical Practical Evaluation administered by the NDAEB as well as the written examination.

The regulation of the profession of dental assisting would impact those who are not formally educated but who are presently working in Ontario. ODAA proposes that these level 1 candidates would have to write ODAA’s level 1 certification examination in order to qualify for licensure.
c.) Access to Care:

The regulation of dental assistants would enable dental assistants to provide more preventive dental care to marginalized communities such as the homeless, seniors in long term health care facilities and First Nations communities in remote areas. In that way, oral health care delivery would be improved. Regulated dental assistants would be able to provide public health screenings, intra-oral hygiene instruction, dietary counseling relative to oral health, which would have a profound effect on access to dental care. Furthermore, the correlation between oral health care and overall health are well documented.

Regulating dental assistants would allow a larger scope of practice and so would permit dental assistants to be delegated duties associated with orthodontics, prosthodontics and periodontal care, improving access to care as well as providing dentists and public health units more choice in terms employment opportunities.

d.) Health Human Resource Productivity:

The profession does not currently measure productivity. However, we believe that the regulation of dental assistants could improve productivity as regulated level 2 assistants could take on more preventive work related to dentistry which would enable hygienists to provide more direct services to clients. Public health units would be able to engage dental assistants in public health screenings.

Furthermore, orthodontists and prosthodontists would be able to delegate additional duties to dental assistants which would contribute to overall productivity.

e.) Health Outcomes:

ODAA does not currently measure health outcomes. There have been many evidence based studies that strongly suggest a correlation between oral health care and overall health. The regulation of the profession of dental assisting will enable dental assistants to provide more preventive dental care, thus having a profound impact on improved access to care resulting in improved overall healthcare.
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Infection Prevention and Control in the Dental Office, Guidelines, RCDSO 2009

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National Dental Assisting Examining Board, Domain Description, January 2011

National Occupational Standards, Dental Assistant, Canadian Dental Assistants Association 2007

Modern Dental Assisting, Torres, Hazel; Ehrlich, Ann; Bird, Doni L.; Robinson, Debbie; Saunders  Elsevier Co. 9th edition
Appendix:
<table>
<thead>
<tr>
<th>Skill/Compétence</th>
<th>BC*</th>
<th>AB</th>
<th>SK</th>
<th>MB</th>
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<td>Chairside / Extra-orale</td>
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<td>Fabricate &amp; Insert Bleaching Trays / Fabrique et mise en place les porte-empreintes de blanchiment</td>
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<td>Mandatory skills for NDAEB Certificate / Compétences requises pour certificat de BNEAD.</td>
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<td>*Skills may be performed by licensed CDA's only.</td>
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<td>1 Completion of module or training required / Instruction requise.</td>
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<td>2 Only extra-oral procedure / Procédures extra-orales seulement.</td>
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<td>3 Using rubber tips &amp; cups; no shaping or finishing / Utilisant instruments en caouchouc. Polir et façonner ne sont pas permis.</td>
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<td>4 Recommended but not mandatory for licensure / Recommandé mais pas obligatoire pour la licence.</td>
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<tr>
<td>5 CDA II's in Ontario are trained in this skill but are not permitted to perform it. / Les ADA de niveau II, en Ontario, reçoivent la formation dans cette tâche mais n'ont pas la permission de l'exécuter.</td>
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<td>6 Licensed CDA's may only fabricate bleaching trays. / Les ADAs licencié(e)s peuvent fabriquer exclusivement des plateaux de blanchiment.</td>
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<tr>
<td>7 CDA's with a minimum of one year full-time chairside experience may fabricate single unit provisional restorations intraorally, including try-in, adjusting occlusion outside the mouth, temporary cementation, removal of provisional cement, and removing provisional restorations. Protho module required for additional duties. / Les ADAs possédant un minimum d'une année d'expérience à temps plein d'assistance à la chaise, peuvent fabriquer une unité de restauration provisoire intra-buccale, incluant essai, ajustement de l'occlusion hors bouche, cimentation temporaire, retrait du ciment provisoire et retrait des restaurations provisoires. Le module de prosthodontie est nécessaire pour accomplir des tâches additionnelles.</td>
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<td>8 With dentist supervision when initiated in the office. / Sous la direction du dentiste lorsque exécuté en clinique.</td>
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</table>
SKILLS CHART:

LEVEL I CERTIFIED DENTAL ASSISTANT SKILLS

- Preparation of the treatment/clinical area
- Cleaning and Sterilization of instruments and handpieces
- Passing instruments to the dentist or hygienist (Single and Two handed technique)
- Proper use of High Volume Evacuator within the Oral Cavity
- Preparation of Restorative Materials
- Perform simple laboratory procedures such as the pouring and trimming of study models
- Maintains supplies and equipment (stocks and replenishes supplies)
- Monitors Inventory
- Assesses emergency situations, aware of emergency protocols, knowledge of First Aid, CPR
- Assists in maintaining emergency drug kits
- Ability to interpret Material Safety Data Sheets
- Conducts spore/biological indicator tests
- Recording data on patient’s record or chart as directed DDS
- Patient and community education on oral health (extra-oral)
- Other extra-oral duties as required by the dentist
- Instruction in care and maintenance of pre-fitted appliances
- Expose, process and mount radiographs as specified by HARP
- Obtains Vital Signs

LEVEL II INTRA-ORAL DENTAL ASSISTANT SKILLS (with NDAEB certificate)

- Includes, but not limited to all duties of CERTIFIED Level I Dental Assistants as listed above
- Mechanical polishing of the coronal portion of the teeth
- Placement and removal of rubber dam
- Taking of preliminary impressions of teeth for study models
- Topical application of anti-cariogenic agents
- Oral hygiene instruction with an intra-oral component
- Dietary counseling relative to dentistry
- Application of materials topically to prepare the surface of the teeth for pit and fissure sealants
• Application of pit and fissure sealants
• Application of topical anaesthetics
• Application of desensitizing agents
• Whitening of the coronal portion of the teeth using materials generally available to the public without prescription
• Polishing restorations
• Oral irrigation

The following skills cannot be performed by Level II Dental Assistants in Ontario at this time as they are Controlled Acts.

• Application of Matrices and Wedges
• Application of Treatment Liners

PREVENTIVE DENTAL ASSISTANT SKILLS (PDA)
(Listed with RCDSO prior to January 1, 2000)

• Includes, but not limited to all duties of CERTIFIED Level I Dental Assistants as listed above
• Chairside Dental Assisting (Level I)
• Mechanical polishing of the coronal portion of the teeth
• Placement and removal of rubber dam
• Taking of preliminary impression of teeth for study models
• Topical application of anti-cariogenic agents
• Oral hygiene instruction with an intra-oral component

DENTAL RECEPTIONIST/FRONT DESK ADMINISTRATIVE ASSISTANTS

• Patient reception and dismissal
• Appointment book control and maintain recall system
• Block out times for reserved emergency and new appointments
• Maintaining and controlling business area
• Handle all incoming calls promptly and efficiently
• Patient follow-up treatment calls
• Public relations
• Bookkeeping
• Managing receivables and payables
• Prepare and balance bank deposits on daily basis
• Age and prepare outstanding account statements
• Maintaining financial records
• Incoming mail, invoices, packing slips and statements (forward to appropriate person for verification and/or payment)
• Maintaining file system
• Ordering and receiving supplies

TREATMENT COORDINATOR DUTIES
• Performs required part of consultation
• Reviews medical history and explains office policies and procedures
• Makes a definite financial agreement with each patient/parent in accordance with the financial policies of the office. Prepares financial agreement form for each patient
• Monitors patient progress through each treatment
• Sends the patient records for consultation with appropriate specialists as required
• Co-ordinates goodwill program
• Helps to co-ordinate practice building and public relations efforts with patients, parents and referring professionals
• Print and proofread patient correspondence
• Keeps treatment acceptance rate within practice goals
• Ensures the follow-up of “will-advice” and mail-in referrals
• Educates patients with respect to appointments and financial
### Answers to Questions

**Member Survey 2011 as of: 10/3/2011 8:51:47 AM**

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<thead>
<tr>
<th>Question</th>
<th>Number Who Answered: 2973</th>
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<tr>
<td><strong>Question: How long have you been a member of ODAA?</strong></td>
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<tr>
<td>Less than 1 year</td>
<td>227 8%</td>
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<tr>
<td>2-5 years</td>
<td>603 20%</td>
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<tr>
<td>5-10 years</td>
<td>562 19%</td>
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<tr>
<td>10-15 years</td>
<td>426 14%</td>
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<tr>
<td>15-20 years</td>
<td>439 15%</td>
</tr>
<tr>
<td>20-25 years</td>
<td>327 11%</td>
</tr>
<tr>
<td>25-30 years</td>
<td>220 7%</td>
</tr>
<tr>
<td>30-35 years</td>
<td>100 3%</td>
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<tr>
<td>35-40 years</td>
<td>57 2%</td>
</tr>
<tr>
<td>Over 40 years</td>
<td>12 0%</td>
</tr>
<tr>
<td><strong>Question: Are you a certified dental assistant?</strong></td>
<td></td>
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<tr>
<td>Yes</td>
<td>2880 97%</td>
</tr>
<tr>
<td>No</td>
<td>94 3%</td>
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<tr>
<td><strong>Question: Do you presently work as a clinical dental assistant?</strong></td>
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<tr>
<td>Yes</td>
<td>2148 72%</td>
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<tr>
<td>No</td>
<td>825 28%</td>
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<tr>
<td><strong>Question: Are you aware that ODAA has requested that the Ontario government regulate the profession of Dental Assisting?</strong></td>
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<tr>
<td>Yes</td>
<td>2915 98%</td>
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<tr>
<td>No</td>
<td>48 2%</td>
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<tr>
<td><strong>Question: Are some of the other DA’s that you work with not certified by ODAA?</strong></td>
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<tr>
<td>Yes</td>
<td>1300 44%</td>
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<tr>
<td>No</td>
<td>1641 56%</td>
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<tr>
<td><strong>Question: Have you ever been asked to provide on the job training to someone without formal education as a DA?</strong></td>
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<tr>
<td>Yes</td>
<td>634 21%</td>
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<tr>
<td>No</td>
<td>2319 79%</td>
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### Answers to Questions, cont’d

<table>
<thead>
<tr>
<th>Question</th>
<th>Number Who Answered: 2972</th>
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<tbody>
<tr>
<td>Do you have an understanding of what it means to be a regulated health professional?</td>
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<tr>
<td>Yes, I understand</td>
<td>2279 (77%)</td>
</tr>
<tr>
<td>Yes, I somewhat understand</td>
<td>668 (22%)</td>
</tr>
<tr>
<td>No, I do not understand this at all</td>
<td>25 (1%)</td>
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<thead>
<tr>
<th>Question: Please rate your level of support for the ODAA’s wish to have the profession of dental assisting regulated.</th>
<th>Number Who Answered: 2970</th>
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</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>2053 (69%)</td>
</tr>
<tr>
<td>Somewhat agree</td>
<td>410 (14%)</td>
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<tr>
<td>Agree</td>
<td>370 (12%)</td>
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<tr>
<td>Somewhat disagree</td>
<td>64 (2%)</td>
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<tr>
<td>Disagree</td>
<td>40 (1%)</td>
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<tr>
<td>Strongly Disagree</td>
<td>33 (1%)</td>
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<thead>
<tr>
<th>Question: ODAA has knowledge that many of our members are doing duties that they haven’t been formally educated to do. Have you ever been asked to do duties that you have not been formally educated to perform?</th>
<th>Number Who Answered: 2969</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>815 (27%)</td>
</tr>
<tr>
<td>No</td>
<td>2154 (73%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question: Do you presently perform temporary crowns or restorations?</th>
<th>Number Who Answered: 2961</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>199 (7%)</td>
</tr>
<tr>
<td>No</td>
<td>2469 (83%)</td>
</tr>
<tr>
<td>Not presently, but I have done this in the past</td>
<td>293 (10%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question: Do you perform ZOOM bleaching?</th>
<th>Number Who Answered: 2957</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>87 (3%)</td>
</tr>
<tr>
<td>No</td>
<td>2690 (91%)</td>
</tr>
<tr>
<td>Not presently, but I have done this in the past</td>
<td>180 (6%)</td>
</tr>
</tbody>
</table>
**Question:** Have you ever performed orthodontic duties such as placement of archwires, bands or elastics?  

<table>
<thead>
<tr>
<th>Answer</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>252</td>
<td>9%</td>
</tr>
<tr>
<td>No</td>
<td>2503</td>
<td>85%</td>
</tr>
<tr>
<td>Not presently, but I have done this in the past</td>
<td>207</td>
<td>7%</td>
</tr>
</tbody>
</table>

**Question:** ODAA is advocating, that once we become regulated, that the scope of practice for qualified Level II assistants should include limited scaling (maximum of 4 mm supragingival), orthodontic duties (placement of wires, bands and elastics), temporary crowns, temporary restorations, pulp vitality testing, and removal of sutures. This wider scope of practice occurs in many provinces that regulate dental assistants. To do many of these duties, additional education will be required. Please advise us of your level of agreement regarding this proposal.

<table>
<thead>
<tr>
<th>Level of Agreement</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>1573</td>
<td>53%</td>
</tr>
<tr>
<td>Somewhat agree</td>
<td>603</td>
<td>20%</td>
</tr>
<tr>
<td>Agree</td>
<td>476</td>
<td>16%</td>
</tr>
<tr>
<td>Disagree</td>
<td>176</td>
<td>6%</td>
</tr>
<tr>
<td>Somewhat disagree</td>
<td>64</td>
<td>2%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>80</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Question:** ODAA estimates that there may be close to 15,000 people working as dental assistants in Ontario. Presently, we have a membership of 8,400 with approximately 7,700 of them being certified. With that large a number, we will be able to keep licensing costs down. That being said, annual licensing fees will be at least $150 per year. Like your certification fees, this is tax deductible. The government needs to know that the membership supports the cost of regulation. Given this information, are you still supportive of our proceeding with this?

<table>
<thead>
<tr>
<th>Support</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, strongly agree</td>
<td>1467</td>
<td>49%</td>
</tr>
<tr>
<td>Yes, somewhat agree</td>
<td>569</td>
<td>19%</td>
</tr>
<tr>
<td>Yes</td>
<td>617</td>
<td>21%</td>
</tr>
<tr>
<td>No, somewhat disagree</td>
<td>205</td>
<td>7%</td>
</tr>
<tr>
<td>No, strongly disagree</td>
<td>62</td>
<td>2%</td>
</tr>
<tr>
<td>No, stop this now</td>
<td>49</td>
<td>2%</td>
</tr>
</tbody>
</table>
Regulation Update

As you know, last March, the Health Minister, Mr. David Caplan, delayed the review by the Health Professions Regulatory Advisory Council (HPRAC) for the regulation of Ontario dental assistants.

The ODAA responded by sending a letter to the Ministry to inform them of our extreme disappointment with this decision. We embarked on a PR campaign and ran ads to raise awareness of the issue. In addition, the CDA sent a letter to the Honourable David Caplan.

In May, Judy Melville and Pam Gutteridge met with a member of the Health Minister’s staff. During this meeting, we were told that Mr. Caplan acknowledges the need for dental assistants to become regulated and understands our desire to have HPRAC review our request for regulation. But he has suggested that finding the money to conduct this review is problematic as Ontario has suffered severely in the economic recession.

Though the ODAA can appreciate that many Ontarians are suffering as a result of our economic woes, we are nonetheless disappointed with the delay. However, we will not give up. We will continue our dialogue with the Health Minister and HPRAC in the hope that our review will happen sooner.

WE NEED TO ACT AS IF WE ARE ALREADY REGULATED

Several years ago, in a meeting with HPRAC officials, it was suggested that the ODAA begin to act as if our profession is regulated. Fortunately, our certification program is similar to regulation in that those who are certified must be formally educated, must have passed an examination and must commit to continuing education. The big difference is that it is voluntary. That said, our membership is growing, and more and more dental assistants are making certification a priority. As well, more and more dentists are committed to hiring only certified assistants, and that gives our members a competitive edge.

However, for Ontario dental assisting to be like a regulated profession, we may have to look at adding a complaints and discipline component to our certification program. The Board of Directors plans to explore this in the coming year, and we will be seeking your feedback.

Meanwhile, we will continue to work at the political level to further our cause for regulation. As well, through our bold media campaigns, we will continue to educate the public regarding the work of dental assistants and the need for dental assisting in Ontario to become a regulated health profession.

THANKS FOR ADDING YOUR MANY VOICES TO OUR CAUSE

We are very pleased that hundreds of ODAA members sent letters to the Health Minister expressing dismay with his decision to delay our review. Concerns voiced by individual citizens are very powerful, and politicians cannot afford to ignore them. The ODAA wishes to thank our members for helping to strengthen our position and ensure that our voices are heard.

Toronto Academy of Dentistry
72nd Annual Winter Clinic
FRIDAY, NOVEMBER 13, 2009
Metro Toronto Convention Centre, South Building
Toronto, Ontario
Pre-Register by November 6th for Early Bird Fees!
For your convenience register online at www.tordent.com
Features Topics such as:
Communicating with Diplomacy and Professionalism
The Conference for Women- Get your Life on Track
Avoiding Dietary Villains and Choosing Nutritional All-Stars
Yoga Sutra for dentistry
Healing Dentistry
….And much more!!

- Over 15 ADA CERP Certified Clinical Programs
- A Hands On Experience on the Exhibit Floor
- Fabulous silent auction items sponsored by our exhibitors!

Program Books will be mailed in September to all Dental Offices in Ontario, containing a full comprehensive outline of lectures, attending exhibitors, special events, the day’s schedule, and more!

Regulation Update - Fall Journal 2009
The ODAA will be seeking input from our members through surveys. Obviously, it is our position that not regulating dental assistants poses a risk of harm to patients. As Ontario dental assistants who take your profession seriously, you will be asked for your position on the argument. We believe that you know what is right for your career and for our industry. We will be communicating regularly with our members through email, so please keep a close eye on your inbox and respond promptly.

Meanwhile, we thought it would be a good time for a refresher on the role of HPRAC in the regulation of health professions in Ontario.

WHAT IS THE ROLE OF HPRAC?

The Health Professions Regulatory Advisory Council (HPRAC) is established under the Regulated Health Professions Act, 1991 (RHPA), with a statutory duty to advise the Minister of Health and Long-Term Care on professions regulatory matters in Ontario. This includes advising the Minister on:

- Whether unregulated health professions should be regulated;
- Whether regulated health professions should no longer be regulated;
- Amendments to the Regulated Health Professions Act (RHPA);
- Matters concerning the quality assurance programs and patient relations programs undertaken by health colleges; and
- Any matter the Minister may refer to HPRAC relating to regulation of the health professions.

The Minister relies on recommendations from HPRAC as an independent source of evidence-informed advice in the formulation of policy related to health professional regulation in Ontario.

When considering health professions regulatory matters, HPRAC ascribes to the following overriding principles:

- Meeting public expectations for improved access to high-quality, safe care;
- Supporting interprofessional care and optimizing the contribution of all health professionals;
- Applying standards for the regulation of health professionals;
- Ensuring a shared accountability agenda that encourages and values collaboration and trust;
- Using resources efficiently;
- Sustaining the healthcare systems; and
- Maintaining self-regulation.

HPRAC presents its recommendations for consideration in a report to the Minister of Health and Long-Term Care. The report is confidential until released by the Minister.
Did you know that Ontario dental assistants are not regulated and therefore are not required to be formally educated and licensed to work in a dental office?

The Ontario Dental Assistants Association, the membership association of Ontario Dental Assistants, has been working hard to change this. It is time to bring dental assisting in Ontario in line with the national standard.

We're pleased to announce that we are getting closer to our goal. HPRAC (Health Professions Regulatory Advisory Council) and the Minister of Health and Long-Term Care are currently reviewing our request that dental assisting be a regulated health profession in Ontario.

For 75 years, we've been working to make the dental office a better place for dental assistants and patients. Now, we're making history.

A message from the Ontario Dental Assistants Association, the certifying body for Ontario Dental Assistants for over 40 years.

869 Dundas Street, London, Ontario  N5W 2 Z8

www.odaa.org
Last year, Ontario dental assistants were all smiles because they thought that dental assisting would soon become a regulated profession. Regulation would mean that only formally trained dental assistants could work in dental offices.

We recognize that the economic crisis has dashed the hopes of many Canadians, and that certain measures are necessary for survival. But we also consider the regulation of dental assisting to be a matter of public health. Dental assistants take x-rays and are responsible for infection control. Yet many are trained on the job in Ontario putting your safety at risk.

We believe that regulation will happen for Ontario dental assistants one day. Until then, to protect your family, ask if ODAA-certified dental assistants are working in your dentist’s office. At least, that’s one good reason to smile.

A message from the Ontario Dental Assistants Association, the certifying body for Ontario Dental Assistants for over 40 years.

869 Dundas Street, London, Ontario N5W 2Z8
www.odaa.org

For five years, we’ve been working for the regulation of dental assistants. Regulation would mandate formal training for all dental assistants. But the Ontario government has postponed our review citing necessary cutbacks in a poor economy.

Posting regulation is like putting off good oral care. Dental assistants take x-rays and are responsible for infection control. Yet many are still trained on the job in Ontario putting public health and safety at risk.

We will continue our fight to ensure that Ontario dental assistants become regulated one day. Meanwhile, to protect your family and preserve your oral health, ask if ODAA-certified dental assistants are working in your dentist’s office.

A message from the Ontario Dental Assistants Association, the certifying body for Ontario Dental Assistants for over 40 years.

869 Dundas Street, London, Ontario N5W 2Z8
www.odaa.org
Dental assistants certified by the Ontario Dental Assistants Association (ODAA) have been formally educated in the prevention of disease transmission, proper sterilization of the instruments and the taking of radiographs. They are continually upgrading their knowledge and skills. They not only help keep your teeth healthy, they also help to protect the well being of you and your family.

Want to know the facts?
Ask your dentist if only certified dental assistants work in your dental office.

FACT: Not all Ontario Dental Assistants are certified.
FACT: Many Dental Assistants are trained on the job.
FACT: Dental Assistants are responsible for infection control and taking x-rays.
Ontario is now the only province in Canada where dental assistants are not a regulated health profession. This means that dentists can hire people without formal education to do the work of dental assistants. Dental assistants take radiographs, are responsible for infection control and may perform other intra-oral duties.

The Ontario Dental Assistants Association (ODAA), the certifying body for Ontario dental assistants feels this is a matter of public safety. Dental patients have the right to know that everyone working in a dental office is educated and formally trained.

The Ontario government will not review the ODAA’s request for regulation until 2013. Meanwhile, for the good of your oral health and safety, ask if your dentist hires only ODAA certified dental assistants.

A message from the Ontario Dental Assistants Association, the certifying body for Ontario Dental Assistants for over 40 years.

869 Dundas Street, London, Ontario N5W 2Z8
www.odaa.org

We’re nearly there!

After sitting on the sidelines for so long, the ODAA (Ontario Dental Assistants Association) will finally have our turn in the spotlight! The Ontario government has agreed to consider the regulation of Ontario dental assistants, and HPRAC (Health Professionals Regulatory Advisory Council) will begin our review in November.

If regulation is passed, then all dental assistants must be formally educated to work in a dental office – rather than being trained on the job.

Regulation will mean that you can be completely confident everyone at your dentist’s office is properly educated to protect your health and safety.

Did you know that dental assistants in eight provinces have been regulated since the ’70s? You can help make the regulation of Ontario dental assistants a reality by talking to your MPP or visiting http://www.hprac.org/en/projects/Dental-Assistants.asp to share your thoughts.

Together we can ensure that Ontario families continue to receive the highest level of safe dental care.

A message from the Ontario Dental Assistants Association, the certifying body for Ontario Dental Assistants for over 40 years.

869 Dundas Street, London, Ontario N5W 2Z8
www.odaa.org
Searching for qualified dental auxiliaries to fill a few seats in your office?

PUT YOUR FREE AD IN FRONT OF 8,400 ODAA MEMBERS.

The Ontario Dental Assistants Association (ODAA) website at www.odaa.org is a rich source of information for our membership base of over 8,400 certified dental assistants.

Only members have access to our Job Postings page, which gets over 15,000 page views a month.

Post your ad on our site free of charge, and receive applications from formally trained and certified dental assistants, receptionists, office managers and treatment coordinators who are ready to get right to work.

You will find the right people quickly and save valuable time by hiring an ODAA-certified dental assistant, receptionist or treatment coordinator. You can rest assured that they are formally educated, have passed all appropriate examinations and are committed to ongoing learning.

Send us an email to mlesarge@ody.ca or fax 519-679-8494 with your ad information including: position available, employer name, contact name, address, phone number, email address, fax number and job description. An ODAA staff member will contact you to confirm the details of your ad.
BOARD POLICY
COMPLAINTS AND DISCIPLINE

ODAA is the Certifying Body for Ontario Dental Assistants and our primary mandate is to ensure that only appropriately educated dental assistants, who pass the appropriate examinations; make a commitment to ongoing continuing education and who abide by our Code of Ethics, work as dental assistants in Ontario.

ODAA wants to be able to respond to complaints about the professional activates of Certified Dental Assistants. Discipline is a process whereby complaints are investigated, and appropriate sanctions may be issued.

Complaints:

In order for ODAA to act on any complaints, a written and signed statement must be received to initiate an investigation. Letters of complaint can be submitted by members of the public, other certified dental assistants or any other health care providers. All complaints must be addressed to the Executive Director. **ODAA will not investigate anonymous complaints.**

Within 30 days of receiving a complaint, the Executive Director has several options for action which include:

- Encouraging the complainant and the person in question to communicate, and resolve the complaint
- Attempting to resolve the complaint with consent from the complainant and the person in question
- Conducting an investigation
- Dismissing the Complaint
- Assessing incapacity

Investigation:

The purpose of an investigation is to collect all pertinent information/evidence relating to the complaint and the conduct of the CDA. The Executive Director generally conducts the investigation.

Notice is sent to the member who is being investigated. After the investigation is completed, the Executive Director will decide whether to refer the matter to the Complaints Committee of the Board of Directors or dismiss the complaint.
**Complaints Committee of the Board of Directors:**

This committee of the Board will be comprised of Certified members of ODAA and the Board may invite non-Directors to be on this committee. The investigated person may be asked to attend the meeting. After consideration of the information and evidence, and in consultation with legal counsel, the Complaints Committee will decide if the conduct of the investigated person constitutes unprofessional behavior. If a finding of unprofessional conduct is made, the Committee may:

- Issue a reprimand
- Issue the need for counseling
- Issue the need for upgrading courses
- Suspend or cancel certification (2/3 Board approval needed for this)

**Appeal Process:**

The person who is subject to discipline may appeal the decision of the Complaints Committee. This appeal would go to the President of the Board of Directors.

**Unprofessional Conduct:**

This means one or more of the following:

- Displaying a lack of knowledge or lack of skill or judgment in the provision of professional services
- Conduct that harms the reputation of the Ontario Dental Assistants Association
MUTUAL RECOGNITION AGREEMENT FOR PURPOSES OF LABOUR MOBILITY - DENTAL ASSISTING

The consensus statements that follow have been agreed to in principle by the registrars of Dental Assisting Regulatory Authorities across Canada as applicable to Level II, Intra Oral Dental Assisting.

Whereas:

It is understood and agreed that this Agreement applies only to Canadian Provinces and/or Territories that regulate Dental Assisting;

Dental Assisting Regulatory Authority is hereinafter referred to as DARA;

DARAs support the Commission on Dental Accreditation of Canada (CDAC) dental assisting program accreditation process;

DARAs encourage all dental assisting programs to become CDAC accredited;

DARAs support the National Dental Assisting Examining Board (NDAEB);

DARAs recognize that each DARA carries out its licensing/listing/certification/registration practices in good faith;

The requirements for initial licensure/listing/certification/registration are the responsibilities of the individual DARAs;

Good standing refers to the status of a person who is currently licenced to practice in a signatory jurisdiction and whose licensure is not encumbered or restricted in any way in any jurisdiction and more specifically is not subject to a discipline order, investigation or ongoing agreement;

Practice as a Level II Dental Assistant over the preceding three years will be demonstrated should any jurisdiction require currency in practice;

There are no residency requirements for licensure/listing/certification/registration of dental assistants in any jurisdiction in Canada; and

For the purpose of this Mutual Recognition Agreement (MRA) the terms licensure/listing/certification/registration shall be herein after referred to as “licensure”.

We, the undersigned agree:

1. Implementation of the provisions of the MRA will occur on or before April 1, 2009 subject to necessary provincial/territorial legislative changes.

2. For the purpose of Canadian inter-jurisdictional mobility, a dental assistant candidate for licensure will have successfully completed training consistent with the domain description for dental assisting in Canada.

3. Initial Licensure:
   
   • For initial licensure, graduates from CDAC accredited dental assisting programs will require the NDAEB Written Certificate. [Other provincial administrative measures for initial licensure may apply, e.g. criminal records check];

   • For initial licensure, graduates from non-accredited dental assisting programs will require the NDAEB Written Certificate and the NDAEB Clinical Practice Evaluation (CPE) or retraining at a CDAC accredited institute in lieu of the CPE [Other provincial administrative measures for initial licensure may apply, e.g. criminal records check].
4. The domain description includes chairside assisting and core skills that represent the minimum standard for dental assistants as defined by the CDAC and the NDAEB. The following core competencies represent a high degree of commonality as defined in Chapter Seven of the Agreement on Internal Trade. The domain description for a licensed dental assistant includes chairside assisting and the following competencies:

- Producing Dental Radiographs
- Application and Removal of Rubber Dam
- Take Preliminary Impressions for Study Casts
- Application of Treatment Liners where there is no Pulpal Involvement
- Application and Removal of Matrices and Wedges
- Selective Rubber Cup Polishing
- Oral Hygiene Instruction
- Dietary Counseling Relative to Oral Health
- Application of Anticariogenic Agents
- Fabricate and insert bleaching trays
- Pit & fissure sealants
- Topical anesthetic
- Desensitizing agents

5. Eligibility For Inter-provincial Mobility:

- For the purposes of inter-provincial mobility all jurisdictions will recognize without further examination and training for licensure in chairside assisting and core skills 1 through 9 a dental assistant licensed in good standing in another Canadian jurisdiction graduating prior to January 1, 2007.

- For the purposes of inter-provincial mobility all jurisdictions will recognize without further examination and training for licensure in chairside assisting and core skills 1 through 13, a dental assistant licensed in good standing in another Canadian jurisdiction graduating on or after January 1, 2007.

6. Since some jurisdictions have additional mandatory skills beyond the core competencies listed in Clause 4, a DARA that requires upgrading for additional mandatory skills in their jurisdiction will provide mechanisms (e.g. restricted licensure) to allow practice while upgrading.

7. As posted on the DARA website, an applicant may be required to meet other requirements as a condition of licensure, such as:

- Satisfying the DARA that he/she is in good standing in all jurisdictions where he/she holds or has held licensure;
- Satisfying the DARA that he/she has complied with the continuing competency/quality assurance requirements of the jurisdiction(s), if any, where he/she currently holds licensure;
• Payment of fees;
• Satisfying the DARA that the applicant’s past and present conduct affords reasonable grounds for the belief that the applicant;
  i) Is mentally competent and physically able to safely practice dental assisting;
  ii) Will practice dental assisting ethically and in accordance with the law;
  iii) has sufficient knowledge, skill and judgment to competently engage in the kind of dental assisting practice authorized by the licence for which he/she is applying; and
  iv) Can communicate effectively and will display an appropriate professional attitude.

8. The signatories of this MRA acknowledge that this is an evolving document. We, the undersigned, agree to review the Agreement every three years or at the request of one or more signatories.

9. Any changes to occupational standards, licensing or legislative requirements such as examination development, mutual recognition practices, accreditation standards, or additional jurisdictions regulating dental assistants that may impact the Agreement will be communicated in writing to all signatories and to the LMCG representatives to provide them with an opportunity to review and comment prior to implementation.

10. DARAs agree to invite non-regulated jurisdiction representatives to future meetings and that the LMCG representatives will be invited to discuss labour mobility matters as appropriate.

11. DARAs agree to abide by this Mutual Recognition Agreement among Provincial and Territorial regulators and will seek action in our respective jurisdictions to make necessary legislative (statutory), regulatory and by-law amendments to give effect to the terms of this Agreement.

12. Each signatory will give written notice to its legislating government and to their LMCG representatives and to other signatories of its intent to withdraw from this agreement at least 12 months before the signatory withdraws or at the earliest possible opportunity. The withdrawal will take effect 12 months after the notification. The notice period is waived where the withdrawal is not within the DARA’s control.

Signed this __________ day of ______________, _____

Signatories to the Agreement:

for College of Dental Surgeons of British Columbia        for New Brunswick Dental Society

for College of Alberta Dental Assistants                for Provincial Dental Board of Nova Scotia

for Saskatchewan Dental Assistants’ Association         for Dental Council of Prince Edward Island

for Manitoba Dental Association                         for Newfoundland Dental Board
Non Regulated Dental Assisting Jurisdictions:

It is recognized that while the following supportive associations have not been delegated authority by law to regulate the profession of dental assisting, they are mandated by their membership to set requirements / standards for membership. The following signatories:

- Participated in the process to develop this MRA;
- Are committed to excellence in the practice of dental assisting;
- Are committed to the continued competence and currency of its members;
- Are committed to the principle and facilitation of inter-provincial labour mobility;

We the undersigned, by demonstrating and monitoring the continued competence of our members, commit to the principles of this agreement.

The DARA agree that by our signing this addendum our members who meet the initial licensure (section 3) requirements of this agreement will be recognized for the purposes of labour mobility.

Per: Ms. Judy Melville, Executive Director
Ontario Dental Assistants Association

Per: Ms. Joanne Longpré, Présidente
Association des assistant(e)s dentair(e)s du Québec

Signed this ________ day of ______________, _____
Guideline for Level II Dental Assisting
May 2008

Current Licence?

Licensed D.A. Process

Non-licensed D.A. Process

Competence / Quality Assurance *

New grad?

CDAC recognized?

NDAEB written?

Registration Eligible

New Graduate Process

Non-licensed Experienced D.A. Process

NDAEB written?

CDAC recognized?

Registration Eligible

Ineligible

Limited license

Discretion of the DARA

Core Skills:

9 before 01/07

13 after

Good standing?

Limited license

Pass NDAEB written

Pass NDAEB CPE

Registration Eligible

Limited license

Pass NDAEB written

Pass NDAEB CPE

Good standing?

Registration Eligible

No

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