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CDSBC | College of Dental Surgeons of British Columbia

BOARD MEETING
Saturday, 24 June 2017

The Hyatt Regency Hotel
655 Burrard St., Vancouver BC
"Grouse Room", 34th Floor

MINUTES

The meeting commenced at 8:33 am

In Attendance

Dr. Don Anderson, President
Dr. Susan Chow, Vice-President
Dr. Patricia Hunter, Treasurer
Dr. Chris Callen
Dr. Doug Conn
Mr. Dan de Vita
Dr. Andrea Esteves
Dr. Michael Flunkert
Mr. Terry Hawes
Mr. Oleh Ilnyckyj
Ms. Dorothy Jennings
Ms. Sabina Reitzik
Dr. Masoud Saidi
Dr. Mark Spitz
Mr. Neal Steinman

Regrets:

Dr. Dustin Holben
Ms. Sherry Messenger

Staff in Attendance

Mr. Jerome Marburg, Registrar & CEO
Ms. Nancy Crosby, Manager of CEO's Office
Dr. Chris Hacker, Director of Professional Practice
Dr. Meredith Moores, Complaint Investigator
Ms. Roisin O'Neill, Director of Registration and HR
Ms. Leslie Riva, Sr. Manager, CDA Certification and QA
Ms. Marife Sonico, Administrative Assistant, Registrars Office
Ms. Anita Wilks, Director of Communications
Ms. Carmel Wiseman, Deputy Registrar
Mr. Dan Zeng, Director of Finance and Administration

Invited Guests

Dr. Richard Busse, Chair, Facial Aesthetics Working Group
Ms. Cathy Larson, Incoming Board member
Dr. Reza Nouri, Ethics Committee
Dr. Brian Wong, Ethics Committee

1. Call Meeting to Order and Welcoming Remarks

   The President referred to the previous day's workshop and mentioned the incredible depth of the board assessment process. He advised the Board that it will be a once a year major event and that there will be a check-in at the in-camera session.

   He also asked the Board to provide him with items they may want to add and the time they need for the discussion, as well as items that could be moved from the in-camera to the open session.

2. Oath of Office – New Board member

   The President introduced Ms. Cathy Larson who is an incoming CDA Board member. Ms. Cathy Larson took the Oath of Office, administered by the Registrar.

3. Consent Agenda

   a. Approve Agenda for 24 June 2017 *(attachment)*

   b. Approval of Board Minutes of 25 February 2017 *(attachment)*

   c. Reports from Committees *(attachments)*

   ***MOTION*: Conn/Jennings**

   That the items on the Consent Agenda for the 24 June 2017 Board meeting be approved.

   Carried

4. Business Arising from the Consent Agenda

   There was no business arising from the consent agenda.

5. Audited Financial Statements

The Board held an electronic vote on 23 May 2017 to approve the Audited Financial Statements. The Motion passed was as follows:

***MOTION**: Hawes/De Vita*

Moved and seconded that the Board approve the Audited Financial Statements for the fiscal year ending 28 February 2017 and authorize the President and Treasurer to sign on behalf of the Board.

6. Executive Limitation Reports *(attachment)*

CDSBC Governance policy requires that the CEO report regularly on matters identified by the Board through a series of Executive Limitations policies. This is one of the ways the Board discharges its oversight obligations without delving into operational issues. The CEO routinely submits these reports to the Board.

EL2: Treatment of Public
EL3: Registration, Certification and Monitoring
EL5: Financial Planning/Budgeting
EL6: Financial Condition and Activities
EL8: Asset Protection

With respect to EL8, the Registrar noted that Dr. Chris Hacker is now a signatory for the College since he moved to the role of Director of Professional Practice.

Under EL 3, the President mentioned that while the response rate for the exit survey is not too high, the feedback received provides great value.

7. Facial Aesthetics Working Group

The Facial Aesthetics Working Group met twice and the first agenda was to draft a Terms of Reference with three main objectives including the definition of dentistry under the HPA as well as orofacial complex and associated structures. Also, they will review the education and training requirements for those who currently provide services in relation to neuromodulators and fillers and those who plan to provide services in the future.

The group will review other resources and look into the standards in other provinces. At their July 10th meeting, their goal is to develop working definitions that will serve to protect the public and safeguard the profession in the event of a lawsuit regarding scope.

The Registrar shared that a national report indicates that Botox is potentially within the scope of practice and would require provincial regulation.

Upon inquiry from the President, Dr. Busse explained that the working group does not have a firm timeline for completion but believes that once they get past the definitions, their work will likely move fairly quickly. He estimated that it may take a year to complete their work.

MOTION: ***Callen/Spitz***

That the Board approves the Terms of Reference for the Facial Aesthetics Working Group as presented.

Carried

8. Sedation and GA Services Committee

- Moderate Parenteral Facilities Inspections Protocols

  Mr. Marburg and Dr. Hunter met to review the document, made the necessary changes and sent the document to the Chair and Vice-Chair of the Sedation Committee, as well as the committee member who was the primary author of the document, for a review and from there to the Committee before resubmitting to the Board in June. The revised document recommended by the Committee is attached.

  Mr. Marburg advised the board that once the document is approved, it will undergo final copy-editing and lay-out for publication to the public and the profession.

  The Registrar also informed the Board that a dental sedation training provider is providing incorrect information about the inspection process for moderate parenteral sedation facilities. They claim that many practices have been found non-compliant and are being asked to suspend delivery of moderate parenteral sedation to patients until deficiencies are corrected. These claims are erroneous. The College has not yet started inspections of practices providing moderate

parenteral sedation. CDSBC will issue an advisory to registrants to provide them with correct information.

MOTION: Saidi/Jennings

That the Board approves the framework for the inspection process for non-hospital parenteral moderate sedation facilities as presented.

Carried

9. First Nations Cultural Safety and Awareness Course

On March 1, 2017, Regulatory Colleges in BC signed a Declaration of Commitment to Cultural Safety and Humility recognizing that quality and safety dimensions are integral components of its public protection mandate. Mr. Marburg expressed pride that the Board was one of the first among other regulatory colleges to recognize the importance if this initiative and authorize the College through the Registrar to sign the declaration.

One of the most direct things to demonstrate our commitment is for the Board to take the cultural safety course offered through the provincial health authority. As this is unbudgeted, approval is also being sought for the College to pay for Board members to take the course (which costs approximately $250/person).

The Board was informed that other health colleges are proceeding with their cultural competency training for leaders, registrants and staff and the CDSBC intends to do the same. The Registrar confirmed that he has registered for the course and staff are likewise encouraged to take it. Registrants will also be encouraged to take the course and will be informed that it counts for continuing education credits.

MOTION: Conn/Hawes

That Board members complete the course and, as this is an unbudgeted item, that the Board approves payment for the course.

Carried

10. Listening Sessions

Dr. Chris Hacker gave an overview on the four listening sessions that were organized by the College from November 2016 to April 2017. The intent is to increase engagement with registrants and other stakeholders in current policy development initiatives.

Feedback was generally positive and indicated that 93% of listening session participants agreed or strongly agreed that CDSBC demonstrated a commitment to listening. Summaries were provided to attendees within a month. Dr. Hacker directed the Board to the comprehensive reports included in the package.

Two more sessions are scheduled for the Fall.

The President affirmed that he is very passionate about this initiative.

11. Presidents Report

The President shared information from the symposium he attended called *The Privilege of Self-Regulation: Use it or Lose it*. He reported on the professions that have lost their right to self-regulate and conclusions that may be pertinent for the College to keep in mind.

Dr. Anderson quoted presenter Geoff Thiele of the Real Estate Council of BC when he said "*Self regulation is best supported when the quality of a profession, craft or trade can only be assessed by peers*." He then emphasized why our authority is so important. He reminded everyone that the public is our key stakeholder.

The President reiterated the value of increasing public engagement and awareness. The listening sessions enable the College to touch base with registrants and get their feedback. It also provides relevant input on what is happening within the profession.

Dr. Anderson emphasized the need to focus on the mandate of public protection and that a high performing staff will not work if the organization is not functioning at the governance level. He noted that regulation is both an art and a science and that it is pivotal to uphold and communicate our mandate.

12. Reports from Deputy Registrar and Director of Professional Practice (Wiseman/Hacker)

    Dr. Hacker presented his report outlining statistics on complaints resolution. He noted that we now have the lowest number of HRPV applications open than in the past.

    He highlighted some key findings of the Complaints Process Exit Survey:

    - Complainants generally agree with how the complaints process is conducted in terms of fairness, timeliness, courtesy, thoroughness and respectfulness

    - Registrants tend to agree in general with the fairness, courtesy and thoroughness of the process, but tend to disagree with timeliness

    - Registrants agree with the way CDSBC communicates with them during the investigation and resolution process

13. Management Report *(attachment)*

    Registrar/CEO Jerome Marburg submitted a written report on behalf of the staff and management of the College.

    He acknowledged Ms. Leslie Riva, Senior Manager, CDA Certification and QA, for completing her final year as President of the NDAEB and highlighted that the NDAEB maintains that they have never had a stronger President than Ms. Riva.

    Mr. Marburg also recognized the invaluable contribution of two outgoing Board members to the College - Dr. Chris Callen and Ms. Sherry Messenger.

This concludes the open portion of the meeting. The meeting ended at 10:05 am

The remainder of the meeting will be held in camera, per Section 2.15 (9) of the College Bylaws under the *Health Professions Act*.

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 3a.

BOARD MEETING

Saturday, 24 June 2017
8:30 a.m. – 4:30 p.m.

The Hyatt Regency Hotel
655 Burrard Street
"Grouse Room", 34th Floor

AGENDA

A.	Description of Agenda Items	Presenter
1.	Call Meeting to Order and Welcoming Remarks	Anderson
2.	Oath of Office – New Member	Marburg
3.	**CONSENT AGENDA**	
	a. Approve Agenda for 24 June 2017 *(attachment)* b. Approval of Board Minutes of 25 February 2017 *(attachment)* c. Reports from Committees *(attachments)* ***MOTION:*** *That the items on the Consent Agenda for the 24 June 2017 Board meeting be approved.*	Anderson
4.	Business Arising from Consent Agenda *Note: Questions, if any, arising from Consent Agenda must be forwarded to the Chair at least 3 business days prior to Board meeting*	Anderson
5.	Audited Financial Statements An electronic vote was held on 23 May 2017 to approve the Audited Financial Statements. The Motion passed was as follows: ***MOTION**: Hawes/De Vita* *Moved and seconded that the Board approve the Audited Financial Statements for the fiscal year ending 28 February 2017 and authorize the President and Treasurer to sign on behalf of the Board.*	Zeng/Hawes

A.	Description of Agenda Items	Presenter
6.	Executive Limitation Reports • EL2: Treatment of Public *(attachment)* EL3: Registration, Certification and Monitoring *(attachment)* EL5: Financial Planning/Budgeting *(attachment)* EL6: Financial Condition and Activities *(attachment)* EL8: Asset Protection *(attachment)*	Marburg
7.	Facial Aesthetics Working Group • Update • Terms of Reference (*attachment*) ***MOTION***: *That the Board approves the Terms of Reference for the Facial Aesthetics Working Group as presented.*	Dr. Richard Busse, Working Group Chair
8.	Sedation and GA Services Committee *(attachment)* • Moderate Parenteral Facilities Inspections Protocols – for final approval *(attachment)* ***MOTION***: *That the Board approves the framework for the inspection process for non-hospital parenteral moderate sedation facilities as presented.*	Hunter/ Marburg
9.	First Nations Cultural Safety & Awareness Course *(attachment)* ***MOTION:*** *That Board members complete the course and, as this is an unbudgeted item, that the Board approves payment for the course.*	Marburg
10.	Listening Sessions *(attachments)*	Hacker
11.	President's Report	Anderson
12.	Reports from Deputy Registrar and Director of Professional Practice *(attachment)*	Wiseman/ Hacker
13.	Management Report	Marburg

This concludes the open portion of our meeting.

The remainder of the meeting will be held in camera, per Section 2.15 (9) of the College Bylaws under the *Health Professions Act*.

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 3b.

BOARD MEETING
Saturday, 25 February 2017

DRAFT

The Terminal City Club
837 West Hastings St., Vancouver BC
"*Presidents Room*

MINUTES

The meeting commenced at 8:30 am

In Attendance

Dr. Don Anderson, President
Dr. Susan Chow, Vice-President
Dr. Patricia Hunter, Treasurer
Dr. Chris Callen
Dr. Doug Conn
Mr. Dan de Vita
Dr. Andrea Esteves
Dr. Michael Flunkert
Dr. Dustin Holben
Mr. Terry Hawes
Mr. Oleh Ilnyckyj
Ms. Dorothy Jennings
Ms. Sherry Messenger
Ms. Sabina Reitzik
Dr. Masoud Saidi
Dr. Mark Spitz
Mr. Neal Steinman

Regrets:

Mr. Richard Lemon

Staff in Attendance

Mr. Jerome Marburg, Registrar & CEO
Mr. Greg Cavouras, Legal Counsel
Ms. Nancy Crosby, Manager of CEO's Office
Dr. Chris Hacker, Dental Policy & Practice Advisor
Dr. Meredith Moores, Complaint Investigator
Ms. Roisin O'Neill, Director of Registration and HR
Ms. Leslie Riva, Sr. Manager, CDA Certification and QA
Ms. Natasha Tibbo, Sedation Program Coordinator
Ms. Anita Wilks, Director of Communications
Ms. Carmel Wiseman, Deputy Registrar
Mr. Dan Zeng, Director of Finance and Administration

Invited Guests

Dr. Maico Melo, Vice-Chair, Sedation & General Anaesthetics Committee
Dr. Peter Stevenson-Moore, Co-Chair, Specialty Recognition Working Group
Drs. Brian Chanpong and Daniel Haas, speaking on Specialty Recognition for Dental Anaesthesia.

1. Call Meeting to Order and Welcoming Remarks

   The President advised the Board and CEO that there will be an in-camera session prior to lunch. This change is for the Board and Registrar to discuss the governance session from the day before. The Governance workshop was facilitated by Mr. Bradley Chisholm, a Governance consultant and Mr. Mark MacKinnon, Executive Director, Professional Regulation & Oversight, Ministry of Health.

2. Consent Agenda

   a. Approve Agenda for 25 February 2017 *(attachment)*

   b. Approval of Board Minutes of 25 November 2016 *(attachment)*

   c. Reports from Committees *(attachments)*

   MOTION: Devita/Messenger

   That the items on the Consent Agenda for the 25 February 2017 Board meeting be approved.

   Carried

3. Business Arising from the Consent Agenda

   There was no business arising from the consent agenda.

4. Executive Limitation Reports *(attachment)*

   CDSBC Governance policy requires that the CEO report regularly on matters identified by the Board through a series of Executive Limitations policies. This is one of the ways the Board discharges its oversight obligations without delving into operational issues. The CEO routinely submits these reports to the Board.

   EL2: Treatment of Public
   EL3: Registration, Certification and Monitoring
   EL4: Treatment of Staff
   EL5: Financial Planning/Budgeting
   EL6: Financial Condition and Activities
   EL7: Emergency Registrar Succession

***MOTION*: Hawes/Jennings**

That the Board receives the following Monitoring Reports:
EL2: Treatment of Public
EL3: Registration, Certification and Monitoring
EL4: Treatment of Staff
EL5: Financial Planning/Budgeting
EL6: Financial Condition and Activities
EL7: Emergency Registrar Succession

Carried

Going forward, the Board will simply be receiving these reports, no motion required.

5. Confidentiality and Code of Conduct Agreements for Final Board Approval (Chow)

The Governance Committee edited these agreements to make them clearer. The policy development process has been incorporated. For Board members, one of the major changes is Item 2.5:

> *2.5 Refrain from speaking on behalf of the College or the Board unless explicitly authorized to do so by the Board, the President, or the Registrar. Board members may engage with stakeholders in accordance with the CDSBC Policy Development Process.*

For Committee members, one of the major changes is Item 2.6:

> *2.6 Refrain from speaking on behalf of the Committee, unless explicitly authorized to do so by the Committee Chair, President, or Registrar. Committee members may engage with stakeholders in accordance with the CDSBC Policy Development Process.*

***MOTION*: Saidi/Jennings**

That the Board approves the Confidentiality and Code of Conduct agreements for Board members and for Committee members as recommended by the Governance Committee

Carried

6. Sedation and GA Services Committee (Dr. Maico Melo, Vice Chair, Sedation & GA Services Committee)

- Moderate Parenteral Facilities Inspections Protocols

The Minimal and Moderate Sedation Standards and Guidelines call for facilities in which moderate parenteral sedation is administered to be inspected periodically. The

proposed inspection process for non-hospital parenteral moderate sedation facilities was created by a sub-committee of the Sedation and General Anaesthetic Services Committee, and analyzed and approved by the Sedation and General Anaesthetic Services Committee.

Dr. Melo directed the Board to the document provided for their review and approval. Dr. Melo reported that much consultation had taken place in the drafting of the document and that he is proud of the Sub-Committee for all the work that they have done.

The Board had a few questions about content and also editing/format of the document. After discussion it was agreed that the Board accept the document in principle with follow-up on two fronts:

1. Mr. Marburg would sit down with Dr. Hunter to review minor wording changes, and

2. A cleaned-up version of the document would be presented to the Board for final approval, recognizing that final layout and editorial/grammatical proofing would occur once the approved document is prepared for publication.

With that in mind, the Board resolved:

***MOTION*: Conn/Spitz**

That the Board approves in principle the proposed framework for the inspection process for non-hospital parenteral moderate sedation facilities.

Carried

7. Specialty Recognition

- Presentation by Dr. Peter Stevenson-Moore, Co-Chair, Specialty Recognition Working Group

Dr. Stevenson-Moore updated the Board on the *ad hoc* Board Working Group constituted to review possible criteria by which this College might undertake the review of any application for the recognition of a specialty, and to consider the feasibility of a College led process if the National (CDRAF) process was to prove to be no longer viable. This work began in 2014 under different leadership. The committee acquired an extensive library of information relating to the issue of

specialty recognition. Analysis of this information has been undertaken, and the project approaches completion.

Dr. Stevenson-Moore highlighted the fact that this matter is complex, and fraught with practical and political problems. If CDSBC were to choose to proceed, there would be the need for a significant investment of time and money in order in the short term to set up the required mechanisms for approval, and in the long-term there are cost and resource implications for the evaluation of new applicants to a new specialty, and the maintenance of quality assurance. Practically speaking, a shortage of examiners and resources to create psychometrically valid, high-stakes examinations is a significant barrier.

Dr. Stevenson-Moore said that at present, only the RCDSO recognizes Dental Anesthesiology as a specialty. Ontario provided that specialty recognition before there was a national process at the CDRAF table. The CDRAF administered process in 2014 led to a decision prefaced with an extensive body of work that established the criteria for specialty recognition. Given that CDRAF have denied specialty recognition of Dental Anesthesiology in 2014, there has been little appetite for other regulators to follow Ontario's initiative. However, at the time that the decision was made, there was concern that while the criteria for making a determination of the sufficiency of an application for specialty recognition were acceptable, the process/procedure in which the Anesthesiology application had been handled was flawed, to the extent that it could have influenced the outcome. It was on that basis that BC had voted against the receipt of the report from the CDRAF committee that was charged with determining the sufficiency of the dental anesthesiology application for specialty recognition. BC did not offer an opinion on the application, but were concerned that improvements of process may have resulted in a different outcome. Until a better process is utilized, we cannot know if the outcome might be different.

Significant changes have taken place at CDRAF since that vote was taken. The Governance structure of CDRAF has been revised. There is now an independent Chief Executive Officer. Also, the Board should be aware that the CDSBC decided to strike the *ad hoc* committee as a result of its discomfort with how the CDRAF process had been handled. The CDSBC position has been that if the CDRAF process were working as it should, these matters should be handled through that office. We have been informed that one of the action items on the CDRAF work plan is to fix the national specialty recognition process and that work on this is underway.

The Board was referred to the briefing note included in the Board package which contains detailed information on the presentation made by Dr. Stevenson-Moore, as well as a copy of his speaking notes attached.

Dr. Stevenson-Moore concluded his presentation by stating that he would happily continue to be involved if this would be of assistance to the Board.

- Presentation by Dr. Brian Chanpong and Dr. Daniel Haas

Dr. Chanpong, a General Dentist, is the Past-President of the American Dental Board of Anaesthesiology; Course director, Local Anaesthesia and Minimal Sedation, Faculty of Dentistry, UBC and Past Director of the American Dental Society of Anaesthesiology.

Dr. Chanpong gave a presentation to the Board requesting that the Board consider dental anaesthesia as a specialty. Dr. Chanpong presented to the CDSBC Board in 2014 on this same topic.

Drs. Chanpong and Haas gave an overview of the history of applications made both in the USA and Canada, as well as their views on how recognition of dental anaesthesia as a specialty could address issues of access to care for certain segments of population which may be under-served at present. They recognized that their comments and submissions require further discussion and consideration

Dr. Chanpong also referred the Board to the written application package/materials supplied to the Board, as well as his powerpoint presentation, a copy of which is appended.

The Board deferred policy discussion of this item until the later part of the meeting to be held *in camera*.

8. Bylaw Working Group – Terms of Reference (*attachment*)

The Board appointed this Working Group in November 2016.

The working group had their first meeting and discussed draft Terms of Reference included in the Board package for consideration, and if acceptable, approval.

***MOTION*: Jennings/Devita**

That the Board approve the Terms of Reference for the Bylaw Working Group as presented.

Carried

9. Presidents Report

   The President gave his report in the in camera session.

10. Deputy Registrar Report (Wiseman)

    Ms. Wiseman presented her report outlining statistics on complaint resolution.

11. Management Report *(attachment)*

    Registrar/CEO Jerome Marburg submitted a written report on behalf of the staff and management of the College.

This concludes the open portion of the meeting. Ended at 11:17 am

The remainder of the meeting will be held in camera, per Section 2.15 (9) of the College Bylaws under the *Health Professions Act*.

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CDSBC Committee Report to Board
For Public Agenda

Committee Name Inquiry Committee

Submitted by Dr. Greg Card, Chair

Submitted on 31 May 2017

Meeting Frequency From 31 January 2017, the date of the last report, until 31 May 2017, the Inquiry Committee as a whole met on the following dates:

- 28 February 2017
- 11 April 2017
- 23 May 2017

Inquiry Committee Panels met on the following dates:

- 14 February 2017
- 22 February 2017
- 07 March 2017
- 21 March 2017
- 28 March 2017
- 03 April 2017
- 12 April 2017
- 18 April 2017
- 19 April 2017
- 17 May 2017

In addition, a Panel of the Inquiry Committee meets weekly electronically to review new complaints received and direct how each new file is to be handled (normally through investigation or early resolution).

Matters Under Consideration

Between 01 February 2017 and 31 May 2017, Inquiry Committee Panels had files involving 15 dentists under review; they had been referred to a Panel because the files are complex, because the registrant has asked to meet with a Panel, or the registrant is a member of either the CDSBC Board or a College Committee.

Connection to Strategic Plan

The Board's strategic plan requires CDSBC to have a transparent, fair, effective and defensible complaints resolution process and procedures and to take active steps to help registrants enhance the standard of care they provide. The complaints process is designed to collect the information necessary to properly investigate and dispose of complaints. If minor concerns with a registrant's practice are noted they are given practice advice. More serious concerns are addressed by agreement with the registrant whenever possible. Such agreements are tailored to the particular concerns raised. When the complaint files are closed, the complainants receive a comprehensive letter outlining the investigative steps taken, what the investigation revealed and how CDSBC has disposed of the complaint. A complainant has the right to request the HPRB review any Inquiry Committee disposition of a complaint short of a citation.

Statistics/Report

62 files were opened and 69 were closed between 01 February 2017 and 31 May 2017.

CDSBC College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 3c.

CDSBC Committee Report to Board

For Public Agenda

Committee Name	Nominations Committee
Submitted by	Dr. David Tobias, Chair
Submitted on	7 June 2017
Meeting Frequency	The Committee met by teleconference on 27 February to go over the details of the awards ceremony.
Matters Under Consideration	2017 Awards Ceremony This event honoured 10 CDSBC volunteers for their contributions to CDSBC. All registrants received an invitation to attend the ceremony, held on 9 March at the Fairmont Waterfront Hotel. Approximately 100 people attended the ceremony, including award winners and their families, board and committee members, staff, and invited guests (Certified Dental Assistants of BC, CDSPI, BC Dental Association, Canadian Dental Association, UBC and other B.C. health colleges.) We were fortunate that Dr. Myrna Halpenny reprised her role as Mistress of Ceremonies. Chair Dr. Tobias did a small introduction of all Merit Award recipients recognizing them as immediate past members of the Board. Members of the committee researched the award winners and Ms. Lane Shupe and Dr. Ash Varma helped present, speaking to the true nature of each person's contributions and adding a personal touch along the way. The acceptance speeches were heartfelt and brought to fore the impact that their volunteerism with the College had on each recipient. The warmth and intimacy of the ceremony has made it an event people enjoy. Feedback received is that it was a stellar event.
Future Trends	None.

Group Shot of Recipients Recognized at 2017 Awards Ceremony

Front row: (L-R) Mr. Samson Lim, Ms. Elaine Maxwell (CDA), Mr. Jerome Marburg, CDSBC CEO/Registrar, Dr. Pamela Barias **Back row:** (L-R) Dr. Eli Whitney, Dr. Ben Balevi, Dr. Robert Coles, Dr. David Tobias, Dr. Jan Versendaal.

2017 Nominations Committee

Front row: (L-R) Ms. Lane Shupe (CDA), Dr. Don Anderson President, Dr. Myrna Halpenny **Back row:** (L-R) Dr. Ash Varma, Dr. Peter Stevenson-Moore, Dr. David Tobias Absent: Ms. Leona Ashcroft (public member).

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Board Meeting
24 June 2017
Agenda Item 3c.

CDSBC Committee Report to Board For Public Agenda

Committee Name	Quality Assurance Committee
Submitted by	Dr. Ash Varma, Chair
Submitted on	24 June 2017
Meeting Frequency	QA Committee met 23 March 2017. QA Working Group met in March and May 2017 – details outlined in the Management Report
Matters Under Consideration	Update from the QA Working Group
Future Trends	Continued discussion of direction of QA Assurance Program

Quality Assurance Working Group consists of:

Mr. Paul Durose
Dr. Alex Hird
Dr. Andrea Esteves
Ms. Shelley Melissa, CDA
Dr. Ash Varma, Chair
Dr. David Vogt

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 3c.

CDSBC Committee Report to Board For Public Agenda

Committee Name	Registration Committee
Submitted by	Dr. Alexander Hird (Chair)
Submitted on	23 June 2017
Meeting Frequency	27 January 2017
Matters Under Consideration	Communication is ongoing with QA Working Group regarding potential changes to QA program.
Statistics/Report	Three requests for renewal of full registration with limitations approved. One request for full registration from applicant who had a one month suspension in 2008, recorded in a foreign jurisdiction, that she failed to disclose on her registration application. Approved
Future Trends	Pending College by-law review will affect registration requirements and categories.

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 3c.

CDSBC Committee Report to Board For Public Agenda

Committee Name	Audit Committee and Finance & Audit Committee Working Group
Submitted by	Mr. Terry Hawes, Chair
Submitted on	5 June 2017
Meeting Frequency	10 May 2016 17 October 2016 7 November 2016 9 February 2017 16 May 2017

Matters Under Consideration

- The Committee/Working Group met with the auditor on 16 May 2017. The auditor presented the Draft Financial Statements, Audit Opinion and related information as to the fiscal 2017 Audit of the College and the Joint Venture. The Committee/Working Group also had an in-camera session with the auditor which is a critical part of the Audit process.

  The Committee/Working Group and management requested some language changes to the Notes to the Financial Statements to make these consistent with the legal framework of the College.

  The Committee/Working Group had a discussion regarding the tax-exempt status and the historical tax filings of the College. It was determined that the instructions to the auditor would be to make the requested change on a prospective basis only.

  No significant issues were raised by the auditor and the Committee/Working Group voted to recommend to the Board to approve the Draft 2017 Financial Statements which were to be amended to include the changes requested by the Committee/Working Group and Management. These changes were ultimately confirmed and these final Draft Financial Statements were presented to the Board for consideration and ultimately approved by teleconference.

- The Committee Chair met with the Registrar/CEO and staff to address various financial processes (Budget and Financial Statements), appointment of an auditor for

fiscal 2018, BCDA Fee agreement, style and detail of interim financial reporting, specific expenses (wages- travel), Strategic Plan – Mind Map, timeline and action items for the remainder of 2017 and 2018.

This discussion also included the process of Budgeting and Authorizing by the Board of inter-fund transfers.

Future Trends

- The Committee (Chair) and management have agreed to continue these discussions with the goal of improving on financial reporting processes, approvals and to expand into other related matters, e.g., Executive Limitation (EL) Reports and the appointment of required members to the Committee/Working Group.

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 3c.

CDSBC Committee Report to Board

For Public Agenda

Committee Name	CDA Advisory Committee
Submitted by	Susanne Feenstra, Chair
Submitted on	24 June 2017
Meeting Frequency	This Committee has not met since the last Board Meeting.
Matters Under Consideration	
Future Trends	Bylaw review for CDAs

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Board Meeting
24 June 2017
Agenda Item 3c.

CDSBC Committee Report to Board For Public Agenda

Committee Name	CDA Certification Committee
Submitted by	Ms. Bev Davis, Chair
Submitted on	24 June 2017
Meeting Frequency	This Committee met twice since the last Board meeting on 2 March and 3 April 2017.
Matters Under Consideration	Applications for certification, recognition of CP Hours, one reinstatement refund request. The committee established a checklist for granting certification once the applicant has practiced illegally.
Future Trends	Further discussion with regard to what are recognized continuous practise hours. Ten years from practice requirements.

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Board Meeting
24 June 2017
Agenda Item 3c.

CDSBC Committee Report to Board For Public Agenda

Committee Name Ethics Committee

Submitted by Dr. Kenneth Chow, Chair

Submitted on June 5, 2017

Meeting Frequency

25 April 2016 (Article 5 Subcommittee)
4 May 2016
30 November 2016
9 January 2017 (Article 5 Subcommittee)
23 January 2017
6 March 2017 (Article 5 Subcommittee)
5 April 2017
25 April 2017 (Article 5 Subcommittee)

Matters Under Consideration

- **Advertising and Promotional Guidelines – Bylaw 12**

  There is a revision of the Bylaw that is out for public consultation which addresses the potential of a legal challenge. It essentially allows degrees and designations as long as they are written out fully for the public to understand and are accompanied by the location and dates of the course or program.

- **Article 5 Review**

  A subcommittee worked on reviewing Article 5 and found seven items that were not captured in the new Bylaws under the *HPA*. The review has been completed and is being forwarded to the Board for discussion.

- **Corporatization and Corporate Structures**

  There is ongoing analysis of the data collected regarding corporate structures and the different types of business models. Further review is ongoing. However, all business models must consider the patient first and foremost which has been captured in several documents regarding Patient-Centered Care and the Business of Dentistry, Building the Dentist/Patient Relationship, Standards of Practice, and the *Code of Ethics* with its Core Values and Principles.

- **Third Party Billing (Lab Fees)**

  A recommendation regarding lab fees and any other third party billing is being forwarded to the Board for consideration. It essentially states that patients must be treated fairly and not be subjected to artificially inflated or hidden fees for no value-added services that are attached to third party billings.

Connection to Strategic Plan

- Following the Mission statement – “in the public interest”
- Following the Mandate – “Establishes, monitors, and regulates standards of practice, guidelines for continuing practice and ethical requirements for all dentists and CDAs”

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Board Meeting
24 June 2017
Agenda Item 3c.

Governance Committee Report to Board For Public Agenda

Committee Name	Governance Committee
Submitted by	Dr. Susan Chow, Chair
Submitted on	24 June 2017
Meeting Frequency	Since the last Board meeting, the committee met on the following dates:

23 March 2017 (HR firm interviews)

18 April 2017 (Susan, Don and Jerome met with Dr. Charlesworth) To discuss the contributors to building the process.

24 April 2017: the Governance Committee met by teleconference to discuss policy regarding the Repository of Registrar/CEO HR files (committee only)

26 April 2017:Teleconference Board Meeting-presented Interim Report to the Board -obtained preliminary approval on the direction the Committee is taking for the repository of the CEO HR files.

17 May 2017 (meeting with Dr. S. Charlesworth to discuss the Summary of discovery and Recommendations in addition to the regular meeting involving recommendation of the Board committee appointments)

24 May 2017 (Susan, Don, Jerome, S. Charlesworth) to discuss the process details.

To continue the process building of the CEO Evaluation and Board self-assessment

Board workshop on CEO evaluation and Board self -assessment

Update the committee membership list as it changes

Feedback to the Bylaw Working group on the proposed Bylaw 4

The committee strives to perform its duties and responsibilities under the areas of board and committee human resources, governance, and policy review.

CDSBC College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 3c.

CDSBC Committee Report to Board for Public Agenda

Committee Name: Sedation and General Anaesthetic Services Committee

Submitted by: Dr. Tobin Bellamy, Chair

Submitted on: 24 June 2017

Meeting Frequency: 27 February 2017
10 April 2017
19 June 2017

Matters Under Consideration

The framework for the inspection process for Non-Hospital Moderate Sedation Facilities was created by a working group and was presented to the Board in February of 2017. The document has been revised and will be submitted for final approval by the Board 24 June 2017.

A working group on Pediatric Sedation is evaluating the current document to make sure that Pediatric Moderate Sedation Standards are appropriate.

A working group on Deep Sedation and General Anaesthesia is working on the revision of the Deep Sedation and the General Anaesthetic Services Standards and Guidelines.

Statistics/Report

Since the last Board Meeting, the Committee has approved the tri-annual inspection of one deep sedation facility. The initial inspection of four new deep sedation facilities are underway. Six deep sedation facilities are in the tri-annual inspection process.

The tri-annual inspection of one general anaesthesia facilities was approved. The initial inspection of one new general anaesthesia facility is in the inspection process. Two general anaesthesia facilities are in the tri-annual inspection process.

Annual self-assessments are sent to a rota of the Committee for approval. Nine self-assessments have been approved since the last Board meeting.

Eleven Registration of Qualifications applications were received, Six were approved. Five are awaiting approval at the next Committee Meeting.

Future Trends

The process for inspection of moderate sedation facilities is being finalized. The recruitment of inspectors for moderate sedation facilities will commence late 2017.

POLICY EL 2: TREATMENT OF THE PUBLIC

With respect to interactions with the public, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
1	**Use forms that elicit information for which there is no clear necessity.**	**Forms collect only the information required.**
2	**Use methods of collecting, reviewing, transmitting, or storing information that fail to protect against improper access to the material elicited.**	**CDSBC has secure document storage facilities for all hard copies. Confidential shredding is used throughout the office for destruction of documents with sensitive information when those documents are slated for destruction. Electronic files are protected by industry standard firewalls and end-point security hardware and software.**
3	**Fail to operate facilities with appropriate accessibility and privacy.**	**CDSBC offices are accessible to any of those staff who require access. Premises are alarmed and monitored. Keypad security is maintained for main office and Suite 103 entry. Private offices and meeting spaces are available and used when required to maintain privacy.**

POLICY EL 2: TREATMENT OF THE PUBLIC

With respect to interactions with the public, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
4	**Fail to establish with members of the public a clear understanding of what may be expected and what may not be expected from the College, including the processes it employs in adjudicating public complaints.**	**Registrar reports compliance. Details are included in complaints and discipline reports tabled at the Board meeting by the Deputy Registrar.** **The CDSBC website contains helpful information about complaints, including a designated "news feed" on the homepage, a complaints form, and a detailed description of the complaints process. A new public-friendly BC Health Regulators video that explains how health colleges investigate complaints has been added to the site.** **Members of the public who contact the College about how to make a complaint or about the complaint process are provided with information promptly. Work is underway to develop and implement an "online" complaint process to help people resolve potential complaints themselves and to lodge a complaint otherwise.** **Beginning March 2016, complainants and registrants about whom a complaint has been made are asked to complete an exit survey upon the closure of the file. This one-year pilot project has been extended for another year.**
5	**Fail to adjudicate complaints as expeditiously as possible.**	**We have made significant progress in this area. More complaint files have been closed than opened so far this fiscal year. However in recent months, the volume of new complaints has started to rise.**

POLICY EL 2: TREATMENT OF THE PUBLIC

With respect to interactions with the public, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
6	**Fail to deal with public inquiries as expeditiously as possible.**	**All inquiries from the public are dealt with as expeditiously as possible. The Director of Communications, in consultation with the Registrar/CEO, responds to media inquiries as quickly as possible.**
7	**Fail to employ alternate dispute resolution where appropriate.**	**CDSBC resolves approximately 90% of all complaints through alternative dispute resolution. CDSBC has deployed resources to place more emphasis on early resolution through appropriate dispute resolution techniques. With the reduction in the backlog of complaints, staff dentists are trying to resolve complaints quickly after a formal complaint is received if the matter is susceptible to early resolution.**

Respectfully Submitted By:

Jerome M. Marburg
Registrar and CEO

Date: 7 June 2017

POLICY EL 3: TREATMENT OF REGISTRANTS

With respect to interactions with registrants, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
1	**Use forms that elicit information for which there is no clear necessity.**	**Forms (both paper and electronic) collect only relevant/statutory information needed for registration. Personal assurance of registration staff and review of Registrar/CEO are evidence of compliance. Changes to renewal process for the 2017/18 year: registrants are not required to input dental corporation information but the system displays the information that they had inputted the previous two years; and 3 questions added relating to personal data needed for the new criminal record check upload process.**
2	**Use methods of collecting, reviewing, transmitting, or storing information that fail to protect against improper access to the material elicited.**	**CDSBC database is secured with password protection and is located on internal servers behind firewall and industry standard end-point protection. Access to said database is restricted to only those persons requiring access for their job functions. Physical files are kept in locked cabinets wherever personal or sensitive information is present. Disposition of paper documents done by confidential shredding. We are now filing all new applications for registration and certification electronically and storing the paper version on-site for one year. All of our active registrant files have been scanned and saved electronically.**
3	**Fail to register applicants as expeditiously as possible.**	**Application process generally is completed within 2-3 weeks unless extenuating circumstances present. We are in late stages of developing an online registration/application process which will further streamline the application process. This project has been delayed until mid 2017 given other IT priorities. As of 1 March 2017 we moved to the new process for submitting Criminal Record Checks (CRC). CDSBC now sends an upload of data for the CRC applications for our new applicants and on our registrants' behalf for their 5-year checks. This process has reduced the time it takes to receive the clearance letters significantly from about 5-8 weeks down to 1-3.**

POLICY EL 3: TREATMENT OF REGISTRANTS

With respect to interactions with registrants, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
4	**Fail to establish with registrants a clear understanding of what may be expected and what may not be expected from the College, including the processes it employs in adjudication of public complaints.**	**The College communicates its expectations for registrants in a variety of ways, such as publications (electronic and print), through courses and presentations. Our newest course, More Tough Topics (about informed consent and other topics that can lead to complaints) will be launched as an online course in Spring 2017. Planning is also underway for a joint course with the BCDA for new registrants.**
5	**Fail to adjudicate complaints as expeditiously as possible.**	**The backlog of complaints has been eliminated. The College continues to close more complaint files than it opens with the result that the inventory has been significantly reduced. In March 2016 we introduced an exit survey pilot project for registrants and complainants. Registrants who are the subject of a complaint are invited to complete an exit survey upon the closure of the complaint. This project has been extended for a second year. The results will be used to improve the complaints process.**
6	**Fail to employ alternative dispute resolution where appropriate.**	**The Complaints team seeks to negotiate solutions at the Inquiry Committee's direction when possible on files where concerns have been identified.**
7	**Fail to respond to registrants' inquiries as expeditiously as possible.**	**All inquiries, whether from registrants or members of the public, are responded to promptly. When a prompt response is not possible, persons are informed of this fact and when a response may be expected.**

POLICY EL 3: TREATMENT OF REGISTRANTS

With respect to interactions with registrants, the Registrar shall not cause or allow conditions, procedures, or decisions which are unfair, unreasonable or disrespectful.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
8	**Fail to develop a College communication strategy.**	**Communications materials support the strategic plan and makes use of new communications tools where appropriate. Although most communication with registrants is electronic, the College uses other methods when warranted. In support of the new policy development framework, we are hosting a series of "listening sessions" with registrants and stakeholders. To improve transparency, we are adding a forum to the website to share comments from registrants and the public in response to public consultations. The College is responsive to trends or issues as they arise.**
9	**Propose registration fees to the Board without a clear rationale.**	**All registration fees are tied to budget and budgeting process over which the Board has oversight and through which the Board and Audit/Finance Committee are consulted. The annual report includes a detailed graphic breakdown to illustrate how registrant fees are allocated to the various functions.**

Respectfully Submitted By:

Jerome M. Marburg
Registrar and CEO

Date: 31 MAY 2017

POLICY EL 5: FINANCIAL PLANNING/BUDGETING

Due Date: Quarterly - Jun, Sep, Dec, Feb

Financial planning for any fiscal year shall not deviate materially from the Board's Ends priorities, risk fiscal jeopardy, or fail to be derived from a business plan.

Further, without limiting the scope of the foregoing by this enumeration, the Registrar shall not plan in a manner that:

	Policy	Response/Report
1	**Risks the organization incurring those situations or conditions described as unacceptable in the Board's policy Financial Condition and Activities.**	Registrar/CEO reports compliance per EL 6 report.
2	**Fails to include credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.**	Monthly financial statements, forecast, and Budget are evidence of compliance.
3	**Fails to maintain a contingency reserve.**	Registrar/CEO reports compliance per EL 6 report.

Respectfully Submitted By:

Jerome M. Marburg
Registrar and CEO

Date: 31 May 2017

POLICY EL 6: FINANCIAL CONDITIONS AND ACTIVITIES

Due Date: Quarterly - Jun, Sep, Dec, Feb

With respect to ongoing financial condition and activities, the Registrar shall not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Ends policies.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
1	**Expend more funds than have been received in the fiscal year to date unless the debt guideline (see 2 below) is met.**	**CDSBC does not debt finance. Financial statements reported monthly show that expenditures do not exceed revenues.**
2	**Indebt the organization in an amount greater than 5% of the annual revenue.**	**CDSBC does not debt finance.**
3	**Use any contingency reserves except as authorized by an extraordinary motion of the full Board.**	**No transfers are undertaken without a Board motion. No contingency reserves have been utilized since last report.**
4	**Fail to report to Board at the earliest opportunity the amount by which any item in the approved operating or capital budget is forecasted to exceed the budget for a category.**	**Monthly financial statements are reviewed with the Board Officers and variances are discussed. Monthly financial statements are also shared with the Audit Committee and Finance & Audit Working Group, and the latest financial statements are received at each Audit Committee and Finance & Audit Working Group meeting. Financial statements are tabled at each Board meeting showing performance against budget. Staff report any item in the approved operating or capital budget that is forecasted to exceed the budget of any category, in the MD&A Report or verbally at the Board meeting.**

POLICY EL 6: FINANCIAL CONDITIONS AND ACTIVITIES

Due Date: Quarterly - Jun, Sep, Dec, Feb

With respect to ongoing financial condition and activities, the Registrar shall not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Ends policies.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
5	**Authorize the payment of any item that was included in the approved operating or capital budget in an amount that will exceed the approved budget for that category by more than $50,000.**	**Registrar/CEO reports compliance.**
6	**Fail to obtain authorization from Board before committing the College to any operating or capital expenditure not included in the approved operating or capital budget that exceeds $25,000 or that creates or increases a cash flow deficiency for the current fiscal year.**	**Registrar/CEO reports compliance.**
7	**Fail to settle payroll and debts in a timely manner.**	**Registrar/CEO reports compliance. All payroll obligations are being met.**

POLICY EL 6: FINANCIAL CONDITIONS AND ACTIVITIES

Due Date: Quarterly - Jun, Sep, Dec, Feb

With respect to ongoing financial condition and activities, the Registrar shall not cause or allow the development of fiscal jeopardy or a material deviation of actual expenditures from Board priorities established in Ends policies.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
8	**Allow tax payments or other government ordered payments or filings to be overdue or inaccurately filed.**	**Registrar/CEO reports compliance.**
9	**Acquire, further encumber or dispose of real property.**	**Registrar/CEO reports compliance.**
10	**Fail to aggressively pursue receivables after a reasonable grace period.**	**All receivables are recovered in a timely manner. CDSBC has one outstanding debt owed to it arising from Discipline case cost/disbursements and fine. We are pursuing collections, however the financial situation of the former registrant may make collection difficult.**

Respectfully Submitted By:

Jerome M. Marburg
Registrar and CEO

Date: 2 June 2017

POLICY EL 8: ASSET PROTECTION

Audit Committee: Annually - April

The Registrar shall not allow the College's assets to be unprotected, inadequately maintained or unnecessarily risked.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
1	**Fail to insure against theft and casualty losses to at least 80% replacement value and against liability losses to Board members, staff and the organization itself in an amount greater than the average for comparable organizations.**	**Registrar/CEO reports compliance. Following is a general summary of the main policies in place. In addition, all CI's carry required CDSPI insurance.** **Theft - The property policy protects against theft (propery coverage is on a replacement cost basis). There is also crime coverage in place that would cover against theft as well. The distinction between the two: the crime policy is designed to cover against theft of money (currency, cheques, money orders etc.) and securities.** **Casualty - the commercial general liability policy protects the Board, staff (including volunteers) and the organization from liability arising from bodily injury or property damage to a third party.** **The commercial general liability policy protects against liabilities arising out of bodily injury and property damage. There is also the non-profit organization liability policy that protects the liabilities of the Board, staff (including volunteers) and the organization itself. This is more commonly referred to as the Directors and Officers policy and offers protection for the following:** **Directors and Officers Liability: Covers liabilities arising out of the activities of governing the organization.** **Employment Practices Liability: Covers liabilities from employment related claims (wrongful dismissal, sexual harassment, failure to promote, etc.).** **Professional Liability: covers negligent act, negligent error or negligent omission committed or alleged to have been committed by the insured in the performance of Professional Services (regulatory activities).**
2	**Subject property and equipment to improper wear and tear or insufficient maintenance.**	**All equipment is on appropriate maintenance schedules. Staff are made aware of proper use and care expectations.**

POLICY EL 8: ASSET PROTECTION

Audit Committee: Annually - April

The Registrar shall not allow the College's assets to be unprotected, inadequately maintained or unnecessarily risked.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
3	**Unnecessarily expose the organization, its Board or staff to claims of liability.**	**Registrar/CEO reports compliance.**
4	**Make any purchases or award any contract: (a) wherein normally prudent protection has not been given against conflict of interest; (b) of over $25,000 without having obtained comparative prices and quality. Orders shall not be split to avoid these criteria.**	**Registrar/CEO reports compliance. All contracts over $5000 require multiple competitive bids. Best value bid is chosen.**
5	**Fail to take reasonable steps to protect intellectual property, information and files from loss or significant damage.**	**CDSBC secures all physical files. All electronic files are routinely backed up, with historical tape backups spanning multiple years held off-site. Critical files and configuration parameters are backed up and stored off-site as well. IT systems have built-in redundancies and daily local backups to disk.**
6	**Fail to implement the auditor's recommendations with respect to financial internal controls.**	**Registrar/CEO reports compliance.**

POLICY EL 8: ASSET PROTECTION

Audit Committee: Annually - April

The Registrar shall not allow the College's assets to be unprotected, inadequately maintained or unnecessarily risked.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
7	**Fail to ensure the following cheque signing authorities: A) two signatures for cheques up to $25,000 from the following: President, Vice-President, Treasurer, Registrar, Deputy Registrar, Director of Registration and HR, Director of Communications. B) two signatures for: (i) cheques over $25,000 of an unbudgeted item - one from each of the following two groups: i) President, Vice-President or Treasurer; ii) Registrar, Deputy Registrar, Director of Registration and HR, or Director of Communications; (ii) cheques over $25,000 of a budgeted item - two signatures from the following: President, Vice-President, Treasurer, Registrar, Deputy Registrar, Director of Registration and HR, or Director of Communications. With the exceptions that: ii) The Registrar, Deputy Registrar, Director of Registration and HR, or Director of Communications, shall not act as a signing officer for an expense that they have approved. iii) No individual shall be a signing officer for a cheque of which they are the payee.**	**All cheques are signed in compliance with this policy.**

POLICY EL 8: ASSET PROTECTION

Audit Committee: Annually - April

The Registrar shall not allow the College's assets to be unprotected, inadequately maintained or unnecessarily risked.

Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:

	Policy	Response/Report
8	**Invest or hold operating capital in insecure instruments or bonds of less than AA rating at any time, or in non interest-bearing accounts except where necessary to facilitate ease in operational transactions.**	**Registrar/CEO reports compliance.**
9	**Fail to establish appropriate procedures governing the confidentiality, disclosure, safekeeping and eventual disposition of all records over which the Board has jurisdiction.**	**CDSBC's electronic records management system includes file plans and records retention and disposal policies and procedures in compliance with this and other requirements. An extensive security and privacy assessment has been undertaken and industry standard policies/procedures are being documented. All current records are retained and secured/backed up as per statements above.**
10	**Fail to protect title and ownership of the College building and equipment.**	**Registrar/CEO reports compliance.**

Respectfully Submitted By:

Jerome M. Marburg
Registrar and CEO

Date: 2 June 2017

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 6.

Quarterly Report

Registration and Certification

1 February 2017 – 30 April 2017

Prepared for the Board

Overview

The Registration/Certification Team, consisting of the Director of Registration & HR, the Senior Manager, CDA Certification and Quality Assurance and four support staff, are responsible for all aspects of registration of dentists and certification of certified dental assistants. It is also responsible for the CDA Certification Committee, CDA Advisory Committee, Registration Committee, Quality Assurance Committee and the Quality Assurance CE Subcommittee.

The following represents a statistical breakdown of the activity in these areas for the period 1 February 2017 – 30 April 2017 inclusive.

Where available, the previous year's statistics for the same period (1 February 2016 – 30 April 2016) are provided in brackets.

Continuing Education
Dentists & Certified Dental Assistants

Continuing education credit submissions are received electronically, by mail and fax and applied to each registrant's Transcript of Continuing Education. Of the more than 10,000 registrants, 3359 have their three-year cycle ending 31 December 2017.

In late August or early September, transcripts are mailed to all registrants with unfulfilled cycles ending that year.

DENTIST STATISTICS		
Practising Dentists - 3496		
NEW REGISTRATIONS		
	1 Feb 2017 – 30 Apr 2017	1 Feb 2016 - 30 Apr 2016
Full Registrations issued (includes Specialists)	43	36
Restricted to Specialty Registrations issued	1	1
Academic Registrations issued	0	0
Limited Registrations issued:		
• Armed services or government	0	0
• Education	0	1
• Post-graduate	0	1
• Research	0	0
• Student practitioner	0	0
• Volunteer	0	0
Temporary Registrations issued	23	15
Non-practising Registrations issued	0	0
GENERAL		
Transfers from Non-practising to Practising	6	6
Transfers from Practising to Non-practising	29	38
Lapsed	88	76
Reinstated	25	13
Resigned/Retired	45	57
Retired (annual $50 fee)	25	38
Deceased	2	6

CDA STATISTICS		
Practising CDAs - 5715		
NEW CERTIFICATIONS		
	1 Feb 2017 – 30 Apr 2017	1 Feb 2016 - 30 Apr 2016
Practising Certifications issued	35	38
Temporary Certifications issued	16	11
Temporary-Provisional Certifications issued	0	0
Limited Certifications issued	2	0
Non-practising Certifications issued	0	0
GENERAL		
Transfers from Non-practising to Practising	35	33
Transfers from Temporary to Practising	3	7
Transfers from Temporary-Provisional to Practising	3	2
Transfers from Limited to Practising	0	0
Lapsed	502	430
Reinstated	198	174
Resigned/Retired	108	100
Retired (annual $25 fee)	33	34
Deceased	0	1

Module designations granted

Orthodontic Module – 3 (3)
Prosthodontic Module – 3 (7)
Dental Radiography Module 26 (*)

CDA Assessments

Initiated assessments:

- 16 (18)

Certification issued as a result of assessment:

- 18 (18)

DRAFT – For Board Approval

College of Dental Surgeons of British Columbia

Facial Aesthetics Working Group

Terms of Reference

Board Meeting
24 June 2017
Agenda Item 7.

Objects

1. The objects of the Facial Esthetics Working Group (the "WG") of the College of Dental Surgeons of British Columbia are:

   (a) To provide research, analysis and advice on the meaning of, and what is/is not captured by the term in the Dental Regulation -- "orofacial complex and associated anatomical structures"

   (b) Provide an framework based on this definition to analyze whether and to what extent:

      (i) Neuromodulators

      (ii) Facial fillers; and/or

      (iii) Other treatments, procedures, devices, etc.

   fall within the defined term "orofacial complex and associated anatomical structures".

   (c) Determine terms and conditions under which practitioners may provide services in any of the areas analyzed in 1(b)(i-iii), which may without limiting include:

      (i) Registration Category;

      (ii) Education/Experience;

      (iii) Qualifications/Certification;

      (iv) Representation of training/qualifications to patients

      (v) Patient Consent.

Composition

2. The WG is appointed by the College Board and consists of up to 6 members.

Term of Membership

3. The Board may remove a member from the WG at any time and appoint a new member in his or her place.

4. A member may resign from the WG at any time on providing written notice to the Board.

Meetings

5. The WG should meet with sufficient frequency to ensure timely fulfillment of its objects.

6. The WG may meet using any combination of members attending in person or by way of electronic media that permits effective communication.

Quorum

7. Quorum for a meeting of the WG is a majority of the members.

WG Chair

8. The Board must designate one member of the WG to serve as Chair.

9. In addition to presiding at WG meetings, the Chair will

    (a) work with College staff to schedule and coordinate meetings, including ensuring that all WG members receive

        (i) reasonable notice of each meeting, and

        (ii) timely delivery of all information to be considered at a meeting, and

    (b) report as needed to the Board regarding the work of the WG.

10. The Chair may resign that position at any time on providing written notice to the Board.

11. The WG will consult with College staff on the preparation of its written recommendations to the Board, recognizing the WG members are the subject matter experts.

Recommendations to the Board

12. Upon completion of a set of recommendations for presentation to the Board, the WG will forward the draft recommendations to the Board with its written recommendation to the Board on consultation in accordance with the Policy Development Process.

Approved by _____

Date: _____

500 – 1765 West 8th Avenue
Vancouver BC Canada V6J 5C6

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SELF-ASSESSMENT
FOR PARENTERAL (IV) MODERATE SEDATION FACILITY

The following attestation must be completed by the facility owner and submitted by the due date, along with the required documentation.

Facility Name: _____

Facility Owner(s)/Director(s): _____

Contact Information

Street Address: _____

_____

City: _____ Province: _____Postal Code: _____

Telephone: _____ Fax: _____

Email: _____ Website: _____

Section 1

Please confirm the following by checking (√) the adjacent box:

1. **Sedation Team**

☐ The sedation provider(s) has their qualifications registered with the CDSBC.

☐ The dentist providing sedation has current certification in ACLS, or an appropriate equivalent (PALS if sedating children).

☐ If sedating patients 12 years of age and under, the dentist has current certification in PALS.

Please note that there is a one-year moratorium (starting on 25 November 2016) on the approval of certification to provide moderate sedation to patients 12 years and under, for dentists who have learned the modality in a short course format (i.e. less than one year).

☐ All clinical staff are current in BLS (CPR-HCP).

☐ The Moderate Sedation Assistant(s) has/have the appropriate training/ qualifications (logged and verified).

☐ The sedation team consists of a minimum of three individuals per the Minimal Moderate Sedation Standards.

☐ The facility has written protocols for emergency procedures (fire, earthquake, power failure, evacuation).

☐ The sedation team conducts mock emergency drills as stipulated in the Standards and Guidelines (excerpt referenced below), and a logbook is kept.

Mock Drill – a dedicated clinical session, which takes place within the facility, in which sedation team members practice the management of medical and/or anesthetic emergencies, as if an actual emergency occurred.

12.2 Recommendations and Requirements for Emergency Drills

1. Dentists and sedation team members who administer minimal sedation only, should participate in mock emergency drills at least every six months.
2. Dentists and sedation team members who administer moderate enteral or parenteral sedation must participate in mock emergency drills at least every three months.
3. Mock drills must include, but are not limited to, difficult airway management, anaphylaxis, laryngospasm, unresponsiveness, seizure and cardiac arrest.
4. An up-to-date record of emergency drills, including names of participants and scenarios covered, must be kept on the premises at all times and be available t for inspection.
5. If the facility utilizes the services of a visiting dentist or physician to administer sedation, they must have documented, up-to-date participation in mock drills.

☐ Each team member knows the contents and location of the emergency cart/kit.

2. Records

☐ Written and verbal pre-anaesthetic instructions are given to each patient or guardian.

☐ Written informed consent is obtained from each patient or guardian for the anaesthetic.

☐ Pre-Sedation patient instructions are followed. (Appendix M)

The following items are recorded on the Pre-Anaesthetic Record:

- ☐ Patient demographics
- ☐ Signed and dated medical history questionnaire
- ☐ Pertinent physical findings (review of systems, airway assessment)
- ☐ Preoperative vital signs
- ☐ For patients with significant medical considerations (ASA III), the dentist consults with primary care physician or medical specialist as appropriate

The following items are recorded on the Anaesthetic Record:

- ☐ Verification of NPO status, escort, medication, allergies, BMI, ASA status, Stop Bang
- ☐ IV access location and fluids administered
- ☐ List of drugs administered, including time, dose, and route
- ☐ List of all monitors/appliances used
- ☐ Blood pressure, pulse rate, respirations and oxygen saturation are monitored and recorded per the Sstandards and Guidelines
- ☐ Record of end-tidal carbon dioxide (with capnography) or record of using amplified, audible pretracheal stethoscope. (If an amplified, audible pretracheal stethoscope is used, the audible output must be monitored by more than one sedation team member.)
- ☐ Start and end time of anaesthetic

The following items are recorded for Recovery:

- ☐ Initial and periodic record of blood pressure, pulse rate, oxygen saturation, respiration, level of consciousness and general status
- ☐ Dose, time, route, site, reason for administration and response to any administered medications
- ☐ Verification of discharge criteria

☐ Verification of provision of verbal and written post anaesthetic instructions

☐ Identification of discharge time and accompanying responsible individual

☐ Name and signature of responsible recovery personnel

In the event of a critical incident it is immediately reported to the Registrar of the CDSBC

3. Infection Control

☐ Universal precautions are used in handling all patient materials.

☐ Staff ~~consistently~~ wash their hands between each patient contact~~s~~.

☐ IV bags, tubing and connectors are discarded between patients.

☐ The same syringe is never used to administer medication to more than one patient, even if the needle was changed.

☐ Sharp devices are handled properly and disposed of in dedicated puncture- resistant biohazard containers.

☐ There is a policy and procedure for management of significant exposures. (Documented and available upon request and/or during inspection) Note: Worksafe BC requirements also need to be met.

4. Recovery and Discharge

☐ There are appropriately trained staff supervising patient recovery. (Reference Section 11.6 in the Standards and Guidelines)

☐ The practitioner administering sedation remains with the patient during recovery until care is transferred to an appropriately trained person. (Reference Section 11.6 in the Standards and Guidelines)

☐ All recovering patients are continuously supervised and monitored using clinical observation and ~~physiologicalmonitoring~~physiological monitoring.

☐ The dentist determines and documents that the level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge. (Reference Appendix N in the Standards and Guidelines)

5. Medical Gas

☐ If the facility has a built-in or "in-wall" medical gas piping and distribution system, it has been inspected and received CSA certification.

☐ A system is in place to designate who turns medical gases on and off each day.

☐ N/A

6. Patient Monitoring/Emergency Equipment

☐ All emergency equipment and drugs are provided by either the facility owner or the visiting dentist/physician. **The shared provision of emergency equipment and drugs is prohibited.**

☐ The facility owner ensures all emergency equipment and drugs are on site prior to providing moderate sedation.

☐ The facility has a sufficient number of physiologic patient monitors to meet or exceed the monitoring requirements of the Standards and Guidelines.

☐ At least one of the facility's patient physiologic monitors (NIBP, HR, SaO_2, ECG has battery power backup.

☐ A portable, battery powered emergency suction unit is immediately available to the sedation/recovery areas. The unit's charging status is checked weekly, with results documented in a logbook.

☐ A manual defibrillator and/or AED is present.

☐ Capnography or amplified, audible pretracheal stethoscope is present.

☐ All equipment is certified by an organization such as CSA that is accredited by the Standards Council of Canada to approve medical equipment, and the monitors bear the mark or label of the certifying organization.

☐ All equipment is inspected and/or serviced at least annually (If a manual defibrillator is used it must be inspected every 6 months).

☐ Details of all inspections/servicing are kept in a logbook that is available at all times.

☐ Inspection/servicing is carried out by either a registered biomedical engineer or biomedical technologist/technician.

☐ An AED is visually checked daily and a manual defibrillator is tested semi-monthly, with results kept in a logbook and available at all times.

7. Essential Airway Equipment

☐ The essential airway equipment outlined in the Standards and Guidelines are readily available. (Appendix K)

☐ A ventilation apparatus or bag valve mask (i.e. Ambu Bag) suitable for the patient being treated is immediately available in both treatment and recovery areas.

8. Moderate Sedation Drugs and Supplies

☐ Drugs are clearly identified and stored/discarded in an appropriate manner and in accordance with the Standards and Guidelines.

☐ Emergency medications required for moderate sedation per the Standards (Appendix D) are present and readily available.

☐ Emergency and sedation medications are replaced prior to their expiry date.

☐ Targeted substances (benzodiazepines, opioids) are kept in a securely mounted and locked cabinet.

☐ Keys to the cabinet are kept in a secure, separate location with limited, authorized access.

☐ An up to date logbook is kept with detailed records of counts and reconciliations.

☐ The logbook is kept in the office at all times, in a secure location, ~~separatefrom~~separate from the drug cabinet.

Any identified loss or theft is reported to Health Canada within 10 days

☐ Intravenous Equipment and Supplies are available per the Standards and Guidelines. (Appendix O)

I, _____, confirm and certify the above to be accurate
(*Name of Responsible Dentist)*
and true.

_____ _____
Signature of Responsible Dentist Date

Section 2

Please complete the following:

- ☐ A list of all sedation monitoring equipment (including AED/dDefibrillator) and their current inspection and service status
- ☐ Current inspection status for the medical gas pipeline system (if applicable)

FACILITY STAFF QUALIFICATIONS

Physician(s) or Dentist(s) providing moderate sedation:

Name _____ College # _____

☐ Certified Specialist ☐ General Practitioner ☐ BLS ☐ ACLS ☐ PALS

Name _____ College # _____

☐ Certified Specialist ☐ General Practitioner ☐ BLS ☐ ACLS ☐ PALS

Dentist(s) providing dental treatment:

Name _____ College # _____

☐ Certified Specialist ☐ General Practitioner ☐ BLS ☐ ACLS ☐ PALS

Name _____ College # _____

☐ Certified Specialist ☐ General Practitioner ☐ BLS ☐ ACLS ☐ PALS

Name _____ College # _____

☐ Certified Specialist ☐ General Practitioner ☐ BLS ☐ ACLS ☐ PALS

Moderate Sedation Assistant(s)

Name _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Name _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Name _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Name _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Name _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Name _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Operative Assistant(s)

Name_____ ☐ CPR HCP

Name_____ ☐ CPR HCP

Name_____ ☐ CPR HCP

Equipment List:

Description	Serial Number	Last Inspection Date	Status (Pass/Fail/Repaired)

Please include: physiological monitors, back-up suction, AED, pulse oximeter etc.

Medical Gas Pipeline System:

☐ **N/A**

Installation Date	Last Inspection	Status

☐ Does the facility provide moderate sedation to patients 12 years of age or under?

☐ If yes, what is the youngest age sedated in the facility?

☐ Who supplies / provides all the emergency equipment and emergency drugs?

☐ The shared provision of emergency equipment and drugs is prohibited.

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ON-SITE INSPECTION OF NON-HOSPITAL PARENTERAL MODERATE SEDATION FACILITIES

Facility Name: _____

Facility Owner(s)/Director(s): _____

Contact Information

Street Address: _____

_____

City: _____ Province: _____Postal Code: _____

Telephone: _____ Fax: _____

Email: _____

FACILITY STAFF QUALIFICATIONS

Physician(s) or Dentist(s) providing moderate sedation:

Name: _____ College #:_____

☐ Certified Specialist ☐ General Practitioner ☐ BLS ☐ ACLS ☐ PALS

Name: _____ College #:_____

☐ Certified Specialist ☐ General Practitioner ☐ BLS ☐ ACLS ☐ PALS

Dentist(s) providing dental treatment:

Name: _____ College #:_____

☐ Certified Specialist ☐ General Practitioner ☐ BLS ☐ ACLS ☐ PALS

Name: _____ College #:_____

☐ Certified Specialist ☐ General Practitioner ☐ BLS ☐ ACLS ☐ PALS

Name: _____ College #:_____

☐ Certified Specialist ☐ General Practitioner ☐ BLS ☐ ACLS ☐ PALS

Moderate Sedation Assistant(s):

Name: _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Name: _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Name: _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Name: _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Name: _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Name: _____

☐ CPR HCP ☐ DAANCE ☐ CDAAC or equivalent

Operative Assistant(s):

Name: _____ ☐ CPR HCP

Name: _____ ☐ CPR HCP

Name: _____ ☐ CPR HCP

Name: _____ ☐ CPR HCP

1. MODERATE SEDATION TEAM	YES	NO
a. Are staff BLS certificates current?	☐	☐
b. Are only qualified dentists/physicians, as stipulated in the Standards and Gguidelines, currently providing moderate sedation services?	☐	☐
c. Do the Moderate Sedation Assistants have the appropriate training/qualifications as stipulated in the Standards and Gguidelines?	☐	☐
d. Do the Operative Assistants have the appropriate training/ qualifications as stipulated in the Standards and Gguidelines?	☐	☐
2. RECORDS	**YES**	**NO**
a. Do the pre-sedation instructions include restrictions regarding pre-sedation food/fluids?	☐	☐
b. Is the pre-sedation informed consent consistent with the requirements of the Standards and Gguidelines?	☐	☐
c. Does each pre-sedation record include areas for the provider to document the following?:	☐	☐
- patient demographics	☐	☐
- preoperative vital signs *(BP, pulse, respirations, SaO_2)*	☐	☐
- pertinent physical examination findings	☐	☐
d. Does each sedation record include areas for the provider to document the following?:	☐	☐
- verification of NPO status, escort, medication allergies and body weight	☐	☐
- intravenous access location and fluids administered	☐	☐
- list of all drugs administered including dose, time, and route of administration	☐	☐
- list of all monitors, airway devices used	☐	☐
- record of blood pressure, pulse rate, respirations, and oxygen saturation	☐	☐
- record of end-tidal carbon dioxide (with capnography) or record of using amplified, audible pretracheal stethoscope (audible output must be monitored/documented by more than one sedation team member)	☐	☐
- start and end time of anaesthetic	☐	☐

e. Does the recovery record include areas for the provider to document the following?:

- ~~i~~initial and periodic record of blood pressure, pulse rate, oxygen saturation, respiration, level of consciousness, and general status ☐ ☐
- dose, time, route, site, reason for administration and response to any administered medications ☐ ☐
- verification of discharge criteria ☐ ☐
- verification of provision of verbal and written post anaesthetic instructions ☐ ☐
- identification of discharge time and accompanying responsible individual ☐ ☐
- name and signature of responsible recovery personnel ☐ ☐

f. Do the post-sedation instructions include the following?:

- written instructions ☐ ☐
- notice not to drive a vehicle or operate hazardous equipment for a minimum of 24 hours ☐ ☐
- the procedure for accessing emergency care if necessary ☐ ☐

g. Is a Resuscitation Record form kept with the defibrillator? ☐ ☐

h. Does the Resuscitation Record include areas for the provider to document the following?:

- time of cardiac event ☐ ☐
- respiratory management ☐ ☐
- cardiac management ☐ ☐
- name, dose, time, route of all drugs administered ☐ ☐
- intravenous access and location ☐ ☐
- type and amount of fluids administered ☐ ☐
- name and signature of involved individuals ☐ ☐

3. EMERGENCY PREPAREDNESS **YES** **NO**

a. Does the facility have an appropriate and documented action plan for the following?:

- power failure ☐ ☐

- earthquake ☐ ☐
- fire and evacuation ☐ ☐
- transportation of an anaesthetized patient out of the facility ☐ ☐
- transportation of patient to a hospital ☐ ☐

b. Does the facility have an appropriate and documented action plan for the following medical emergencies?:

- Syncope ☐ ☐
- asthma~~-/-~~broncospasm ☐ ☐
- anaphylaxis ☐ ☐
- hypoglycemia ☐ ☐
- seizure ☐ ☐
- stroke ☐ ☐
- cardiac arrest ☐ ☐

c. Are emergency phone numbers readily available and posted at all facility telephones? ☐ ☐

d. Is emergency equipment well organized and readily available? ☐ ☐

e. Is the log book of emergency mock drills up to date, including the individuals present? ☐ ☐

4. INFECTION CONTROL	**YES**	**NO**
a. Are sharp devices handled properly and disposed of in dedicated puncture-resistant biohazard containers?	☐	☐
b. Is there a policy and procedure for management of significant exposures?	☐	☐

5. TREATMENT AREAS	**YES**	**NO**
a. Do the operating and recovery area(s) meet the requirements of the Standards and G~~g~~uidelines?	☐	☐
b. Are the surgical lights suitable for the treatment performed?	☐	☐
c. Is emergency lighting readily available?	☐	☐
d. Does the table/chair have sufficient accessories to anaesthetize, position and restrain the patient safely?	☐	☐
e. Does the table/chair permit Trendelenburg positioning?	☐	☐

f.	Are electrical outlets accessible and adequate to accommodate all necessary equipment?	☐	☐

6. RECOVERY AREAS		**YES**	**NO**
a.	Are patients able to be visually monitored by recovery staff?	☐	☐
b.	Are electrical outlets accessible and adequate to accommodate all necessary equipment?	☐	☐
c.	Is emergency lighting readily available?	☐	☐
d.	Is there adequate room to allow for emergency care for a patient?	☐	☐
e.	Are the following immediately available at each patient station?:		
	- Oxygen	☐	☐
	- Suction	☐	☐
	- bag-valve-mask device	☐	☐
	- physiologic monitor, including pulseoximetry, with audible alarm and ECG	☐	☐

7. SUCTION		**YES**	**NO**
a.	In the event of a central power failure, is a battery-powered portable suction unit readily available?	☐	☐
b.	Is access to the central suction restricted to staff, by either a lock or prudent location?	☐	☐
c.	Is the suction unit switch situated or protected so as to prevent accidental turn-off?	☐	☐

8. GAS STORAGE / PIPING		**YES**	**NO**
a.	Are gas cylinders secured to the wall or floor or in a cylinder rack?	☐	☐
b.	Does the facility have a sufficient main supply of oxygen to accommodate anaesthesia delivery to the expected range of daily patient flow?	☐	☐
c.	Is there an alternate source of oxygen available (with gauge, regulator and wrench) in the event of central oxygen distribution failure?	☐	☐
d.	If the facility has a Medical Gas Pipeline System, does it have CSA certification?	☐	☐
e.	Are all gas hoses, cylinders, flow-meters and control valves colour-coded?	☐	☐

f. Are the gas connectors non-interchangeable at all connection sites? ☐ ☐

g. Are there pressure gauges and alarms to show the status of the Medical Gas Pipeline System? ☐ ☐

h. Is inspection and service of the gas system provided by qualified personnel? ☐ ☐

i. Since receiving CSA Certification, have the gas pipelines been modified or changed? ☐ ☐

9. MONITORING EQUIPMENT	**YES**	**NO**
a. Does all medical electrical equipment bear the mark or label of a certifying organization such as CSA that is accredited by the Standards Council of Canada to approve electrical medical equipment?	☐	☐
b. Does the frequency of equipment inspection/testing/service meet requirements?	☐	☐
c. Are inspections/testing/service carried out by a registered biomedical engineer or biomedical technologist/technician?	☐	☐
d. Is there evidence that equipment deficiencies/repairs are promptly corrected/carried out?	☐	☐
e. Is the monitoring equipment inspection and service logbook up-to-date?	☐	☐
f. Is the manual defibrillator and/or AED testing log book up-to-date?	☐	☐
g. Are the following devices/equipment available for each sedated patient?:		
- sSystem for monitoring blood pressure	☐	☐
- pPulse oximeter	☐	☐
- ECG monitor	☐	☐
- cCapnography or amplified, audible pretracheal stethoscope	☐	☐
h. Is at least one battery-powered physiologic monitor available in the event of a central power failure?	☐	☐

10. NITROUS OXIDE / OXYGEN DELIVERY SYSTEM (if applicable)	**YES**	**NO**
a. Does the nitrous oxide/oxygen equipment have a fail-safe system?	☐	☐
b. Does the nitrous oxide/oxygen equipment have an appropriate gas scavenging system?	☐	☐

c. Is the nitrous oxide/oxygen equipment periodically inspected as recommended by the manufacturer? ☐ ☐

11. ESSENTIAL AIRWAY EQUIPMENT	**YES**	**NO**
Are the following available?:		
- rescue airways (e.g. King Airway, LMA, or iGel), oropharyngeal airways, bag-valve-mask devices and facemasks in a selection of sizes appropriate to the expected range of patient age and size	☐	☐
- 100% oxygen source (2 E tanks available)	☐	☐
- Yankauer suction tip	☐	☐
- ~~s~~Stethoscope	☐	☐
- capnography monitoring system or pretracheal stethoscope. ~~(for pediatric patients)~~	☐	☐

12. ANAESTHESIA SUPPLIES	**YES**	**NO**
Does the facility have an adequate supply of the following?:		
- administration set for adults	☐	☐
- administration set for children	☐	☐
- physiologic intravenous solution	☐	☐
- dextrose intravenous solution	☐	☐
- intravenous catheters	☐	☐
- needles	☐	☐
- syringes	☐	☐
- ECG monitoring electrodes	☐	☐
- defibrillator pads/paste	☐	☐
- lubricant	☐	☐
- tape	☐	☐
- patient padding	☐	☐
- puncture proof biohazard container	☐	☐

13. DRUG CONTROL	**YES**	**NO**
a. Are drugs stored in an appropriate manner and clearly identified?	☐	☐

b. Are controlled drugs (benzodiazepines, opioids, ketamine) stored in a secure, locked cabinet? ☐ ☐

c. Is the controlled drug log book locked in a secure location, separate from the drug cabinet? ☐ ☐

d. Does the controlled substance logbook contain a record of administration date, administering doctor, patient name and a drug count / reconciliation that is signed and witnessed? ☐ ☐

e. Are records kept detailing who has access to the narcotics key? ☐ ☐

14. EMERGENCY MEDICATIONS **YES** **NO**

Are the following drugs available?:

- Acetylsalicylic Acid (1 small bottle) ☐ ☐
- Atropine (6 ampoules of 0.6mg) ☐ ☐
- Diphenhydramine or Chlorpheniramine (2 vials of 50mg) ☐ ☐
- Epinephrine (6 ampoules) ☐ ☐
- Flumazenil (1 vial) ☐ ☐
- Hydrocortisone Succinate (2 vials of 100mg) ☐ ☐
- Naloxone (2 ampoules) (if narcotic is used) ☐ ☐
- Nitroglycerine (1 oral spray~~pump~~) ☐ ☐
- Salbutamol Inhalation Aerosol (1 inhaler) ☐ ☐
- Supplemental glucose for oral use (2 sources) ☐ ☐

15. ELECTRICAL SUPPLY **YES** **NO**

a. If power bars are utilized in direct patient care, are they hospital grade? ☐ ☐

b. Do the receptacles in the patient care areas have a green dot on their face to identify them as hospital grade receptacles? (NOTE: The presence of receptacles that are not hospital grade does not affect accreditation, but the clinic should assure that whenever a receptacle needs to be replaced, the replacement is a hospital grade receptacle.) ☐ ☐

c. Is the electrical panel board located such that it can be easily accessed but only by the facility staff? ☐ ☐

d. Does the panel board index clearly identify which receptacles and equipment are controlled by each circuit breaker? ☐ ☐

e. Are the receptacles in the patient care areas labelled with the corresponding panel board and circuit breaker number? ☐ ☐

f. Are receptacles that are within 1.5 meters of a sink protected with a Ground Fault Circuit Interrupter (GFCI)? (NOTE: Receptacles that provide power to equipment to which power should not be interrupted do not need GFCI protection.) ☐ ☐

g. Are receptacles that are protected with a panel board CGFCI or feed-through GFCI labelled as such? ☐ ☐

Inspector Recommendations

☐ Full Authorization

☐ Provisional Authorization

☐ Unacceptable for Authorization

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

Name of Inspector: _____ College #: _____

Signature of Inspector: _____ Date: _____

500 – 1765 West 8th Avenue
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APPLICATION FOR NON-HOSPITAL SEDATION FACILITY INSPECTOR

Name of Dentist: _____

Address: _____

Office Phone: _____ Cell Phone: _____

Email: _____

Active BC Dental Licence: Yes ☐ No ☐

CDSBC Full Registration Number: _____

SEDATION EXPERIENCE:

Dates	Location	Types of Anaesthesia	Number of Sedations Performed Annually

INSPECTION PROCESS	YES	NO
Willing to participate in an initial training/calibration in the protocol for evaluating offices?	☐	☐
Willing to evaluate whether or not the facility meets the requirements set out in the (College Standards and Guidelines), including the physical space, equipment, equipment maintenance, sedation and emergency medications, documentation, protocols, etc.?	☐	☐
Willing to work closely with CDSBC personnel?	☐	☐
Agreed to submit the inspection report to CDSBC within 2 weeks of an inspection?	☐	☐
Agreed to conduct at least 5 inspections per year?	☐	☐
Agreed to participate period training or re-calibration as needed?	☐	☐
Agreed to maintain the highest ethical standards and confidentiality in regards to their work on behalf of CDSBC?	☐	☐

TYPES OF INSPECTION:	YES	NO
Willing to conduct inspection for general anesthetic (GA) facilities?	☐	☐
Willing to conduct inspection for deep sedation facilities?	☐	☐
Willing to conduct inspection for moderate sedation facilities?	☐	☐

Note: Inspectors with current experience of providing GA services can conduct inspections for moderate sedation, deep sedation and GA facilities. Inspectors with current experience of providing deep sedation services can conduct inspections of deep and moderate sedation facilities. Inspectors with current experience of providing moderate sedation services can ONLY conduct inspections for moderate sedation facilities.

GEOGRAPHIC AREA(S):	YES	NO
Willing to travel and conduct inspections in the Lower Mainland – Southwest Area of British Columbia?	☐	☐
Willing to travel and conduct inspections in the Vancouver Island – Coastal Areas of British Columbia?	☐	☐
Willing to travel and conduct inspections in the Cariboo – Prince George Area of British Columbia (Prince George, Williams Lake)?	☐	☐
Willing to travel and conduct inspections in the Thompson – Okanagan Area of British Columbia (Kamploops, Kelowna)?	☐	☐
Willing to travel and conduct inspections in the Kootenay Area of British Columbia (Cranbrook, Castlegar)?	☐	☐
Willing to travel and conduct inspections in the Northern Area of British Columbia (Fort St. John, Dawson Creek)?	☐	☐
Willing to travel and conduct inspections in the Skeena – North Coast Area of British Columbia (Prince Rupert, Smithers)?	☐	☐

I hereby certify that the above statements and information are true and correct to the best of my knowledge.

Dated this _____ day of _____, 20_____.

Name of Applicant: _____

Signature of Applicant: _____

CDSBC College of Dental Surgeons of British Columbia

Manual for the Authorization of Moderate Sedation Facilities

February 2017

Table of Contents

AUTHORIZATION OF NON-HOSPITAL MODERATE SEDATION FACILITIES

INTRODUCTION

Dental offices, clinics and facilities providing moderate parenteral sedation services independent of a hospital must have current authorization from the College of Dental Surgeons of British Columbia (CDSBC) or the College of Physicians and Surgeons of British Columbia (CPSBC). The authorization process is designed to ensure that the delivery of moderate parental sedation conforms to the standards and guidelines. The issuance of an authorization is not, however, an endorsement of any particular facility, anesthetic technique or practitioner.

Note: Facilities that are authorized to provide general anesthesia or deep sedation services automatically meet the requirements for moderate parenteral sedation and do not require a further authorization.

AUTHORIZATION CLASSIFICATIONS

Authorization status is determined by the committee on the basis of an inspector's summary report regarding a site visit to the facility.

Full Authorization

Full authorization is granted when the facility achieves or exceeds the minimum requirements outlined in the guidelines. This status is valid for a period of 4 years from the date of the visit. When full authorization is granted following a provisional or unacceptable status recommendation, the term of the authorization is for the balance of the 4 year term calculated from the date of the original site visit.

Provisional Authorization

Provisional authorization is granted when it has been determined that the facility has deficiencies or weaknesses in one or more areas, but is still considered adequate to provide minimum standards of patient care. This status requires follow up and in some cases may require an additional site visit.

Unacceptable For Authorization

This status is indicated when identified deficiencies or weaknesses are such that patient care is at risk. This status results in immediate cessation of moderate parenteral sedation services in the facility. Once deficiencies have been corrected, the owner may apply for another site visit.

ON-SITE INSPECTION

- An on-site inspection of each facility is required every 4 years
- Normally conducted during regular business hours
- The facility owner must be present for the inspection
- The inspector examines the following:
    - staff qualifications
    - staff training
    - patient monitoring equipment and maintenance log
    - essential airway equipment
    - sedation drugs and administration supplies/equipment
    - emergency armamentarium
    - sedation protocols
    - emergency protocols
    - sedation forms and records
    - logs for management of controlled substances and mock emergency drills

- At the completion of the inspection the inspector debriefs the owner regarding the results

FACILITY INSPECTORS

Inspectors are dentists who undergo specific training regarding the inspection process. Inspectors must maintain an active BC Dental License and currently provide sedation services to patients.

The inspector visits the site and is responsible for preparing a written summary report of their findings, including the determination of the appropriate authorization status. A roster of qualified inspectors is maintained by the CDSBC and is provided to the facility owner. The owner is responsible for coordinating the site visit with the inspector.

Duties of Inspector

- Conduct a site inspection of the sedation facility
- Verify that the facility meets or exceeds the requirements outlined in the guidelines
- Identify weaknesses and/or deficiencies to the facility owner
- Prepare a written inspection report which includes the authorization status recommendation

Conflict of Interest

It is important that both the owner and inspector feel there is no potential conflict of interest between them that could jeopardize the integrity of the authorization process. Any concerns must be raised to the CDSBC before the inspection takes place.

Confidentiality

Confidentiality is an integral part of the authorization process. All documentation and discussions related to the site visit are confidential. Facility inspectors must sign a confidentiality statement.

INSPECTION REPORT

The inspection report is based on the college guidelines. Weaknesses and/or deficiencies are specifically identified. The inspector may also offer suggestions which could lead to an improvement in the facility. However, the owner is under no obligation to implement these suggestions and the results of the site visit would not be affected.

The inspection report is sent to the facility owner, who then reviews the report for factual accuracies and implements the required changes. The owner then provides a written response to the College which confirms resolution of any identified concerns, as well as any general comments. The inspection report and the facility response is presented to the Committee for ratification. Following this review, the appropriate authorization status is granted, effective as of the date of the site visit.

The Committee may accept or reject the recommendation of the inspector. If the committee is having difficulty accepting the recommendation, the Committee will advise the facility owner. Where possible to do so without jeopardizing patient safety, the committee will allow the facility owner to present his or her own view to the Committee for consideration before a final decision is made.

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A facility that receives provisional authorization is required to correct the deficiencies identified in the inspection report or by the Committee. The facility owner then provides a written progress report which outlines how the deficiencies have been ratified. In some cases a further site visit may be required. During this time the facility can continue to provide sedation services.

In the situation where the Committee concludes that a facility is unacceptable for authorization, the owner will be advised so in writing and the facility must immediately cease the provision of moderate parenteral sedation services until such time that provisional or full authorization is obtained. If the facility owner presents documentation concerning the rectification of deficiencies, which satisfies the Committee that patient safety is no longer jeopardized, the Committee will issue a provisional authorization to the facility. A further site visit may be required and an additional inspection fee may be charged.

APPEAL PROCEDURE

In the event that anything less than full approval is granted, the facility has the right to request reconsideration. A written request must be submitted to the college within a period of 30 days of the decision. In the event of a reconsideration request, the

authorization status at the time of the site visit remains in effect until the decision of the reconsideration.

APPLICATION FOR INSPECTION

Dental offices, clinics or facilities that wish to provide moderate parenteral sedation services must first complete an Application for Facility Authorization and submit it to the College, along with the applicable fee of CAD$1200. Facility inspection and authorization typically takes 6 - 8 months.

If you own a facility, and intend to have another dentist or physician administer moderate parenteral sedation, you must have your facility inspected and authorized by the College before administering sedation services.

If you intend to administer moderate parenteral sedation to patients in a facility, you must confirm that the facility is authorized by the College, and you must have your qualifications registered with the College. To register your qualifications, please complete the Application for Registration of Qualifications and submit it to the college along with the applicable fee of CAD$150. Your application will be processed in 2 - 3 months.

Note: The authorization process for moderate parenteral facilities will begin in 2017. The College recognizes that many facilities in the province are currently providing sedation services and that a transition phase will be required. The initial step for these "active" facilities is to submit an Application for Facility Authorization along with the applicable fee. You will be asked to complete a Self-Assessment of your facility. Assuming all is in order, your facility will be granted a Provisional Authorization and you can continue providing sedation services. The initial authorization of all facilities in BC is expected to take approximately 2 years.

SCHEDULING AN INSPECTION

The College will send out a reminder to the facility owner approximately 6 months prior to expiry of the authorization. The facility is provided a list of inspectors. The facility is responsible for contacting an inspector and coordinating the inspection in a timely fashion.

MAINTAINING AUTHORIZATION STATUS BETWEEN SITE VISITS

Continued authorization to provide sedation services during the four year period between site inspections is dependent upon submission of an Annual Self-Assessment document (see below). An annual reminder is sent to the facility approximately 2 months prior to the anniversary date.

ANNUAL SELF ASSESSMENT

An Annual Self-Assessment must be submitted to the College by the facility owner in order to maintain the facility's authorization status. The aim of the assessment is to help the owner regularly scrutinize the functioning and preparedness of their facility. Each Self-Assessment is evaluated by the Committee and any identified concerns are communicated to the owner for clarification and/or correction.

MODERATE SEDATION SERVICES STANDARDS AND GUIDELINES

CDSBC Minimal and Moderate Sedation Services in Dentistry

This document can be found online at:
https://www.cdsbc.org/CDSBCPublicLibrary/Minimal-Moderate-Sedation-Standards.pdf

EMERGENCY MANAGEMENT

In the event of a natural or man-made emergency, dentists and staff members need to act quickly to safeguard themselves and their patients. Facility owners are expected to create an Action Plan for the following emergencies: fire, building evacuation, power failure and earthquake. Each plan must clearly outline employee's duties/responsibilities, explain the management of patients/visitors, as well as include a procedure for accounting for all employees in the event of an evacuation. All employees should undergo initial training followed by periodic re-training. New facility employees should be made aware of the action plan.

NON – MEDICAL EMERGENCIES

1. **FIRE**

If a fire breaks out in the facility, or if the building fire alarm goes off, you must prepare to evacuate. If the fire is within the facility, immediately call 911 to report it. If the facility is within an office building, elevators are not to be used. A pre-determined, designated outdoor meeting space is necessary to confirm that every employee has left the building.

The following is an example of a Fire Action Plan, which can be modified to suit the facility:

FIRE ACTION PLAN

Receptionist Actions:

- Stay calm
- Evacuate reception area(s)
- Use south stairwell (just outside office door) to exit building
- Other receptionist(s) report to treatment area(s) to assist with transfer of sedated and/or recovering patients
- Do not bring family/escorts into treatment area

Assistant Actions:

- Remain calm
- Turn off all gas cylinders
- Lock drug cupboards
- Gather portable patient monitor, portable suction unit, portable oxygen supply, portable emergency drug kit, portable light source and transfer blankets

Sedated patients:

- Stop treatment
- Suture/pack any surgical sites
- Consider reversing sedation medication(s)
- Maintain intravenous access
- Transfer patient to wheelchair/stretcher (if needed)
- Transfer patient to north stairwell, using transfer blanket if necessary, and exit building

Patients recovering from sedation:

- Accompany patients to north stairwell and out of building

Designated meeting place: Parking lot west of building

2. ELECTRICAL POWER FAILURE

In the event of a central power failure, the most important consideration is for the safety of patients undergoing sedation or those in post-sedation recovery. The Action Plan should focus on rapid initial assessment and subsequent re-assessment, since power outages can be either brief or prolonged.

The following is an example of an Electrical Power Failure Action Plan, which can be modified to suit the facility:

ELECTRICAL POWER FAILURE ACTION PLAN

- Stay calm
- Stop ongoing treatment
- Assistant to bring portable battery-powered suction, battery powered patient monitor (if applicable), and flashlight into sedation area
- Open all window blinds (if applicable)
- Recovering patients to be monitored by designated staff member
- Receptionist(s) to reassure patients/visitors
- Re-evaluate situation
- Discontinue sedation/treatment as needed

3. EARTHQUAKE

The Action Plan must mitigate the risk of injury to both patients and employees. Although the incidence/risk of an earthquake varies according to where in BC the facility is located, every office should be prepared. In situations where the earthquake is slight, there may be no disruption to services and evacuation is not required.

The following is an example of an Earthquake Action Plan, which can be modified to suit the facility:

EARTHQUAKE ACTION PLAN

- Stay calm
- Stop sedation/treatment
- Maintain intravenous access and monitor patient
- Remove any objects that could fall on sedated patient

"DROP, COVER, HOLD"

- **Drop** to ground. If feasible, move sedated patient with you.
- **Cover** your head with your hands. If possible, take cover under a sturdy table or counter
- stay away from windows and look away from windows
- **Hold** onto something. If it moves, move with it.
- Wait for shaking to stop
- Stay calm
- Expect aftershocks
- If you need to evacuate, follow fire evacuation protocol

MEDICAL/ANAESTHETIC EMERGENCIES

As stipulated in the Standards and Guidelines, the facility must have written plans for the management of medical / anaesthetic emergencies and must conduct mock emergency drills on a regular basis.

Mock Emergency Drills

The best approach to working mock drill training into your office schedule is to set aside regular, pre-determined time. This allows staff to look forward to and prepare for the drills as well as eliminating interruptions from patient-related matters.

- An opportunity to rehearse various office emergencies.
- An opportunity to identify problems with equipment and/or protocols
- All staff must participate in mock emergency drills.
- Dentist is the team leader.
- An alternative leader is a good idea (in case the dentist is incapacitated).
- The facility should be empty.
- The emergency simulations should be conducted in a serious tone.
- A permanent log of dates, participants and scenarios must be kept.

During Drills

- Participants must speak clearly and directly, with eye contact.
- Participants must use close loop communication.
- Comments or suggestions are welcome.
- A pre-planned protocol for communicating with a 911 operator must be implemented.

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Duties/Roles of Sedation Team members

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Person 1

- Directs team members
- Positions the patient
- Performs ABCs (Airway, Breathing and Circulation)
- Communicates clearly and calmly
- Promotes closed loop communication

Person 2

- Brings emergency kit/cart
- Brings portable oxygen
- Brings automated external defibrillator (AED)
- Monitors vital signs
- Assists with basic life support (BLS)

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Person 3

- Calls 911
- Recorder
- Assists with BLS

Person 4

- Manages other patients
- Assists with BLS
- Meets and guides emergency medical services (EMS) crew

Debriefing following Drills

- Extremely valuable learning opportunity
- Complete debriefing immediately after the drill.

1. Situation

- When was emergency detected?
- Was it unexpected or predictable?

2. Team

- Performance of team members should be assessed.

- Problems identified should be addressed.
- Modify roles requirements and/or assignments if necessary.
- Other changes can be implemented for improvement.
- Designate specific team member(s) to implement change(s)

3. Equipment

- Was the emergency kit in the designated location?
- Were all the equipment present and functional?
- Were any of the medications expired?

ADVANCED CARDIOVASCULAR LIFE SUPPORT (ACLS) GUIDELINES

The 2015 Heart Stroke Foundation of Canada Guidelines Update for CPR and ECC (including ACLS) can be found online at:

www.heartandstroke.ca/-/media/pdf-files/canada/cpr-2017/ecc-highlights-of-2015-guidelines-update-for-cpr-ecclr.ashx

Highlights of the 2015 American Heart Association Guidelines Update for CPR and ECC (including ACLS) can be found online at:

http://eccguidelines.heart.org/wp-content/uploads/2015/10/2015-AHA-Guidelines-Highlights-English.pdf

FREQUENTLY ASKED QUESTIONS (FAQ)

Question 1: If a patient has a heart attack in my office I would call 9-1-1 and provide basic life support until the paramedics arrive. So why do I need to be certified in Advanced Cardiac Life Support (ACLS)?

Answer 1: ACLS courses are readily available across the province and provide the dentist with skills in the management of any emergency situation. In addition, they reinforce airway management techniques.

Question 2: In the past our staff used to take CPR-C. Why do we now have to take CPR-HCP (Health Care Provider)?

Answer 2: CPR-HCP provides instruction in the use of a bag-valve-mask device.

Question 3: I would like to provide moderate sedation to patients using multiple oral sedative agents. Can my associate dentist teach me?

Answer The Committee is currently looking at scenarios to expand these options.

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Question 4: Why does an Ambubag need to be immediately available in the operatory and recovery area?

Answer 4: Rapid assessment and treatment of an airway emergency is essential to prevent complications. Emergencies can happen during treatment or in recovery.

Question 5: A dentist visits my office to provide intravenous moderate sedation and brings his own monitoring equipment. How do I know that the equipment has been inspected?

Answer 5: It is the responsibility of the facility owner to confirm that the monitoring equipment has been at least annually inspected/serviced. The visiting dentist must provide you with the appropriate log book/records.

Question 6: How do I go about having my nitrous oxide delivery system inspected/serviced?

Answer 6: Contact you dental supply company. Manufacturers of nitrous oxide delivery units have recommendations and can work with you and your supplier to have your equipment periodically tested/serviced.

Question 7: In the past, I would supply the emergency airway equipment and the visiting dentist would bring his own emergency drugs. Why is this no longer allowed?

Answer 7: By having either the facility or the visiting dentist supply the equipment and drugs there is much less chance for important item(s) to be misplaced, forgotten, or overlooked.

Question 8: My patient monitor does not have a Canadian Standards Association (CSA) label or sticker. Is this a problem?

Answer 8: As long as the equipment is certified by an organization that is accredited by the Standards Council of Canada to approve medical equipment, and the monitor bears the mark or label of that organization, it is acceptable.

Question 9: I usually keep track of the narcotics for my sedation cases. Why do I now need a second person involved?

Answer 9: Health Canada requires dental professionals to maintain accurate record keeping practices regarding Controlled Substances. This involves maintenance of a log that includes a “Count and Reconciliation” where the quantity of the drug on hand must equal the initial quantity, minus that utilized on the day of sedation. The count must be done by two regulated health professionals concurrently; one performs the count and one witnesses the count.

Question 10: Our protocol for mildly anxious patients is to provide then with Ativan beforehand. The patient arrives an hour before their appointment and my CDA gives them the Ativan. Why can she no longer do this?

Answer 10: According to the Health Professions Act, CDAs are not allowed to dispense medications to patients.

Question 11: Do we need to use a pulse oximeter when we provide minimal sedation to our adult patients?

Answer 11: No. It is up to the individual practitioner to decide whether or not he/she feels it is useful or valuable.

Question 12: We provide IV moderate sedation 1-2 times per week to patients. Occasionally we are short staffed and have a CDA help us out who has not participated in our emergency mock drills. Is this a problem?

Answer 12: Yes. In the event of a medical anesthetic emergency each member of the team must be familiar with protocols and equipment.

Question 13: While providing oral moderate sedation there is usually just my CDA (who has completed the DAANCE course) and I in the operatory. Does a third staff member need to be in the room?

Answer 13: No. The third staff member does not have to be in the room, but must be immediately available to assist you if needed.

Question 14: Why do I need to have emergency airway equipment immediately available if my patients are conscious?

Answer 14: It is not always possible to predict how an individual will respond to intravenous sedative medications. In the event that a patient enters deep sedation, the dentist must be able to “rescue” the patient, which often requires the support of ventilation. Rapid intervention is critical.

Question 15: I provide oral moderate sedation in my office. Our patient monitor has a printer that provides a “strip” of the patient’s blood pressure and oxygen saturation. Is this sufficient?

Answer 15: A printed record of the patient’s vital signs is sufficient and must be kept as part of the permanent patient record.

Question 16: The guidelines state that during intravenous sedation we must record vital signs at a minimum of every 15 minutes. A lot can change in 15 minutes. Is this often enough?

Answer 16: Documenting is not the same as monitoring. While the recording must be documented at a minimum of every 15 minutes, the actual taking of the vital signs can be done more often. It is up to the practitioner to determine the frequency that measurements are taken, typically based on was it clinically indicated. In other words, while the minimum documentation is every 15 minutes, the practitioner may check vital signs every 5 minutes. As well, remember that the most important part of patient monitoring is the team's ongoing focus on the patient's oxygenation, ventilation, circulation and level of consciousness.

Question 17: Can any physician administer intravenous moderate sedation to my patients while I do dentistry?

Answer 17: No. Only physicians who are qualified by the College of Physicians and Surgeons of BC to provide anaesthetic services may provide sedation.

Question 18: I use a "butterfly needle" to administer the intravenous sedative. Is this sufficient/reasonable?

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Answer 18: A continuous venous access must be maintained throughout the sedation and recovery period. The best choice for armamentarium is an indwelling catheter connected to an intravenous administration set and fluid. This assures a continuous patent access.

Question 19: We provide minimal sedation with either lorazepam or nitrous oxide/oxygen. Are we required to run mock emergency drills?

Answer 19: You are encouraged to, but not required.

Question 20: We have a portable "E" cylinder of oxygen in our office that we occasionally use when administering intravenous sedation. Do we need to have a second cylinder as well?

Answer 20: Yes. You must have an oxygen source specifically designated for use in case of an emergency.

Question 21: I own a dental office that provides intravenous moderate sedation. Periodically I have a dentist, who is registered and approved by the college to provide deep sedation, visit as well. Is it okay for him to provide deep sedation in my office?

Answer 21: No. Dentists qualified to provide deep sedation services must only do so in facilities authorized to provide deep sedation or general anesthesia.

Question 22: My CDA has assisted me during IV sedation cases for many years. Does she need to take a course in order to continue to assist me?

Answer 22: Yes. The new guidelines require the sedation assistant to have completed a course specific to dental anaesthesia assisting.

Question 23: When sedating a patient I inject the medication into a port on the IV administration set. If I change the injection needle between patients, why can't I use the same medication syringe for several patients?

Answer 23: Syringes, needles and cannulae are considered contaminated once used to access a patients IV bag or administration set.

Question 24: How often do I need to replace essential airway equipment?

Answer 24: Most single-use items (i.e. Laryngeal mask airway) have expiry dates. If an item has no identifiable date, you must replace the item when it shows signs of deterioration.

Question 25: Do I need to copy and send in each staff member's CPR certificate?

Answer 25: No. The College is only interested in confirming that staff members maintain currency in CPR-HCP. An easy means of doing this is to create a spreadsheet that lists each of your staff, their sedative role, qualifications for their role and CPR status.

Question 26: What are mock drills and why are we required to do them?

Answer 26: Mock drills are “practice drills” where the dental team rehearses their roles and actions in various emergencies. It has been shown that individuals and teams that practice emergency scenarios are much more effective if/when a crisis arises.

Question 27: What is the difference between “continual” and “continuous” with regard to patient monitoring?

Answer 27: Continual means something is repeated regularly and frequently in steady succession. An example is taking a patients’ blood pressure during sedation. Continuous means there is no interruption, such as when utilizing a pulse oximeter to measure oxygen saturation/heart rate.

Question 28: Why do our extension cords for our equipment have to be “hospital grade”?

Answer 28: Hospital grade power bars have superior quality, strength and grounding capability compared to standard “residential” type bars/cords.

Question 29: What do I need to know about storage of oxygen cylinders?

Answer 29: The cylinders must be stored in a fashion that prevents injury to the gas outlet on the top of the tank. It is not appropriate to have cylinders laying on the floor or standing up unsecured. The best method of storage of “E” cylinders is to have them standing up and chained to the wall or solid object. You can also purchase cylinder racks that hold the bottles upright. Larger gas cylinders must be secured to the wall with chains.

Question 30: Why do we have to label electrical receptacles and the electrical panel?

Answer 30: If patient monitors or other sedation-related equipment lose their power supply during sedation/recovery, the labeling of receptacles and the circuit board allows for more rapid trouble shooting.

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Question 31: Do we need to label all of the facility receptacles?

Answer 31: No, only the receptacles in the sedation and recovery area(s).

Question 32: Can I use a King Airway instead of an LMA as my rescue airway?

Answer 32: It is always best to utilize equipment which you are familiar/comfortable with. A King Airway is a suitable choice for a rescue airway. Depending on the size of your patient, you will need to stock size 3, 4 and 5.

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Question 33: What is an i-Gel and is it suitable as a rescue airway?

Answer 33: Some courses recommend clinicians to use an i-Gel airway as their rescue airway. They feel an i-Gel is easier to use in an emergency situation where the doctor is not as familiar with airway management. The i-Gel is also a suitable rescue airway.

Question 33: What type of epinephrine should we have: ampoules or pre-filled syringes?

Answer 33: It ultimately comes down to what the clinician feels most comfortable with. Many choose pre-filled syringes because of their ease of use during an emergency. Their disadvantage is in a situation where multiple doses need to be administered to a patient, such as in a cardiac arrest. Several syringes would need to be stocked, which occupies space in the kit/cart, and is also significantly more expensive than ampoules. In most cases, facilities choose to stock ampoules of epinephrine 1:1000 (1mg/ml). They are relatively inexpensive and easy to store. It is also the dilution used for administration by the intramuscular or subcutaneous route. The disadvantage of the 1:1000 ampoules is if administered by the IV route it must be first diluted to 1:10,000 concentration (1mg/10ml.), which requires time and an individual trained in diluting medications. Another disadvantage of the 1:1000 form is the potential for accidental undiluted IV administration of the drug. Some clinicians choose to stock both forms of epinephrine in their kit/ cart.

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APPENDIX A - AED CHECKLIST

AED CHECKLIST

Manufacturer_____

Model Number _____

Serial Number _____

Date	General Condition	Battery ✓	Non-Expired Pads	Comments / Corrective Action	Initial

APPENDIX B
EMERGENCY SIMULATIONS (MOCK DRILLS) LOG

EMERGENCY SIMULATIONS (MOCK DRILLS) LOG

Scenario	Completed ✓	Debrief ✓	Staff Present	Notes
Syncope				
Anaphylaxis				
Asthma/bronchospasm				
Hypoglycemia				
Seizure				
Stroke				
Cardiac Arrest				
Difficult Airway				
Laryngospasm				
Unresponsiveness				

Signature of Dentist_____ **Date** _____

APPENDIX C - CALLING 911

CALLING 911

- It is best to call 911 from a landline because it provides the operator with information regarding your office location, should you be disconnected.
- Stay on the telephone until the operator tells you to hang up.
- Tell the operator that a staff member will meet the EMS crew and guide them to the emergency location
- Post the following guide beside your telephone(s) to refer to in an emergency

Questions from 911 operator	**Your answer (example)**
1. Police, fire or ambulance?	"Ambulance"
2. Who are you?	"This is…….. " (give your first name only).
3. Your address?	"_____"
4. Nature of emergency?	"We have a 75 year old man who had extreme chest pain and is now unconscious"
5. What is being done?	"We are providing CPR"
6. What is the best entrance to your office/building?	"The main entrance on Columbia Street"

APPENDIX D - CONTROLLED DRUG RECORD

The following is an example record that illustrates how to keep track of Controlled Drugs in your facility. Each day sedation drugs are used, a Count and Reconciliation must be completed and witnessed (see Standards and Guidelines).

According to Federal Regulations, you must keep records for 2 years time.

On the following page is a blank form that you can copy and use.

A common approach is to keep the Record in a binder, inside a locked cabinet.

CONTROLLED DRUG RECORD

		DRUG							
		USED	WASTED						INITIALS
Date	Patient Name	mg or ml	mg or ml	Vials or Vol	Vials or Vol.	Vials or Vol	Vials or Vol	Vials or Vol.	

SAMPLE - CONTROLLED DRUG RECORD

This is an example of a Controlled Drug Record, which illustrates:

- The date of sedation and patient name
- The amounts of drug(s) administered and wasted
- A running Count/ Reconciliation
- Initials of the individual counting and the witness
- The addition of drugs to the stock and subsequent Count

Note: This Record is for a facility where only one dentist is administering sedation. If the facility has multiple sedation providers, the record must include the name of the dentist who was administering the drug(s).
Per federal regulations, Controlled Drug Records must be kept for a minimum of 2 years following administration.

SAMPLE - CONTROLLED DRUG RECORD

		DRUG							
		USED	WASTED	Fentanyl 2 ml	Fentanyl 5 ml	Midazolam 1mg/ml (5ml)			INITIALS
Date	**Patient Name**	**mg**	**mg**	**Vials**	**Vials**	**Vials**	**Vials**	**Vials**	
		or ml	**or ml**	**or Vol**	**or Vol.**	**or Vol**	**or Vol**	**or Vol.**	
01/01/17	Count			10	2	3			
01/01/17	S. Black	75	25	9					
		3	2			2			
01/01/17	T. Roberts	60	40	8					
		2	3			1			
01/01/17	Count			8		1			
08/01/17	Add			10		5			
08/01/17	Count			18		6			
08/01/17	L. Turner	75	25	17					
		3	2			5			
08/01/17	S. Smith	60	40	16					
		3	2			4			
08/01/17	Count			16		4			

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 8.

CDSBC Policy Submission to Board
Framework for Inspection Process – Moderate Sedation Facilities

Submitted by
Jerome Marburg and Dr. Patricia Hunter – on behalf of and with knowledge and consent of Sedation and GA Services Committee (the Committee) Chair and Vice Chair.

Submitted on
24 June 2017

Issue
At the February 2017 Board meeting, Dr. Melo presented the attached (now further edited) document to the Board for review and comment. The Board passed a motion to accept, in principle, the proposed framework for the inspection process for non-hospital parenteral moderate sedation facilities. The Board felt that the document could be strengthened by making more direct reference (where possible) to the underlying policy documents. Dr. Hunter volunteered to work with Mr. Marburg to propose edits.

Authority
CDSBC Bylaws.

Analysis
Dr. Hunter and Mr. Marburg met to review the concerns raised by Dr. Hunter at the Board meeting. Together they proposed a modest set of edits which were then canvassed with the Chair, Vice Chair and principal author of the document. Each have signed off on the edits which, while not substantive, did add further clarity to the document.

Connection to Strategic Plan
Core mandate of Public Protection

Impact on Resources

As noted in originating submission. These edits have minimal staff impact. The inspection regime itself has significant impact which has been anticipated in budget and operational planning and which will be phased in to pilot and perfect the inspection process.

Recommendation
That the Board approve the framework for inspection of non-hospital moderate parenteral sedation facilities which will then undergo final editorial proofing and formatting for publication and utilization.

Attachments: Framework for Inspection of Non-Hospital Moderate Parenteral Sedation Facilities

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 9.

Memo

TO: CDSBC Board

CC: Jerome Marburg, Registrar/CEO

FROM: Anita Wilks, Director of Communications

DATE: June 7, 2017

SUBJECT: **San'yas Indigenous Cultural Safety Program**

The purpose of this memo is to outline how the College intends to meet its obligations as set out in the Declaration of Commitment to Cultural Safety and Humility, and to ask that board members agree to complete a training program that is designed to provide a more culturally safe and effective healthcare system for First Nations peoples. The full text of the Declaration is included below.

This memo includes excerpts from a 1 March 2017 press release from the BC Health Regulators: *"All regulated health professions commit to a safer health system for First Nations and Aboriginal People."*

Background

Systemic racism and discrimination towards First Nations people continues to be a major problem in many contemporary health care settings. Systemic racism, which includes personal biases and unintentional stereotyping, leads to inappropriate treatment and barriers to accessing health care.

On March 1 of this year, 23 health professions regulators in B.C. became the first in Canada to pledge their commitment to making our health system more culturally safe and effective for First Nations and Aboriginal peoples. CDSBC is a signatory to the Declaration of Commitment that is based on the principles of cultural safety and humility. This includes promoting the value of cultural safety training to the professionals we regulate.

The declaration is endorsed by the First Nations Health Authority and the Ministry of Health and was signed by their representatives and the members of the BC Health

Regulators. The signing of the declaration was witnessed by over 230 delegates attending a forum focused on improving the quality of care for indigenous people.

About the training

The Provincial Health Services Authority has developed a facilitated online training program designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Aboriginal people. Participants will learn about terminology; diversity; aspects of colonial history such as Indian residential schools and Indian hospitals, timeline of historical events; and contexts for understanding social disparities and inequities.

The San'yas Indigenous Cultural Safety Training Program is available for both clinical and non-clinical professionals. The course takes 8-10 hours to complete over a period of eight weeks. For those not directly employed by the Ministry of Health or a BC Health Authority, the cost is $250 per person. It has been approved by the Quality Assurance Committee for continuing education credit.

Next steps

All B.C. health colleges have pledged to report on their progress annually to demonstrate how they are meeting their commitment to cultural safety. Two of our peer colleges -- the College of Physicians and Surgeons of BC (CPSBC) and the College of Registered Nurses of BC (CRNBC) -- are proceeding with the cultural competency training for their leaders, registrants and staff as follows:

1. All board members have committed to and completed the cultural competency training (CPSBC)

2. Promote the course to registrants and track the completion rates via registration and/or renewal (CPSBC and CRNBC)

3. All staff have been encouraged to take the training with costs covered by the college (CRNBC)

We recommend taking similar steps to address our responsibilities as set out in the Declaration of Commitment:

- We have moved forward on item 2 by promoting the cultural safety training in a recent issue of our e-newsletter. We plan to track the rates at which registrants complete it, beginning in 2018.
- We will encourage all complaints staff to take this training and will build this into the professional development budget for the 2017/18 year.

The staff recommendation is for all board members to take the cultural competency training to demonstrate your leadership in this important area – and that this be included as part of the orientation for incoming board members. Doing so will help to bring the signed commitment to life.

Motion

That Board Members complete the course and, as this is an unbudgeted item, that the Board approves payment for the course.

CULTURAL SAFETY AND HUMILITY IN THE REGULATION OF HEALTH PROFESSIONALS SERVING FIRST NATIONS AND ABORIGINAL PEOPLE IN BRITISH COLUMBIA

DECLARATION *of* COMMITMENT
MARCH 1, 2017

Our Declaration of Commitment is an important step towards advancing cultural safety and humility among regulated health professionals who are involved in the delivery of health services to First Nations and Aboriginal people in British Columbia. This commitment reflects the high priority we, as the designated BC health profession regulatory leaders, place on cultural safety and humility as quality and safety dimensions that are integral components of our public protection mandate.

This Declaration of Commitment is based on the following guiding principles of cultural safety and humility:

> *Cultural humility is a life-long process of reflection to understand individual and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust.*

> *Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. Cultural safety is the outcome of people feeling safe when receiving health care services.*

> *Cultural safety must be understood, upheld and practiced at all levels of the health system including governance within health profession regulatory bodies and within individual professional practice.*

> *All stakeholders, including First Nations and Aboriginal individuals, Elders, families, communities, and nations must be involved in co-development of action strategies and in the decision-making process with a commitment to reciprocal accountability.*

Strong leadership on concrete actions is essential to achieving our vision of a culturally safe health system for First Nations and Aboriginal people in our province.

We, the undersigned representatives of BC's health profession regulators commit to:

CREATE A CLIMATE FOR CHANGE BY:

> *Articulating the pressing need to establish cultural safety as a framework to improve First Nations and Aboriginal health services in BC.*

Opening an honest, informed and convincing dialogue with all stakeholders to show that change is necessary.

Forming a coalition of influential leaders and champions who are committed to the priority of embedding cultural humility and safety into the regulation of BC health professionals.

Contributing to the provincial vision of a culturally safe health system as a leading strategy to enhance professional regulation in BC.

Encouraging, supporting and enhancing cultural safety and cultural competency amongst health professionals in BC.

ENGAGE AND ENABLE STAKEHOLDERS BY:

Communicating the vision of culturally safe health profession regulation for First Nations and Aboriginal people in BC and the critical need for commitment and understanding on behalf of all stakeholders, health professionals and clients.

Openly and honestly addressing concerns and leading by example. Identifying and removing barriers to progress. Monitoring and visibly celebrating accomplishments.

IMPLEMENT AND SUSTAIN CHANGE BY:

Encouraging and empowering our organizations' staffs, governors and volunteers to develop cultural humility and foster a culture of cultural safety.

Facilitating processes where organizations and individuals can raise and address problems without fear of reprisal.

Leading and enabling successive waves of actions until cultural humility and safety are embedded within all levels of health professional regulation.

REPORTING ON PROGRESS BY:

Working with the Ministry of Health and the First Nations Health Authority to prepare a public annual report on strategic activities, outlining and demonstrating how the commitment is being met.

Our signatures demonstrate our long-term commitment to the regulation of health professionals to promote and advance cultural safety and humility for First Nations and Aboriginal people in British Columbia and to championing the process required to achieve this vision.

This Declaration is endorsed by the Ministry of Health and the First Nations Health Authority and signed by their representatives and the members of the BC Health Regulators.

SIGNED ON THIS DATE: March 1, 2017

First Nations Health Authority – Joe Gallagher, CEO, FNHA

Ministry of Health – Stephen Brown, Deputy Minister

– and BC Health Regulators:

College of Chiropractors of BC – Michelle Da Roza, Registrar

College of Dental Hygienists of BC – Jennifer Lawrence, Registrar

College of Dental Surgeons of BC – Jerome Marburg, Registrar

College of Dental Technicians of BC – Ronald Revell, Registrar

College of Denturists of BC – Louise Crowe, Registrar

College of Dietitians of BC – Fern Hubbard, Registrar

College of Licensed Practical Nurses of BC – Carina Herman, Registrar

College of Massage Therapists of BC – Eric Wredenhagen, Registrar

College of Midwives of BC – Louise Aerts, Registrar

College of Naturopathic Physicians of BC – Howard Greenstein, Registrar

College of Occupational Therapists of BC – Kathy Corbett, Registrar

College of Opticians – Connie Chong, Registrar

College of Optometrists of BC – Robin Simpson, Registrar

College of Pharmacists of BC – Bob Nakagawa, Registrar

College of Physical Therapists of BC – Brenda Hudson, Registrar

College of Physicians and Surgeons of BC – Heidi Oetter, Registrar

College of Podiatric Surgeons of BC – Valerie Osborne, Registrar

College of Psychologists of BC – Andrea Kowaz, Registrar

College of Registered Nurses of BC – Cynthia Johansen, Registrar

College of Registered Psychiatric Nurses of BC – Kyong-ae Kim, CEO

College of Social Workers of BC – Chelsea Cooledge, Registrar

College of Speech and Hearing Health Professionals of BC – Cameron Cowper, Registrar

College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC – Mary Watterson, Registrar

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CDSBC | College of Dental Surgeons of British Columbia

Board Meeting
24 June 2017
Agenda Item 10.

Memo

TO: CDSBC Board

CC:

FROM: Dr. Chris Hacker, Director of Professional Practice
Anita Wilks, Director of Communications

DATE: June 8, 2017

SUBJECT: **Listening Sessions**

The College has hosted four listening sessions in support of the new policy development framework:

- Victoria (November 2016)
- Surrey (February 2017)
- Nanaimo (March 2017)
- Nelson (April 2017)

These two-hour sessions were designed with the help of the public engagement specialist who helped us design the policy development framework, Susanna Haas Lyons, and facilitated by Dr. Chris Hacker. They feature short presentations by board members, committee members and/or senior staff, with the bulk of the time devoted to small group discussion.

A report is generated for each session that includes the format, presenters, all comments gathered at the session, and the evaluation results from the participants.* The four listening session reports are attached here. Overall, 93% of listening session participants agreed or strongly agreed that CDSBC demonstrated a commitment to listening.

We committed to the participants that their feedback would be submitted to the relevant committee and/or the Board. For this reason, we draw your attention to participant responses to two sets of questions in particular:

- *Opening question:* Thinking about your own practice and what you are seeing in the profession, what would you like your regulator to know?

- *Business of dentistry and corporate structures:* What aspects of corporate dentistry are affecting patient-dentist interactions, and how do you know this? What could CDSBC do to address these challenges?

There are two listening sessions scheduled for this fall: in Vancouver on Monday, September 25 (afternoon) and in Kelowna on Thursday, October 19 (evening). Board members are encouraged to attend to hear directly from registrants and stakeholders.

The sessions are not without their challenges, the largest of which may be the difficultly in attracting participants to an event that is not eligible for continuing education credit. However, feedback has been consistently positive and points to the value of this ongoing conversation with registrants and other stakeholders.

**The Nelson session had to be structured differently "on the fly" based on smaller attendance; no evaluation was done for this session.*

CDSBC | College of Dental Surgeons of British Columbia

We're All Ears: Listening Session

Victoria Conference Centre
3 November 2016

Participant Input Summary Report

28 November 2016

Table of Contents

INTRODUCTION

CDSBC recently approved a policy development process that emphasizes engagement with registrants and other stakeholders. CDSBC is building on this commitment by hosting a series of listening sessions, where registrants can learn about and engage with key topics and share their views with College representatives. The listening sessions are a province-wide opportunity to engage registrants in current policy development initiatives. More sessions will be held over the next several months.

Purpose

To strengthen the College's relationship with registrants and enhance the quality of work being done by CDSBC on key topics, by hosting an in-person event that presents information and emphasizes registrant discussion and CDSBC listening.

About this report

This report is a summary of our first listening session that took place 3 November 2016 in Victoria, B.C. It describes the session, participants and topics; it also includes a complete list of participant input and feedback compiled during the session.

A note about participant comments

The appendices contain a complete list of participant comments recorded at the listening session on flip charts. Comments representative of a theme are included in the participant input summary for each topic. Where appropriate, some comments have text in blue to indicate additional comments made by the discussion hosts for the purpose of clarifying the comment's meaning and/or for theming purposes. Corrections have been made to address spelling or other errors that did not change the meaning of the comment.

AGENDA

6:00 pm	Welcome
6:15 pm	Opening discussion
6:40 pm	Five-minute presentations on four topics
7:15 pm	Rotate through discussion stations for each topic
7:55 pm	Evaluation and closing
8:00 pm	Adjourn

SESSION FORMAT

Dr. Chris Hacker, CDSBC's Dental Policy & Practice Advisor, facilitated the listening session. After a welcome and introductory remarks, participants discussed an opening question with the other participants at their tables. They recorded their individual thoughts on sticky-notes and each table took turns sharing some of their best ideas with the entire group.

College representatives then gave short presentations on four topics. Participants were divided into eight groups (two per topic), each with its own discussion host. The groups answered questions about each topic and recorded their discussion on flip charts. The groups rotated through all four topics over the course of the evening. They had 12 minutes to discuss the first topic and seven minutes for each subsequent topic to build on the previous groups' ideas.

SESSION OVERVIEW

Topic	Presenter	Discussion hosts*	How participant input will be used
Opening Question		Various	Participant input will be considered by the Board.
Topic 1: Quality Assurance Program	**Dr. Ash Varma** *Chair, Quality Assurance Committee*	Dr. Ash Varma Dr. Alex Hird	Participant input will be considered by the QA Committee working group that is tasked with reviewing and updating the QA program.
Topic 2: Business of dentistry and corporate structures	**Greg Cavouras** *Legal Counsel*	Greg Cavouras Jerome Marburg	Participant input will be considered by the Board.
Topic 3: Dental laboratory fees	**Dr. Peter Stevenson-Moore** *Member, Ethics Committee and Past-President*	Dr. Peter Stevenson-Moore Rick Lemon	Participant input will be shared with the Ethics Committee, and considered in upcoming engagement with these issues.
Topic 4: Emerging issues in dentistry	**Jerome Marburg** *CEO/Registrar*	Dr. Patricia Hunter Dr. Susan Chow	Participant input will be considered by the Board and relevant committees to inform College strategy.

The following individuals also helped to support the listening session:

- Dr. Dustin Holben, Board Member
- Dr. Adam Pite, Vice-Chair QA committee
- Leslie Riva, Senior Manager, CDA Certification and Quality Assurance
- Anita Wilks, Director of Communications

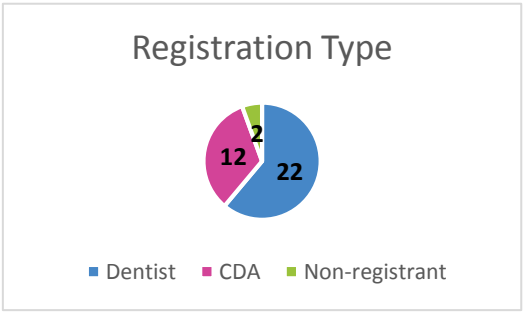
WHO PARTICIPATED IN THE SESSION

The listening session was held in Victoria, BC and 36 participants attended.

Registration type

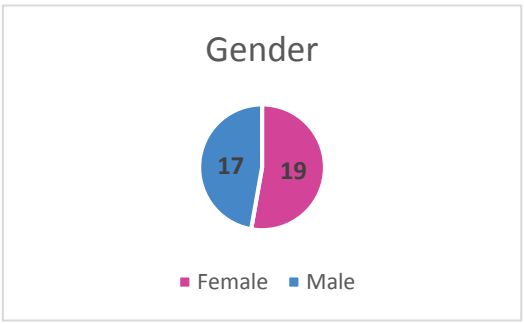
Of the 36 participants, 22 were dentists, 12 were certified dental assistants (CDAs), and 2 were non-registrants (other members of the dental team). All of the registrant participants are currently practising, with the exception of one retired dentist.

The ratio of dentists to CDAs at the listening session is not representative of the actual makeup of the College's registrants (there are almost twice as many CDAs as dentists, while at the listening session this ratio is flipped).



Gender

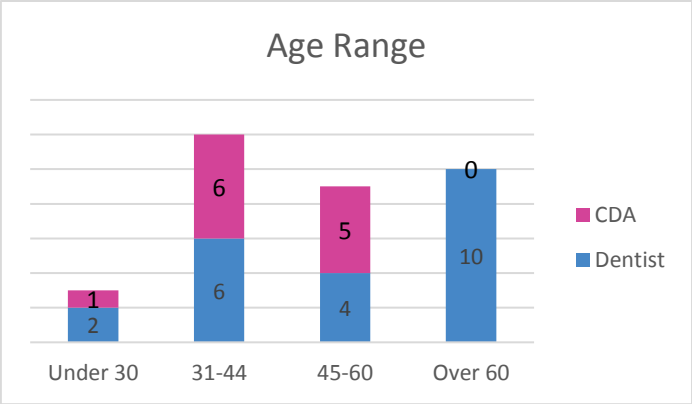
Overall, the listening session was evenly represented by both male and female registrants. All of the CDA participants were female, which reflects the College's CDA registrants overall (99% female). Among dentists at the session, males were over-represented compared to the College's registrants overall (3:1 at the session vs 2:1 overall).



Age

Participants at the listening session were generally representative of the College's registrant overall makeup, given the smaller size of the group.

Participants at the session skewed older overall, with fewer attendees in the youngest age bracket, and more attendees in the oldest bracket.



OPENING DISCUSSION

To open the listening session, participants discussed the following question, writing down their responses and sharing their ideas with the rest of their table. Responses are themed into general categories along with some examples of comments from participants in the table below.

The purpose of this question was to allow the participants to share some general concerns with early on in the session, and to allow items to be raised that may not fall within the four discussion topics on the agenda. We designed this question to give attendees the opportunity to be heard on the issues that matter to them, without limiting their responses by way of the session's structure.

Discussion question

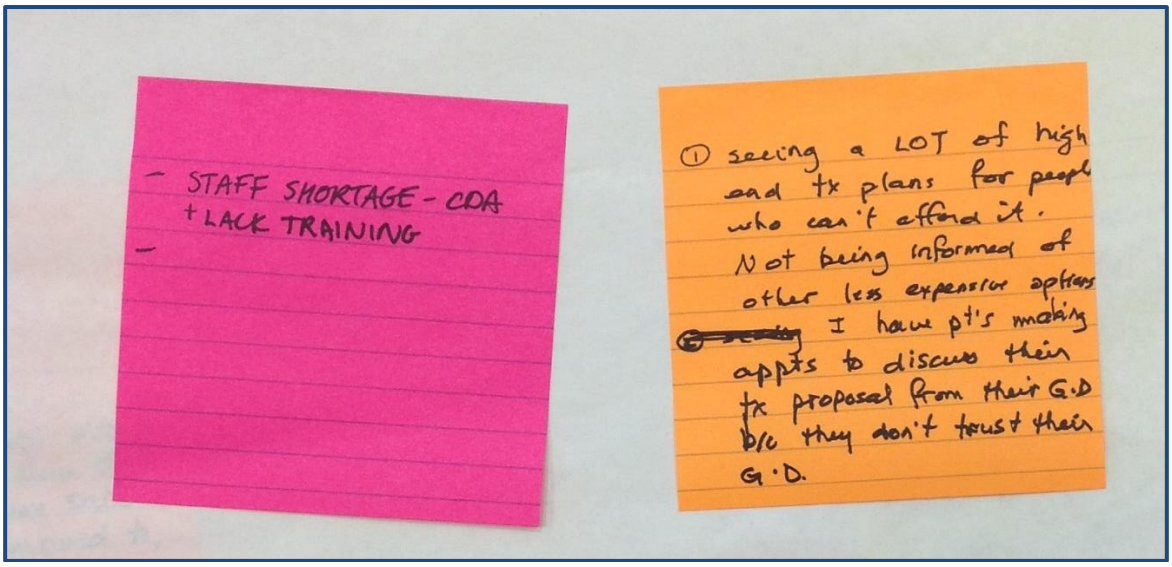
- Thinking about your own practice and what you are seeing in the profession, what would you like your regulator to know?

Participant input

General themes	What participants said
CDA capacity challenges	"Difficulty in obtaining CDAs in rural setting" "Staff shortage – CDAs lack training" "New CDA grads not as competent as they should be…" "There are not enough CE courses (for CDAs) around unless you go to a bigger city or have to be registered under DDS to go"
"Corporate Dentistry"	"How do we / a patient know a practice is corporate? How does an individual practice compete?" "Corporate dentistry and patient-centred practice in my experience are mutually exclusive concepts" "Dental practice management companies that don't know enough about dentistry / Practice (often dentist) managers either have business or dental training not both"
The reputation of the profession	"I am worried about the reputation of our profession (as a medical/health profession) against the corporate dentistry and cosmetic practices (i.e. Botox, fillers, etc.)" "Unethical advertising / advertising violations are a key threat to collegiality / public respect. I feel the College should be more proactive re: advertising enforcement" "Less collegiality amongst members of the profession. Particularly new graduates. Is ethics being taught at school? Should our regulator be educating the membership more?" "Seeing a lot of high end treatment plans for people who can't afford it. Not being informed of other less expensive options. I have patients making appointments to discuss their treatment proposal

	from their General Dentist because they don't trust their General Dentists"
Concerns related to clinical treatment / standards & guidelines	"Clarification of infection control policy regulations" "Sedation guidelines as is are too restrictive in the area of moderate sedation, especially in regards to use of 2 medications. This relates more to the adult patient." "Quality of Dentistry for First Nations dental treatment. No follow up / quality of dentistry"
Concerns related to new dentists	"New dentists and debt load" "New dentist in a very saturated market" "Legal advice or education at the student level may be required / Liaison / mentor I have noticed that young dentists seem to be signing contracts with unreasonably restrictive covenants which would not be defensible in court"

See **Appendix A** for a full list of participants' answers to the opening discussion question.



TOPIC 1: QUALITY ASSURANCE PROGRAM

Topic overview

The College Board has directed the Quality Assurance (QA) Committee to establish a working group to begin the process of enhancing its QA Program. The working group will research and develop a comprehensive plan that will:

- promote career-long hands-on learning.
- encourage collaborative discourse amongst colleagues.
- improve treatment outcomes for patients.

This initiative will require a high level of engagement with registrants and stakeholders, with a particular focus on two main topics: continuing education (CE) requirements and continuing practice hours.

Discussion questions

- What are your thoughts about the current system of Continuing Education?
- What else might help you grow dental knowledge and skills?
- (Optional) What might be a better way than continuing practice hours to demonstrate that you are current in your practice skills?

Participant input

Participants discussed both main questions, offering feedback on the current system of CE and suggestions on how they might grow their dental knowledge and skills. Continuing practice hours were also discussed, but conversation focused more on continued learning.

General themes	What participants said
Opportunities/inadequacies exist within the current program but a one-size-fits-all solution won't work	"Poor quality courses" "CE should make you better." "Mandatory CE some courses should be required" "Geographic locations (challenges)" "Sometimes confusing when it comes to selecting categories for credit" "CE ok as is" "Hands on not good for all learning types. Have flexibility in how you get CE"
Support for hands-on and group mentoring/support	"Mentorship - want more opportunities" "Hands on is good

	○ Hours more valuable ○ Limited options for CDAs”
Concerns specific to CDAs learning options	“CE for CDAs good → hard to find subject / variety” “CDA CE Requirements should be rigourous” “CDA possible hands on courses ○ rubber dam application ○ provisional restorations ○ sealants ○ impression making ○ radiography”
Opportunities for the future	“Expanded opportunities – online” “Online forum – for feedback and learning” “More podcasts”
Continuing Practice Hours seem arbitrary	“Inflexible – does not account for changing career models” “Nothing a College can do to verify reporting – Quality of Continuing Practice Hours varies. Continuing Practice Hours are meaningless.” “Bare minimum (CDA)”

See **Appendix B** for a full list of participants’ comments.

TOPIC 2: BUSINESS OF DENTISTRY AND CORPORATE STRUCTURES

Topic overview

The "corporatization" of dentistry, as an ownership structure, continues to be a topic creating a lot of discussion within the profession. Subject to the ownership rules and accountability, the College is primarily concerned with patient care and not corporate structures, but does recognize that there are inherent challenges for dentists as both a business person and a healthcare professional. The College has tools addressing both quality of care and ownership to ensure that appropriate care is being delivered by the appropriate people. The College wants to hear from registrants about what problems/challenges they see, so that any gaps in the tools that we do have can be identified and addressed.

Discussion questions

- What aspects of corporate dentistry are affecting patient-dentist interactions, and how do you know this?
- What could CDSBC do to address these challenges?

Participant input

Participants discussed several aspects of "corporate dentistry", including anecdotal feedback, and provided potential solutions to the concerns they raised.

General themes	What participants said
Financial needs of the business taking priority over patient care	"Creating 'wants' rather than treating dental needs" "Overtreatment - No justification (evidence) for proposed treatment" "Quotas (hearing about anecdotally)" "Big corps are squeezing 'costs' by reducing staff and driving down wages"
Autonomy and staff concerns	"Dental loss of professional autonomy • Procedures/materials/referral specialists being determined by manager/principal" "CDAs / Hygienists / Receptionists are incentive driven • Bonuses for meeting • If earn X this month, everyone gets a bonus • Certain targets" "Staff issues • Unfair treatment of associate dentists and staff by managers/principals • Loss of continuity due to high staff turnover and reliance on temporary staff"

Ownership/structure solutions	"Can we limit the number of practices a dentist can own?" "Can we mandate owner must practice in their "owned" office? i.e. must do general dentistry at least X% of time in practice" "Need to ensure Accountability of non-dentist managers"
Ethical concerns	"Address 'quotas' of any sort as an ethical issue → speak to it in code of ethics / articles" "Need to reinforce ethical conduct and accountability of clinicians • Increased education/involvement w/ students"

See **Appendix C** for a full list of participants' comments.

TOPIC 3: DENTAL LABORATORY FEES

Topic overview

The College was recently asked to investigate a complaint regarding dental laboratory fees that had ethical considerations. The Inquiry Committee asked the Board for direction, which in turn tasked the Ethics Committee with considering a framework for dental lab fees. There are a number of considerations, including lab ownership, third-party vs. in-house labs, discounts/incentives, and the blending or averaging of lab costs. The College wants to hear from registrants about their experiences in this area to gain further insight.

Discussion questions

- What are your concerns, if any, about how some offices are charging the patient for laboratory fees?
- What are the models you have seen?
- What else should CDSBC consider on this topic?

Participant input

Participants engaged with the questions by sharing some anecdotes and discussing a few of the models they have seen. Participants were largely unaware of these kinds of issues with dental laboratory fees.

General themes	What participants said
Lack of awareness of issue	"Not known if widespread" "Are we fishing for a problem?" "Require more information/specifics"
Competition issues	"Look into implications of response of competition" "Large managed group practice dictates to associates where lab work is done – not acceptable – should be the associate practitioner's choice as to where work is sent, with the opportunity to consider local recommendations. Potential for conflict of interest if the owner also owns the laboratory." "Outsourcing for cheaper fee?"
Estimate/billing models (particular lack of support for "averaging" lab costs)	"Wide variety of costs depending on material size of restoration" "Estimates - How best to handle cost variation when estimating? • Lump sum – clinic and lab not separated in estimate • Separate items – clinic and lab • Add % to cover warranty? o A cost variation"

	"Lab fees should be passed to patient and not averaged" "Discounts on bulk amounts or gift cards pass along to patient or insurer"
Ethics / conflict of interest / transparency / informed consent concerns	"Dentists inflating lab cost" "Must be communicated to patient" "Questionable ethics?"
General feedback	"Some labs encourage use of cheaper materials to new dentists – be careful" "Tendency to rely on / trust labs"

See **Appendix D** for a full list of participants' comments.

TOPIC 4: EMERGING ISSUES IN DENTISTRY

Topic overview

The bulk of the College's time and resources are spent on items required by legislation. The Board has set its priority items (outside of those core activities) for the year ahead. Dentistry is constantly changing, and the Board would like to hear from registrants about the issues that it is likely to need to prepare for in the future to fulfill its mandate to protect the public.

Discussion question

Thinking ahead to five years from now, what emerging issues do you want the College to be aware of to meet its mandate of public protection?

Participant input

General themes	What participants said
Effects of "corporatized practice"	"Financial pressures (Over treatment/overcharging)" "Corportization → public is the real loser" "Convince government it's in public interest that dentist must own dental practise"
Ethical concerns	"Stress on ethics • Financial • Cultural • Professional • corporate structure"
Access & quality of care concerns	"Access to care – where do people go who don't have the resources" "Quality of care for indigenous population – should be equal to everyone else" "5 years → even more dentists. Have a plan to give incentive to new dentists in rural areas"
Patient focus	"Patient's lack of voice" "Patient expectations" "College support in educating patients about dental plans"
Increased competition	"Too many dentists (BC is a desirable place to live)" "Labour mobility → more foreign trained dentists" "Advertising: enforcement of bylaws / be more proactive about searching out people not following the bylaws"

See **Appendix E** for a full list of participants' comments.

EVALUATION AND NEXT STEPS

Registrants were asked to complete an evaluation form at the end of the session. Overall, registrants liked the opportunity to have guided small group discussions with their peers and a few commented that session could have been longer and suggested more Q&A time with the entire group or a debriefing at the end.

Survey responses

General themes	What participants said
What worked well	"Working in small groups!" "Keeping discussion focused, not moving it to get off topic - could have gone on all night without good control/leadership. Thx!" "Less formal."
What could be improved	"Need more time to discuss /add/create.- perhaps pre-session email of this is what's happening and think of more things?" "Need more time for summary of all the different group ideas. Looking forward to the written summary." "More Q&A time - addressing the entire crowd."

See **Appendix G** for all of the registrant evaluations.

What happens next?

This report will be shared with the Board and relevant committees for their consideration as outlined in the session overview.

The first listening session was a success and the College will continue this listening exercise by hosting more sessions throughout the province in 2017. Upcoming listening session dates will be posted to the events page of the College website.

APPENDICES

Appendix A: Opening discussion

Opening Question: Thinking about your own practice and what you are seeing in the profession, what would you like your regulator to know?

- Training – DAs / CDAs – wants to do his own training
- Difficulty in obtaining CDAs in rural setting
- Less collegiality amongst members of the profession. Particularly new graduates. Is ethics being taught at school? Should our regulator be educating the membership more?
- Respect for dentist and professional judgement
- Regulatory decisions cost money in dental practices and effect access to care
- Lack of ethics
- Overuse of aggressive billing

- I worry about large corporate dentistry
- Staff shortage – CDAs lack training
- Seeing a lot of high end treatment plans for people who can't afford it. Not being informed of other less expensive options. I have patients making appointments to discuss their treatment proposal from their General Dentist because they don't trust their General Dentists
- Seeing a lot more patients that need treatment finished because practitioner got a lot over their head. They end up losing a patient forever. The patient likely would have preferred to have a good experience in a specialist's office than go back to general dentist for good exp.
- Quality of dentistry for First Nations dental treatment. No follow up / quality of dentistry / overbilling
- Value of additional modules for CDAs
- Clarification of infection control policy regulations
- Unethical advertising / advertising violations are a key threat to collegiality / public respect. I feel the College should be more proactive re: advertising enforcement

Transparency / Communication

- (1) Maximum of 2 consecutive terms in executive
- (2) More details on discipline matters, names, etc. Transparency

Improvement /OPP

- Mentorship program

Promotion / Reputation of Profession

- Integrity and cheapening the profession
- Advertising
    - Out of control
    - Disregard for other members
    - Misrepresentation and manipulation
        - Advertising flyers

Alignment with other Health Professions

- More support between college and medical profession
    - Regarding pre-antibiotics

- Hygiene registration → Dentist/CDA

- I am worried about the reputation of our profession (as a medical/health profession) against the corporate dentistry and cosmetic practices (i.e. Botox, fillers, etc.)
- Scope of practice for CDA staff

- QA
- CDA shortage
- New dentists and debt load
- New dentist in a very saturated market
- Ethical suggestions regarding child oral health negligence
- New grade not up to snuff / not as willing to learn – not same work ethic
- When providers move offices, previous office won't say where said provider has moved to and patients upset
- Clarity on upcoming promotional activity changes
- New CDA grads not as competent as they should be … attitudes / Dentists need to know their CDAs need a break
- Dental practice management companies that don't know enough about dentistry / Practice (often dentist) managers either have business or dental training not both
- New CDA grads don't seem to know everything they should and poor work ethic
- Private Hygiene Clinics not following 365 Rule
- Corporate dentistry and patient-centred practice in my experience are mutually exclusive concepts
- How do we / a patient know a practice is corporate? How does an individual practice compete?
- Legal advice or education at the student level may be required / Liaison / mentor I have noticed that young dentists seem to be signing contracts with unreasonably restrictive covenants which would not be defensible in court
- Patient to be informed when a private practice has been purchased by a management company / what this means to them
- Why can't CDAs give patient NSAIDS once DDS has instructed dosage?
- There are not enough CE courses around unless you go to a bigger city or have to be registered under DDS to go
- Associate dentist contractually

- College as part of its mandate to protect the public need to impress on the government the need to provide better coverage for patients with disabilities, especially the patients with mental issues
- Need more input in regards to the 900 hrs. rule as it pertains to female dentists who take leave for pregnancy or a dentist who is undergoing treatment for a serious disease (i.e. cancer)
- Sedation guidelines as is are too restrictive in the area of moderate sedation, especially in regards to use of 2 medications. This relates more to the adult patient.

Appendix B: Quality Assurance Program

Discussion host: Dr. Ash Varma

Continuing Education

- Poor quality courses
- Not enough good ones
- Good as is
- More CE for CDA: (hours)
- CE should make you better
- Mandatory CE some courses should be required
    - CPR
    - Recordkeeping
    - Others?
- Sometimes confusing when it comes to selecting categories for credit
    - All the time for some
- Not enough time to get CE
- Expanded opportunities
    - Online
- Like current system
- Online forum – for feedback and learning
- Not enough specifics for CDAs
- How to access learning opportunities
- Put on website
- How to find courses
- Geographic locations (challenges)
- Mentorship want more opportunities
- More podcasts
- Study clubs
- CDA possible hands on courses
    - rubber dam application
    - provisional restorations
    - sealants
    - impression making
    - radiography

Continuing Practice Hours

- CP has value
- Can get rusty if not
- bare minimum (CDA)

Discussion host: Dr. Alex Hird

Continuing Education

- Okay now
- Limits on subject/category ok
- CE ok as is.
- Hands on not good for all learning types
    - Have flexibility in how you get CE
- Encourage business development
    - Healthy practices / profession for public good
- CE for CDAs good → hard to find subject / variety
- CDAs need to be more included in different subjects

- Needs of CDAS need to be considered
- CDA CE Requirements should be rigourous
- Some don't like recertification for CDAs
- Peer evaluation
    - Who is doing it
    - Colleagues
- Increase practice management hours
    - Local Norms?
    - Affects cost of care
- Currently easy to pass
- Hands on is good
    - Hours more valuable
    - Limited options for CDAs
- Current quality of treatment inadequate
    - Increase education
- Mentorship
- Categorize CE courses by subject
- Clusters of practitioners to call upon

Continuing Practice Hours

- CPH
    - inflexible
    - Does not account for changing career models
- Nothing a College can do to verify reporting
    - Quality of CPHs varies
    - CPH meaningless

Appendix C: Business of dentistry and corporate structures

Discussion host: Jerome Marburg

1. Overtreatment
    - No justification (evidence) for proposed treatment
2. Is stage of career affecting treatment planning
    - Young or too idealistic
    - More experienced = more conservative
    - Some say exactly the opposite. Young dentists not over treating. Older dentists are.
3. Quotas (hearing about anecdotally)
4. Philosophy driven by certain CE institutes and organizations – Creating "wants" rather than treating dental needs
5.
    a) How do/can new dentists compete with established practices
    b) Big corporations are buying practices at a premium – driving price up for others
6. CDAs / Hygienists / Receptionists are incentive driven
    - Bonuses for meeting certain targets
        - E.g. If earn X this month, everyone gets a bonus
7. Big corps are squeezing "costs" by reducing staff, driving down wages
8. Who is the patient's dentist
    - Continuity of care
    - Dental staff turn-over due to #7 squeeze

Solutions:

- Can we mandate owner must practice in their "owned" office?
    - Must do general dentistry at least X% of time in practice you own
- Can we limit the number of practices a dentist can own?
- How can we get people affected by corporate dentistry practices to speak out / share their experiences?
    - Dentists
    - Staff
    - Patients
- Model clauses in:
    - Practise / sale agreement (earning quota in sales agreement)
    - Associate
    - Employment
- Address "quotas" of any sort as an ethical issue → speak to it in code of ethics / articles

Discussion host: Greg Cavouras

- $ Business taking priority over patient care
    - Quotas
    - Focus on maximizing revenue instead of what is best for the patient
- Dentist loss of professional autonomy
    - Procedures/materials/referral specialists being determined by manager/principle
- Staff issues
    - Unfair treatment of associate dentists and staff by managers/principles
    - Loss of continuity due to high staff turnover and reliance on temporary staff
- Need to ensure Accountability of non-dentist managers
    - Concern that College rules don't apply to corporate practices
- Inadequate/incomplete information for patients about ownership and who is responsible for treatment
- Need to Reinforce ethical conduct and accountability of clinicians
    - Increased education/involvement w/ students

Appendix D: Dental laboratory fees

Discussion host: Rick Lemon

- Running fees through secondary labs for a fee (Must have informed consent)
    - Where is lab? / Out of country?
- Not known if widespread
- No clarification to patients about extra fees
- Is there a breakdown on fee guide for this?
- Not supportive of averaging
- Require more information / specifics
- Some labs encourage use of cheaper material to new dentists – be careful
- Tendency to rely on / trust labs
- Is it a "policing lab issue"
- Are we fishing for a problem?
- Must be communicated to patient
- Dentists inflating lab cost
- Need to clarify lab fees
- Wide variety of costs depending on material size of restoration
- Discounts on bulk amounts or gift cards pass along to patient or insurer
- Questionable ethics?

Discussion host: Dr. Peter Stevenson-Moore

Anecdotes:

- Out-sourcing
    - Received new lab slip
    - Work of lesser quality than local techs – now shut down relationship with China
    - Open pack – smell is wrong – don't feel right
- Associate gets benefit for using Cerec
    - Deceased compensation to associate
- Large managed group practice dictates to associates where lab work is done – not acceptable – should be the associate practitioner's choice as to where work is sent, with the opportunity to consider local recommendations. Potential for conflict of interest if the owner also owns the laboratory.
- Lab fees should be passed to patient and not averaged
- Quote should provide cost to patient
- Charge the actual cost
- Look into implications of response of competition
- Estimates - How best to handle cost variation when estimating?
    - Lump sum – clinic and lab not separated in estimate
    - Separate items – clinic and lab
    - Add % to cover warranty?
        - A cost variation
- Outsourcing for cheaper fee?

Appendix E: Emerging issues in dentistry

Discussion host: Susan Chow

1. Too many dentists
    - B.C. is a desirable place to live
2. Financial pressure
    - over treatment
    - over charging
3. Patient's lack of voice
4. Who is advocating for old + young patients?
5. Ethics
6. Re-certification → ? → valid
7. Education →
8. 5 years → even more dentists. Have a plan to give incentive to new dentists in rural areas
9. Monitor → surprise visits
10. Business of dentistry mentorships to new dentists
11. Corportization → public is the real loser
12. Labor mobility → more foreign trained dentists
13. Computer technology
14. Access to care for the disabled: medically compromised

Discussion host: Patricia Hunter

1. Increased number of dentists and decreased ratio of Patient/Dentist
2. Stress on ethics
    - Financial
    - Cultural
    - Professional
    - Corporate structure / Culture
3. How do you do corporate dentistry so it's done well
    a) non-practising dentist not allowed to own
    b) need to be major practising dentist in each dental practice they own
    c) managers – know dentistry and business (formal training)
    d) don't allow quotas

* Each dentist should have control over their treatment plan and maintain own "patient family"

4. Pay licensing fee based on income – and/or the number of (complaints – with legitimate issue) a dentist has had against them, i.e. based on how much time they take up in the "inquiry system" so the "frequent fliers" would pay more.
    - this might result in dentists paying off patients to avoid complaints
5. Advertising
    - Enforcement of bylaws
    - Be more proactive about searching out people not following bylaws
6. Release newest guidelines on antibiotic pre-med
7. Patient expectations
8. College support in educating patients about dental plans
9. Access to care – where do people go who don't have the resources
10. Quality of care for indigenous population – should be equal to everyone else
11. Convince government it's in public interest that dentist must own dental practise

Appendix F: Speaker Biographies

Dr. Ash Varma
Chair, Quality Assurance Committee

Ash has been a volunteer with the College since 1989. He has served on many committees, and chairs the QA committee and the CE subcommittee. He served as both President and Vice-President of the College Board. Prior to that, he was the Upper Island board member for several years. Ash practises in Powell River.

Greg Cavouras
Legal Counsel

Greg is Legal Counsel for the College. He acts for the College in a wide range of legal proceedings, including discipline cases, unauthorized practice and complaints review before the Health Professions Review Board. Prior to joining the College, Greg was a litigator for a leading national law firm.

Dr. Peter Stevenson-Moore
Member, Ethics Committee and Past-President

Peter is a long-time volunteer with the College. He has chaired several committees and served the Board as President, Vice-President and Treasurer – and prior to that was the Certified Specialist board member. Peter is currently the Vice-Chair of the Nominations Committee and member of the Ethics Committee. He practises prosthodontics in Vancouver.

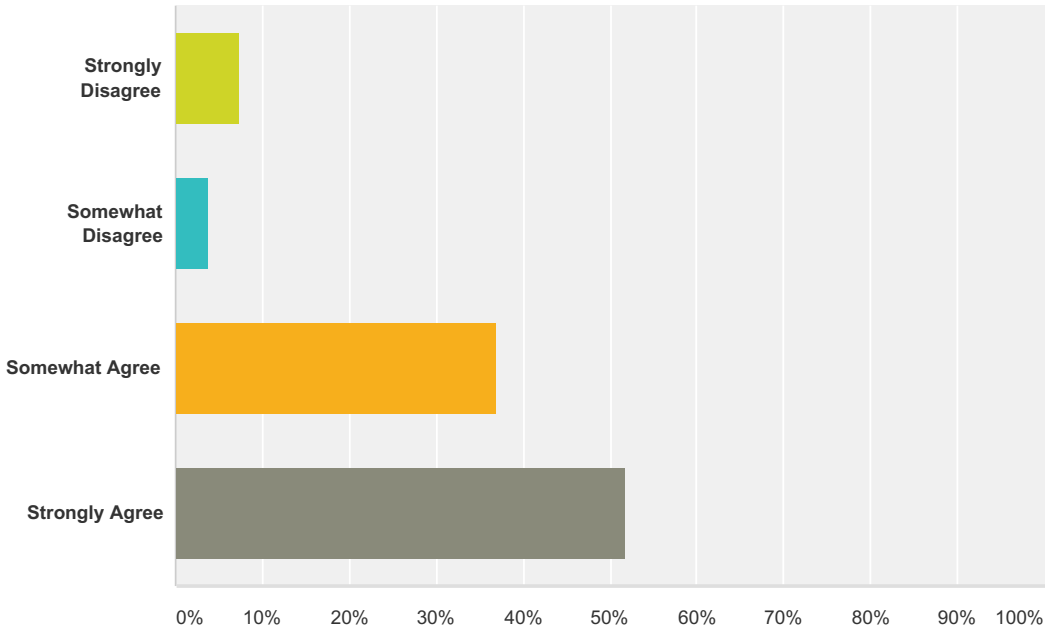
Jerome Marburg
CEO/Registrar

Jerome is the College's Registrar and CEO. He directs all administrative and operation matters, including the regulatory and policy responsibilities set out in the *Health Professions Act*, regulations and CDSBC Bylaws. Jerome has extensive experience as a regulator, executive manager and general counsel for professional regulatory bodies, with a strong background in board governance, policy analysis and practical business administration.

Appendix G: Participant evaluations

Q1 I had adequate opportunities to express my views.

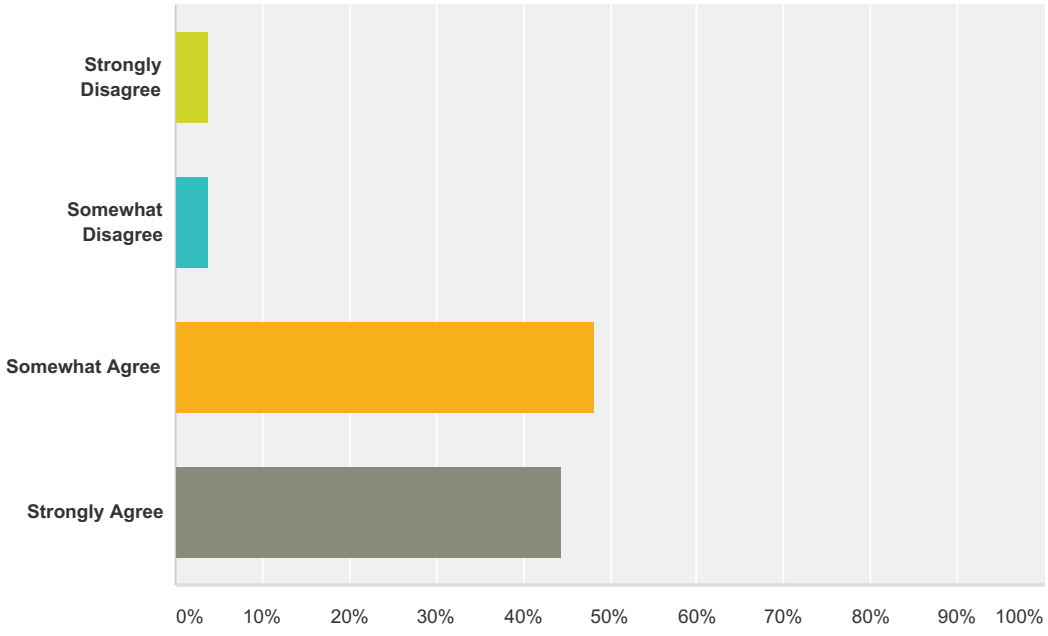
Answered: 27 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	**7.41%**	2
Somewhat Disagree	**3.70%**	1
Somewhat Agree	**37.04%**	10
Strongly Agree	**51.85%**	14
Total		**27**

Q2 There was adequate opportunity for participants to exchange views and learn from each other.

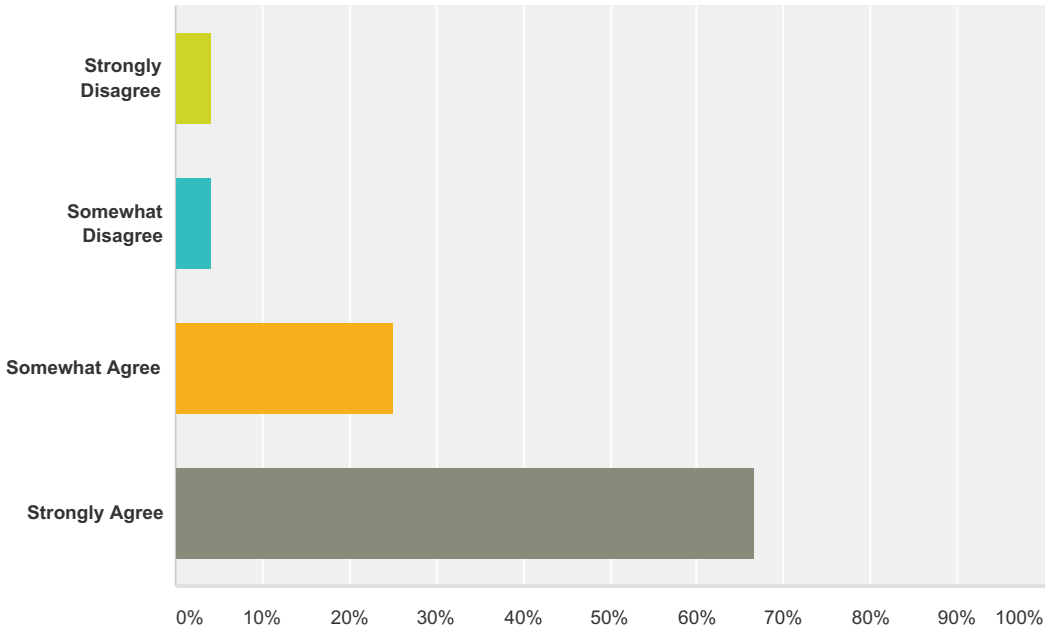
Answered: 27 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	**3.70%**	1
Somewhat Disagree	**3.70%**	1
Somewhat Agree	**48.15%**	13
Strongly Agree	**44.44%**	12
Total		**27**

Q3 CDSBC demonstrated a commitment to listening.

Answered: 24 Skipped: 3



Answer Choices	Responses	
Strongly Disagree	**4.17%**	1
Somewhat Disagree	**4.17%**	1
Somewhat Agree	**25.00%**	6
Strongly Agree	**66.67%**	16
Total		**24**

Q4 Additional comments on the Quality Assurance Program review?

Answered: 10 Skipped: 17

#	Responses	Date
1	Support programs for CDAs - safe.	11/4/2016 11:00 AM
2	Seemed to mute discussion and control the outcome!	11/4/2016 10:59 AM
3	How do patients know what good dentistry looks like? How do patients know what makes a good dentist? ie. skills just not personable and charming.	11/4/2016 10:55 AM
4	Thank you for trying but I don't think the College can ever really assure quality.	11/4/2016 10:54 AM
5	Need more hands on learning opportunities.	11/4/2016 10:46 AM
6	Emphasis on multifaceted approach.	11/4/2016 10:45 AM
7	Antibiotic overuse. Informed consent - Pt. need to be given their options. Competency within office specialties - ortho, implants.	11/4/2016 10:28 AM
8	Could be more effective of more time allowed perhaps a one day event. A positive start to be receptive to the registrants.	11/4/2016 10:26 AM
9	Everything comes back to "ethics"	11/4/2016 10:18 AM
10	It's difficult to address or achieve anything with such chopped up time slots for each zone.	11/4/2016 10:07 AM

Q5 Additional comments on Business of dentistry and corporate structures?

Answered: 6 Skipped: 21

#	Responses	Date
1	Got to share all my thoughts.	11/4/2016 10:54 AM
2	Need more control over this type of practice and evacuation of ethical practices.	11/4/2016 10:46 AM
3	Crystalise the issues by creating structure to control/regulate.	11/4/2016 10:45 AM
4	$ is the focus. Large corporations. Corporatization is the mechanism for $. Symptoms: Compromised ethics. Advertising. Poor patient tereatment	11/4/2016 10:37 AM
5	Are owners of dental corp etc. licensed to practise in the province of their clinics?	11/4/2016 10:21 AM
6	Everything comes back to "ethics"	11/4/2016 10:18 AM

Q6 Additional comments on Dental laboratory fees?

Answered: 8 Skipped: 19

#	Responses	Date
1	Didn't know there was an issue.	11/4/2016 10:57 AM
2	Didn't know this was a problem.	11/4/2016 10:54 AM
3	This is not a problem?? Why we talk about?	11/4/2016 10:51 AM
4	Interesting to know.	11/4/2016 10:48 AM
5	Perhaps survey and put out a cost recommendation/range like the fee guide.	11/4/2016 10:45 AM
6	If the patient is clear on costs, I don't see an issue.	11/4/2016 10:37 AM
7	What! I didn't know there was a problem. Maybe address on a case by case basis?	11/4/2016 10:23 AM
8	Ethics	11/4/2016 10:18 AM

Q7 Additional comments on Emerging issues in dentistry?

Answered: 5 Skipped: 22

#	Responses	Date
1	Tighter regulations for CDA programs (schools).	11/4/2016 10:54 AM
2	Pt. care vs. $$. What's more important now.	11/4/2016 10:51 AM
3	Access to care.	11/4/2016 10:37 AM
4	Accreditation of foreign dentists --> too may dentists.	11/4/2016 10:21 AM
5	Ethics	11/4/2016 10:18 AM

Q8 What worked well at the Listening Session?

Answered: 20 Skipped: 7

#	Responses	Date
1	Group discussion and way groups were established.	11/4/2016 11:07 AM
2	Many concerns brought to light.	11/4/2016 11:05 AM
3	For me - conversing with my peers.	11/4/2016 11:00 AM
4	Very disorganised.	11/4/2016 10:59 AM
5	Hearing the different concerns from the different team members.	11/4/2016 10:57 AM
6	Everything!	11/4/2016 10:55 AM
7	Group discussion	11/4/2016 10:54 AM
8	Being in groups and discussing different topics and taking the time to discuss.	11/4/2016 10:51 AM
9	Some ability to express opinion.	11/4/2016 10:49 AM
10	Adjudicators - fabulous	11/4/2016 10:48 AM
11	Small groups.	11/4/2016 10:46 AM
12	Short guided discussions.	11/4/2016 10:45 AM
13	Keeping discussion focused, not moving it to get off topic - could have gone on all night without good control/leadership. Thx!	11/4/2016 10:39 AM
14	More structured, less individual opportunity to talk about "real" concerns or individual concerns.	11/4/2016 10:33 AM
15	Working in small groups!	11/4/2016 10:28 AM
16	Breaking into smaller groups with a board member to discuss large issues.	11/4/2016 10:23 AM
17	Multiple ideas and approaches - brainstormed.	11/4/2016 10:21 AM
18	Good interaction	11/4/2016 10:18 AM
19	Dentists should have more say (a vote) in any financial or budgetary issues.	11/4/2016 10:07 AM
20	Less formal.	11/4/2016 10:02 AM

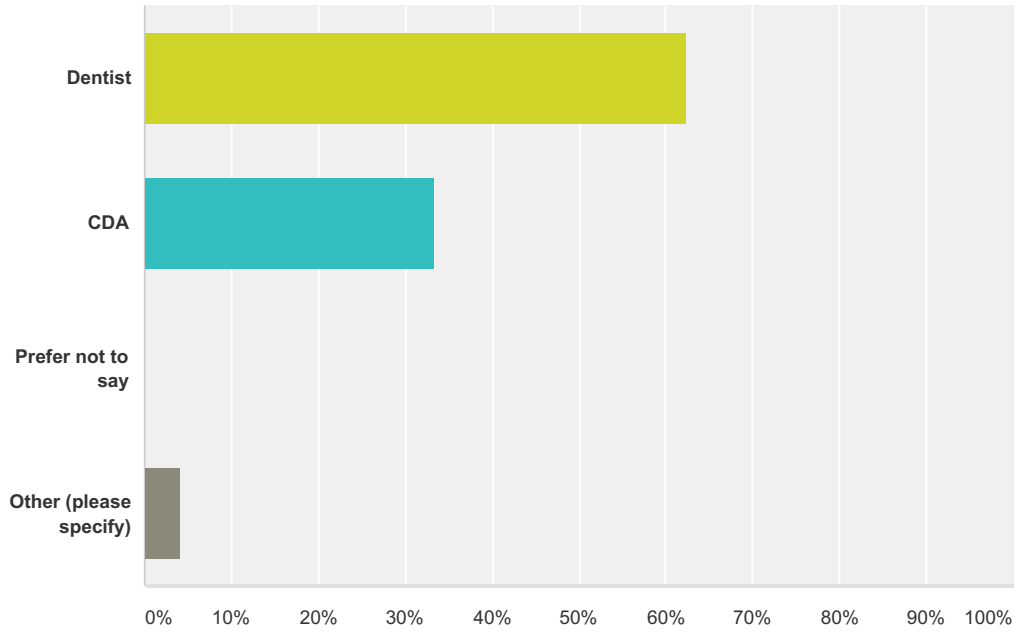
Q9 What could have been improved about the Listening Session?

Answered: 18 Skipped: 9

#	Responses	Date
1	Possibly a larger discussion? I was satisfied with the length of time for discussion but some wanted more.	11/4/2016 11:07 AM
2	Debriefing session: all present participating-->open discussion.	11/4/2016 11:05 AM
3	Time allowance.	11/4/2016 11:00 AM
4	Q&A.	11/4/2016 10:59 AM
5	Time length: too many topics and speakers and discussion forums for 2 hour session. Felt rushed.	11/4/2016 10:57 AM
6	Perhaps a little longer.	11/4/2016 10:55 AM
7	Could have been wine.	11/4/2016 10:54 AM
8	More time. The session was not long enough. And some wine please. :)	11/4/2016 10:51 AM
9	Ask each participant for their opinion.	11/4/2016 10:49 AM
10	"Merry" go round!	11/4/2016 10:48 AM
11	Slightly longer sessions. Use a bell or ringer. Designate numbers to people beforehand. (There was a bit of confusion).	11/4/2016 10:45 AM
12	More Q&A time - addressing the entire crowd.	11/4/2016 10:29 AM
13	Nothing.	11/4/2016 10:28 AM
14	Too many issues in a short time. Maybe break into two sessions.	11/4/2016 10:23 AM
15	Need more time for summary of all the different group ideas. Looking forward to the written summary.	11/4/2016 10:21 AM
16	Would have been good to have a few more local people here participating - maybe next time.	11/4/2016 10:18 AM
17	Longer session.	11/4/2016 10:07 AM
18	Need more time to discuss /add/create.- perhaps pre-session email of this is what's happening and think of more things?	11/4/2016 10:04 AM

Q10 To which of the following groups do you belong?

Answered: 24 Skipped: 3



Answer Choices	Responses	
Dentist	**62.50%**	15
CDA	**33.33%**	8
Prefer not to say	**0.00%**	0
Other (please specify)	**4.17%**	1
Total		**24**

#	Other (please specify)	Date
1	no response	11/4/2016 10:05 AM


1
2
3
CDSBC

CDSBC | College of Dental Surgeons of British Columbia

We're All Ears:
Nanaimo Listening Session

28 March 2017

Participant Input Summary Report

28 April 2017

Table of Contents

INTRODUCTION

The College's policy development process emphasizes engagement with registrants and other stakeholders. CDSBC is building on this commitment by hosting a series of listening sessions, where registrants can learn about and engage with key topics and share their views with College representatives. The listening sessions are a province-wide opportunity to engage registrants in current policy development initiatives. Sessions will continue to be held over the coming months.

Purpose

To strengthen the College's relationship with registrants and enhance the quality of its work being done on key topics by hosting an in-person event that presents information and emphasizes registrant discussion and CDSBC listening.

About this report

This report is a summary of the listening session held in Nanaimo, B.C. on 28 March 2017. It describes the session, participants and topics; it also includes a complete list of participant input and feedback compiled during the session.

A note about participant comments

The appendices contain all participant comments recorded at the listening session. Comments representative of a theme are included in the participant input summary for each topic. Where appropriate, some comments have text in blue to indicate additional comments made by the discussion hosts to clarify the comment's meaning and/or theme. Corrections have been made to address spelling or other errors that did not change the meaning of the comment.

SESSION AGENDA

6:00 pm	Welcome
6:15 pm	Opening discussion
6:40 pm	Five-minute presentations on three topics
7:05 pm	Rotate through discussion stations for each topic
7:55 pm	Evaluation and closing
8:00 pm	Adjourn

SESSION FORMAT

Dr. Chris Hacker, CDSBC's Dental Policy & Practice Advisor, facilitated the listening session. After a welcome and introductory remarks, participants discussed an opening question with each other at their tables. They recorded their individual thoughts on sticky-notes and each table took turns sharing some of their best ideas with the entire group.

College representatives then gave short presentations on three topics. Participants were randomly divided into groups (two per topic), each with its own discussion host. The groups answered questions about each topic and recorded their discussion on flip charts. The groups rotated through all three topics over the course of the evening. They had 15 minutes to discuss the first topic and 10 minutes for each subsequent topic to build on the previous groups' ideas.

SESSION OVERVIEW

Topic	Presenter	Discussion hosts	How participant input will be used
Opening Question		Various	Participant input will be considered by the Board.
Quality Assurance Program	**Dr. Andrea Esteves** *Member, Quality Assurance Committee and QA Program Working Group*	Dr. Andrea Esteves Leslie Riva *Senior Manager, CDA Certification and Quality Assurance*	Participant input will be considered by the QA Committee working group.
Business of dentistry and corporate structures	**Jerome Marburg** *CEO/Registrar*	Dr. Don Anderson *President /* Dr. Susan Chow *Vice-President* Greg Cavouras *Legal Counsel*	Participant input will be considered by the Board.
Sedation dentistry and public protection	**Dr. Tobin Bellamy** *Chair, Sedation & General Anaesthetic Services Committee*	Dr. Tobin Bellamy Jerome Marburg	Participant input will be considered by the Sedation & General Anaesthetic Services Committee.

The following individuals also helped to support the listening session:

- Anita Wilks, Director of Communications

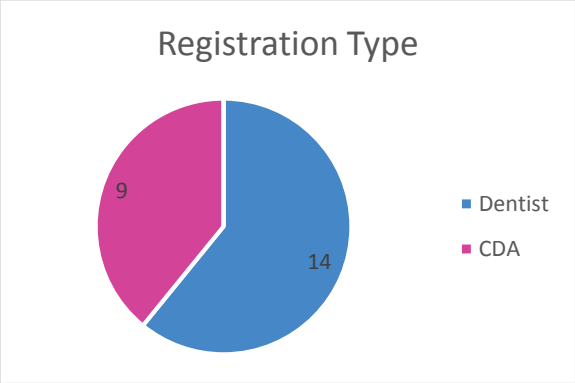
WHO PARTICIPATED IN THE SESSION

The listening session was held in Nanaimo, B.C. and 23 participants attended from the Vancouver Island district.

Registration type

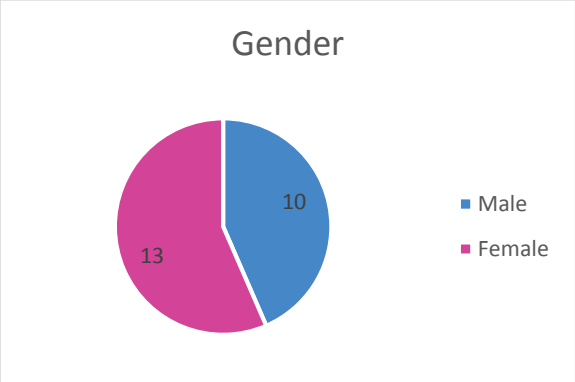
Of the 23 participants, 14 were dentists and 9 were certified dental assistants (CDAs). All of the participants hold practising status.

The ratio of dentists to CDAs at the listening session is not representative of the actual makeup of the College's registrants (there are almost twice as many CDAs as dentists).



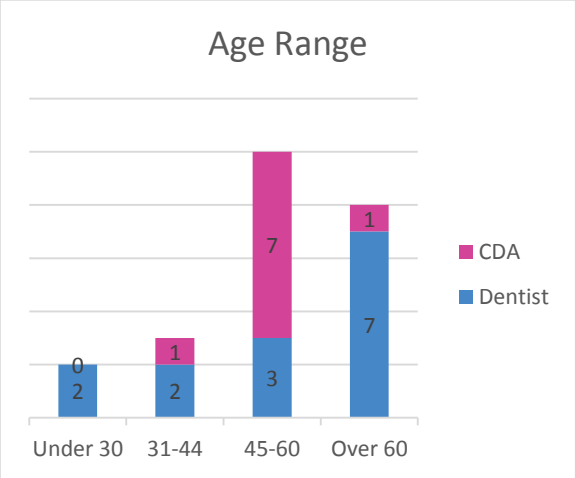
Gender

Overall, the listening session was generally representative of both male and female registrants. All of the CDA participants were female, which reflects the College's CDA registrants overall (99% female). Dentists at the session were nearly representative of the College's overall gender split (1/3 female, 2/3 male).



Age

Participants at the listening session were generally representative of the College's overall registrant makeup, though they did skew older, particularly among dentists. Of those attendees who were younger than 45, all were female.



OPENING DISCUSSION

To open the listening session, participants answered the question below, first by writing down their responses and then sharing their ideas with the rest of their table. Examples of participant comments are found in the table below, organized by theme.

The purpose of this question was to allow the participants to share some general concerns early on in the session, and to allow items to be raised that may not fall within the three discussion topics on the agenda. We designed this question to give attendees the opportunity to be heard on the issues that matter to them, without limiting their responses by way of the session's structure.

Discussion question

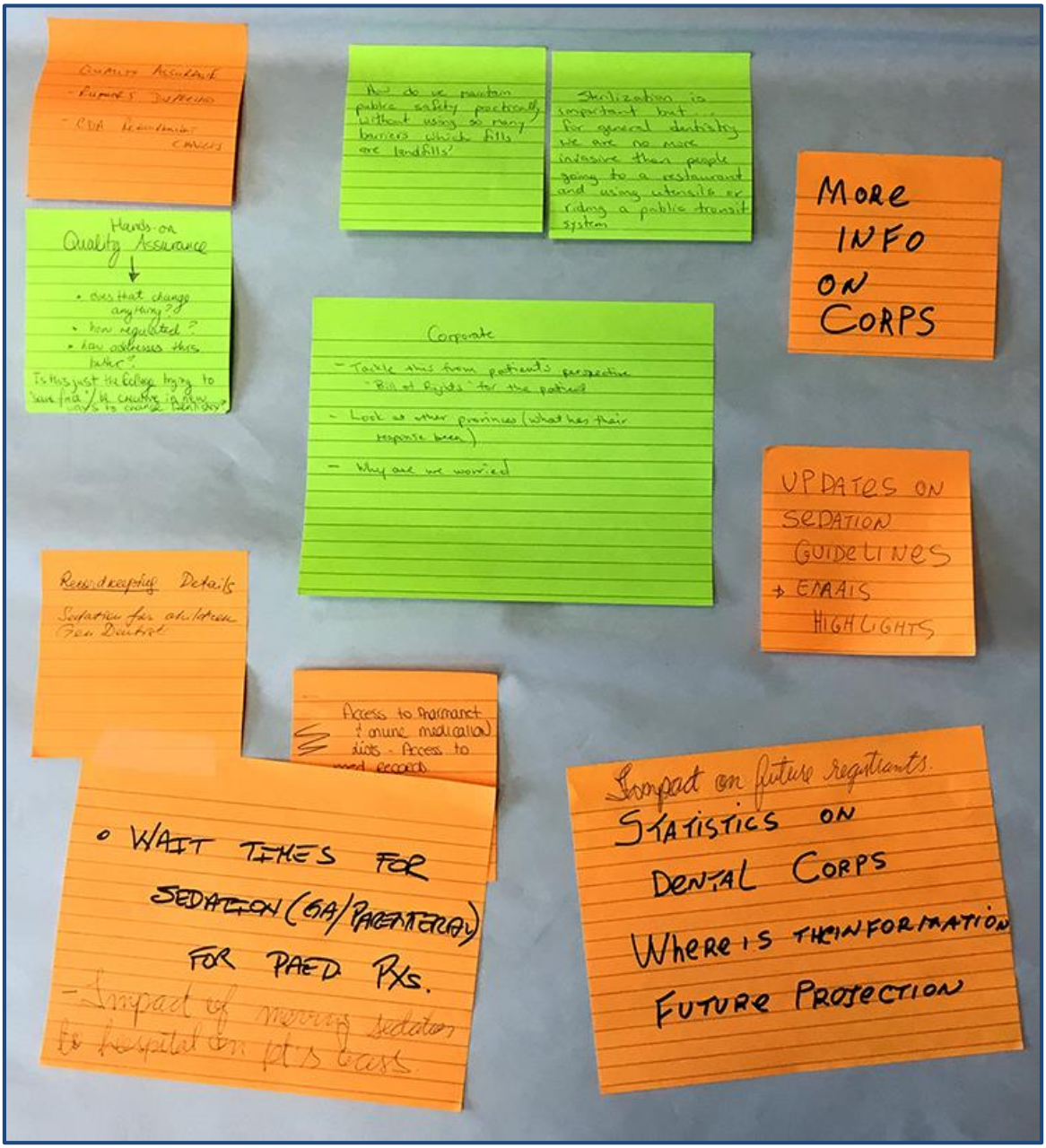
- Thinking about your own practice and what you are seeing in the profession, what would you like your regulator to know?

Participant input

General themes	What participants said
"Corporate Dentistry"	"Tackle this from patient's perspective: "Bill of Rights" for the patient. Look at other provinces (what has their response been?) and see why we are worried." "Continuity of care, patients seeing several different dentists, changing often – which leads to losing trust"
Business/Financial Concerns	"Manpower problems – training increases required for CDA / hygienists – internship, more clinical training for dentists" "Costs of materials and certain fees" "People going to third world places to get jobs done cheaper"
Concerns related to Quality Assurance	"Hands-on quality assurance → does that change anything? Why required? How to better addresses this? Is this just the College trying to "save face" / be creative in new ways to change dentistry?" "'Catching' outliers while not punishing (time, $, stress) the ones who aren't a problem" "Dispel the rumours about QA. CDA requirement changes"
Concerns related to new dentists	"The pressure new grads face in terms of student debt is immense. It is easy to see how there is pressure to compromise patient care to pay off debt. → need better accountability for university grads" "Personally I see the system working. However my greatest concern is the lack of training given to students in posterior composites. In my opinion amalgam does not belong in dentistry."
Concerns about sedation	"Wait times for sedation (GA/Parenteral) for patient treatment" "Impact of moving sedation to hospitals on patients' access" "Recordkeeping details: sedation for children and general dentists"

Public protection, scope of practice	"Access to PharmaNet and online medication lists – access to medical records" "Scope of Practice - Protect the public - Ortho skill sets - Implant skill sets → credentials – training" "CDAs want to utilize the skills they have within their scope of practice"

See **Appendix A** for a full list of participants' answers to the opening discussion question.



TOPIC 1: QUALITY ASSURANCE PROGRAM

Topic overview

The College Board has directed the Quality Assurance (QA) Committee to establish a working group to begin the process of enhancing CDSBC's QA Program. The working group will research and develop a comprehensive plan that will:

- promote career-long hands-on learning
- encourage collaborative discourse amongst colleagues
- improve treatment outcomes for patients

This initiative will require a high level of engagement with registrants and stakeholders, with a particular focus on two main topics: continuing education (CE) requirements and continuing practice hours.

Discussion question

- What do you think are the best ways to maintain and improve clinical skills and dental knowledge?

Participant input

Participants offered feedback on challenges with the current system of CE and suggested ways in which they might grow their dental knowledge and skills. The groups were particularly interested in mandatory courses focused on recordkeeping (and other topics) as well as the balance of online courses to in-person opportunities such as hands-on courses, mentorship, and study clubs.

General themes	What participants said
Difficulties obtaining CE	"Away from lower mainland, it is difficult to access CE" "Some hands-on courses are more marketing rather than information on improving skills or techniques" "Having the good courses online is helpful" "Lecture preparation does not count → writing paper does not count"
Mandatory courses, with a focus on recordkeeping	"Need universal charting system from office-to-office – nationally" "How often is bad recordkeeping the cause of poor patient outcomes?" "Required/Mandatory courses (or webinar) - Recordkeeping

	- Pharmacology - Pre-set topics per year - Standard charting - Infection control”
Hands-on courses	“Hands-on courses for CDA - role playing - have dentist play CDA - ergonomics / dentist-CDA relationship” “Hands-on courses are expensive and you don’t know if they are good” “Hands-on courses: tooth preparation with new materials”
Professional interactions as a part of QA	“Mentorship: on call” “Study clubs are great – include CDA - individual is important if takes good cases” “Study clubs - share failures – you learn from this” “Mandatory meetings/course once a year to interact”
Online courses	“Less/limited online courses” “Barcodes for all courses (apps or tags) and tracking #s for online courses associated with bar codes that make them accountable for showing up.” “Online courses should be split ½ self-time ½ interactive listening. Online sessions are not that interactive.” “Online is too remote but can be part of it (QA)”
Elements of a good QA program	“QA should have: - Diversity - Interpersonal interaction - Accessibility of hands-on and cost - Openness to required courses - Online - Study-clubs - Peer review - Mentorship - self-assessment - Residency year (graduated licensing) for new graduates / Mentorship – for new dentists - Sound foundation on every topic. All spec. general dentists should know all subjects: i.e. ortho surgery - Peer review → educated to not be judgemental” “Dentist responsibility to support CDAs’ QA” “Life stages may affect how to engage in QA”

	"Split CE categories:
	- Self-study
	  - Remote areas - some
	  - Urban areas – less
	- Specific to areas
	  - Endo
	  - Clinic
	  - Surgery"

See **Appendix B** for a full list of participants' comments.

TOPIC 2: BUSINESS OF DENTISTRY AND CORPORATE STRUCTURES

Topic overview

The "corporatization" of dentistry, as an ownership structure, continues to be a topic creating a lot of discussion within the profession. Subject to the ownership rules and accountability, the College is primarily concerned with patient care, but does recognize that there are inherent challenges for dentists as both a business person and a healthcare professional. The College has tools addressing both quality of care and ownership to ensure that appropriate care is being delivered by the appropriate people. The College wants to hear from registrants about what problems/challenges they see, so that any gaps in the tools that we do have can be identified and addressed.

Discussion questions

- What aspects of corporate dentistry are affecting patient-dentist interactions, and how do you know this?
- What could CDSBC do to address these challenges?

Participant input

Participants discussed several aspects of "corporate dentistry," including anecdotal feedback, and provided potential solutions to the concerns they raised.

General themes	What participants said
Concerns	"Continuity of care a challenge and a real problem. Revolving door with regards to staff." "Different dentist (or office manager) treatment plan vs. providing treatment" "Prioritization of money over patient" "Production-based mentality" "Comes down to ethics. Continuity of care #1 issue in my experience of why brave/informed patients leave these practices." "Loss of autonomy" "Corporations are hiring new grads who are in debt and need to work and only have corporate guidance."
Solutions	"Ask patients what their experiences are and develop a patient rights document with training for the public as to what is appropriate care" "Patient informed about ownership/dentists" "Accountability for corporations/individuals" "Complaint process" "Consider prohibiting assignments" "Marriage between UBC and College and also BCDA – all involving ethics" "Mentorship starting first year dental school"

See **Appendix C** for a full list of participants' comments.

TOPIC 3: SEDATION DENTISTRY AND PUBLIC PROTECTION

Topic overview

The Sedation & General Anaesthetic Services Committee's work includes reviewing and modifying CDSBC's sedation regulations to ensure they are consistent with, or exceed, best practice recommendations, and that they are based on current medical/dental literature. In 2016, the Sedation Committee made several changes to the standards and guidelines for minimal and moderate sedation, deep sedation, and general anaesthesia, to better protect the public. Also in 2016, the College placed a one-year moratorium on new applications to register credentials to provide moderate pediatric sedation for dentists who have learned the modality in a short-course format. Against the backdrop of these changes and some tragic incidents where patients were seriously harmed, the College wants to know what further changes registrants think are needed.

Discussion question

- What additional changes should CDSBC make to the requirements for dental sedation to further protect the public?

Participant input

Participants were generally focused on the public protection aspect of the question, suggesting a variety of means to improve access, training, and resources related to sedation.

General themes	What participants said
Hospital access	"No availability to schedule O.R. time at hospitals is a big barrier." "Lack of dental hospitalists prevents care for patients who present with dental emergencies at hospitals (Edmonton U of A has 3 on-staff dentists)" "Try to establish dental hospitalists in major hospitals to provide alternative for patients needing sedation i.e. young, special needs, geriatric. Hospital time available to dentists to provide sedation/GA in safest environment."
Changes to the standards & guidelines	"Better to split min/mod sedation so each has its own standards and guidelines document covering: - N_20 - Single Oral - Doses - Chart"

Training and resources	"Consistent/standard period of time to recertify CPR/HPS (more frequent than provider suggests) → efficacy not cost driver" "Routine – mock drills, including dental emergency for team / for non-sedation providers" "Pharmanet – access" "Med emergency course" "Mandatory QA component on at least certification requirements and risks for sedation and to know how/where to refer" *Concern expressed that since children under two on North Vancouver Island must be transported to BC Children's Hospital means some dentists may try more risky sedation just so that patients can get treatment.*

See **Appendix D** for a full list of participants' comments.

EVALUATION AND NEXT STEPS

Registrants were asked to complete an evaluation form at the end of the session. Overall, registrants indicated that they had adequate opportunities to express their views and learn from each other. Comments supported the format of the event, though some would have liked more time for discussion.

Survey responses

General themes	What participants said
What worked well	"Everyone had an opportunity in my group at least to express opinion and brainstorm solutions. I learned a lot." "Small groups. Easier to talk than in front of a large group." "Moving from topic to topic as a group. Facilitation keeping groups on track."
What could be improved	"A little longer sessions by 10 min each." "Let participants know the format before the session. More time to bring the conversation back to the larger group." "Felt there was some personal bias of conversation leaders pushing the conversation in their direction. Good experience - feel that the separation of groups artificial - conversations would probably be more free flowing if groups were just people that were compatible with each other."

See **Appendix F** for all of the registrant evaluations.

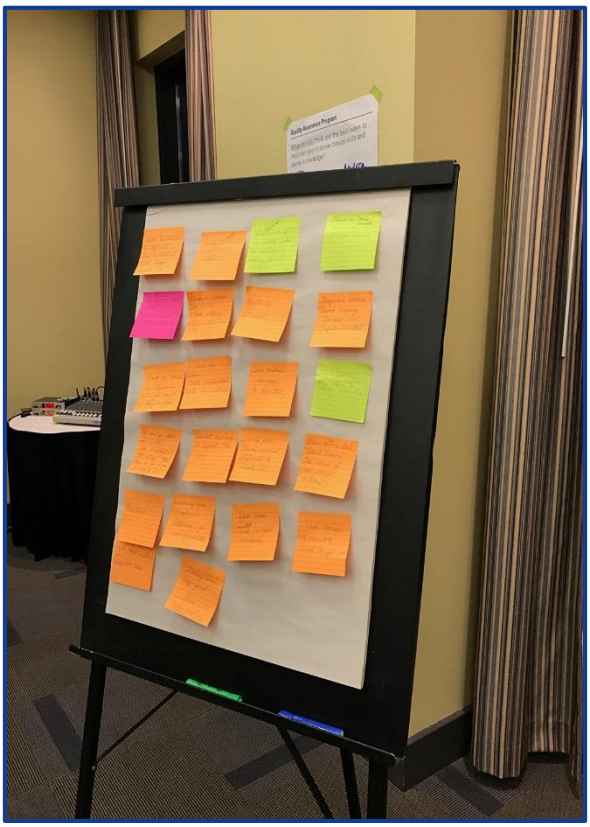
What happens next?

This report will be shared with the Board and relevant committees for their consideration as outlined in the session overview.

The next listening session will be held in Nelson on 28 April. Additional sessions are planned for the fall and once scheduled will be promoted and details posted to the events page of the College website.

APPENDICES

- Appendix A – Opening discussion
- Appendix B – Topic 1: Quality Assurance Program
- Appendix C – Topic 2: Business of dentistry and corporate structures
- Appendix D – Topic 3: Sedation dentistry and public protection
- Appendix E – Speaker Bios
- Appendix F – Participant evaluations



Appendix A: Opening discussion

Discussion question: Thinking about your own practice and what you are seeing in the profession, what would you like your regulator to know?

- The pressure new grads face in terms of student debt is immense. It is easy to see how there is pressure to compromise patient care to pay off debt. → need better accountability for university
- Reduce tuition costs – indebted dentists stresses diagnosis and patient welfare
- Personally I see the system working. However my greatest concern is the lack of training given to students in posterior composites. In my opinion amalgam does not belong in dentistry.
- Manpower problems – training increases required for CDA / hygienists – internship more clinical training for dentists
- Quality assurance
    - Rumours dispelled
    - CDA requirement changes
- How do we maintain public safety practically without using so many barriers which fill our landfills?
- Sterilization is important but… for general dentistry we are no more invasive than people going to a restaurant and using utensils or riding a public transit system.
- More info on corps
- Hands-on quality assurance → does that change anything? How required? How addresses this better? Is this just the College trying to "save face" / be creative in new ways to change dentistry?
- Corporate
    - tackle this from patient's perspective "Bill of Rights" for the patient
    - Look at other provinces (what has their response been?)
    - Why are we worried
- Updates on sedation guidelines – ErAAiS Highlights
- Recordkeeping details
    - Sedation for children
    - General dentists
- Access to PharmaNet and online medication lists – access to medical records
- Wait times for sedation (GA/Parenteral) for patient treatment
- Impact of moving sedation to hospitals on patient's access
- Impact on future registrants
- Statistics on dental corp. where is the information? Future projection?
- QA – "catching" outliers while not punishing (time, $, stress) the ones who aren't a problem
    - If clinical, hands on – certain skills vs. all skills
- Corporate → continuity of care, patients seeing # different dentists changing often – losing trust
- CDAs want to utilize the skills they have within their scope of practice
- Dentist need to be aware of CDA scope of practice and HPA bylaws
- Scope of Practice
    - Protect the public
    - Ortho skill sets
    - Implant skill sets → credentials – training
- Costs of materials and certain fees
- People going to 3rd world places to get jobs done cheaper.

Appendix B: Quality Assurance Program

Discussion question: What do you think are the best ways to maintain and improve clinical skills and dental knowledge?

Discussion host: Dr. Andrea Esteves

- Access to courses are difficult . How to find out about courses outside BC?
- Webinar / Mandatory courses
    - Recordkeeping
    - Pharmacology
    - Topics per year
- Some hands-on courses are more marketing rather than information on improving skills or techniques
- Having the good courses online is helpful
- Hands-on course example: ergonomics / dentist-CDA relationship
- Courses: Out-of-provinces? USA? Intercontinental? CE point recognition?
- Hands on courses for CDA
    - role playing
    - Have dentist play CDA
- Mentorship: on call
- Lectures preparation not counting → writing paper does not count
- Required course
    - Recordkeeping
    - Standard chart
    - Infection control
- Life stages may affect how to engage in QA
- Hands on courses are expensive and you don't know if they are good
- Hands-on courses:
    - Tooth preparation with new materials
- Less online courses or limited
- Need universal charting system from office-to-office – nationally
- If one is short on CPH, who to contact at the College? What to do if you forsee you will be short?
- Dentist responsibility to support CDAs' QA
- Away from lower mainland difficult to access CE
- Sinergy from sedation/ethics to include in QA
- How often bad recordkeeping the cause of poor patient outcomes?
- HPA – and hand skills
- Barcodes for all courses (apps or tags) and tracking #s for online courses associated with bar codes that make them accountable for showing up.
- Online courses should be split ½ self-time ½ interactive listening sessions online is not that interactive i.e. CDSBC conference calls with exams should be the same for online.
- QA
    - Diversity
    - Interpersonal interaction
    - Accessibility of hands-on and cost
    - Openness to required courses
    - Online
    - Regular
    - Study-clubs
    - Peer review
    - Mentorship
- Residency year (graduated licensing) for new graduates
- Office review – not a good measure
- Peer review → educated to not be judgemental

- QA will not help with those unethical ones → regulate those
- Study clubs are great – include CDA - individual is important if takes good cases
- How do we bring people back? How engage?
- Online is too remote but can be part of it
- Mandatory meetings once a year to interact course
- Rotary for dentist – community → Sense of → Get together → Share cases → Needs a leader

Discussion host: Leslie Riva

- Hands-on / discussion
- Study clubs - share failures – "you learn from this"
- Better collegiality
- Required self-assessment
- Split CE categories
    - Self-study
        - Remote areas some
        - Urban areas – less
    - Specific to areas
        - Endo
        - Clinic
        - Surgery
- Sound foundation on every topic
    - All spec. general dentists should know all subjects: i.e. ortho surgery
- Mentorship – new dentists
- CDA – study clubs

Appendix C: Business of dentistry and corporate structures

Discussion questions: What aspects of corporate dentistry are affecting patient-dentist interactions, and how do you know this? What could CDSBC do to address these challenges?

Discussion hosts: Dr. Don Anderson & Dr. Susan Chow

- Positive: staff and CDAs get better benefits
- Do not see the same dentist all the time.
- Ask patients what their experiences are
- Mentorship starting first year dental school
- Role models after graduation
- Marriage between UBC and College and also BCDA – all involving ethics
- ETHICS!
- Positive: 1 stop shopping like Walmart for just emergent care
- Treatment plan by office manager (treatment time) – anecdotal
- Corporations are hiring new grads who are in debt and need to work and only have corporate guidance. →Graduated license
- Not just corporations as problems can come from solo practitioners
- Turnover leads to problem of continuity of care
- Recordkeeping inconsistency
- Not all dental students should graduate. Should be a failure rate.

Discussion host: Greg Cavouras

Concerns

- Continuity of care
- Prioritization of money over patient
- Production – based mentality
- Dictating billing
- Loss of autonomy
- Production/quota
- Loss of continuity
- Different dentist treatment plan vs. providing treatment
- Making insurance plans to patient detriment
- $ targets / quotas
- Business taking priority over patients

Solutions / Directions:

- Patient must come first.
- Accountability for corporations/individuals
- Complaint process
- Mechanisms to discipline corporations
- Shared responsibility for corp/dentist if a company
- Patient informed about ownership / dentists
- More info/education in dental school for new grads
- Consider prohibiting assignments

Appendix D: Sedation dentistry and public protection

Discussion question: What additional changes should CDSBC make to the requirements for dental sedation to further protect the public?

Discussion host: Jerome Marburg

- Consistent / standard period of time to recertify CPR/HPS (more frequent than provider suggests) → efficacy not cost = driver
- Routine – mock drills, including dental emergency for team / for non-sedation providers
- No availability to schedule OR time at hospitals is a big barrier.
- Lack of dental hospitalists in hospitals prevents care for patients who present with dental emergencies at hospitals (Edmonton U of A has 3 on-staff dentists)
- *Concern expressed that since children under two on North Vancouver Island must be transported to BC Children's Hospital means some dentists may try more risky sedation just so that patients can get treatment.*
- Mandatory QA component on at least certification requirements and risks for sedation
    - to know how/where to refer
- Know your limits

Discussion host: Dr. Tobin Bellamy

- Better split min/mod sedation
    - N_20
    - Single Oral
    - Doses ??
    - Chart
- Consent
- Training (min)
- Pharmanet – access

- NPO – N_2O
- Med Emergency Course

Appendix E: Speaker Biographies

Dr. Andrea Esteves
Board Member
Member, Quality Assurance Committee and Quality Assurance Program Working Group

Andrea has been a member of the Quality Assurance Committee since 2012. She currently serves on the CDSBC board as the UBC Faculty of Dentistry member. Andrea is the Associate Dean, Clinical Affairs at UBC Dentistry and she has been the clinic director at the Nobel Biocare Oral Health Centre since 2009. As a clinician, Andrea has supported many of the Faculty's geriatric dentistry research projects.

Jerome Marburg
CEO/Registrar

Jerome directs all administrative and operational matters at the College, including the regulatory and policy responsibilities set out in the *Health Professions Act*, regulations and CDSBC Bylaws. Jerome has extensive experience as a regulator, executive manager and general counsel for professional regulatory bodies, with a strong background in board governance, policy analysis and practical business administration.

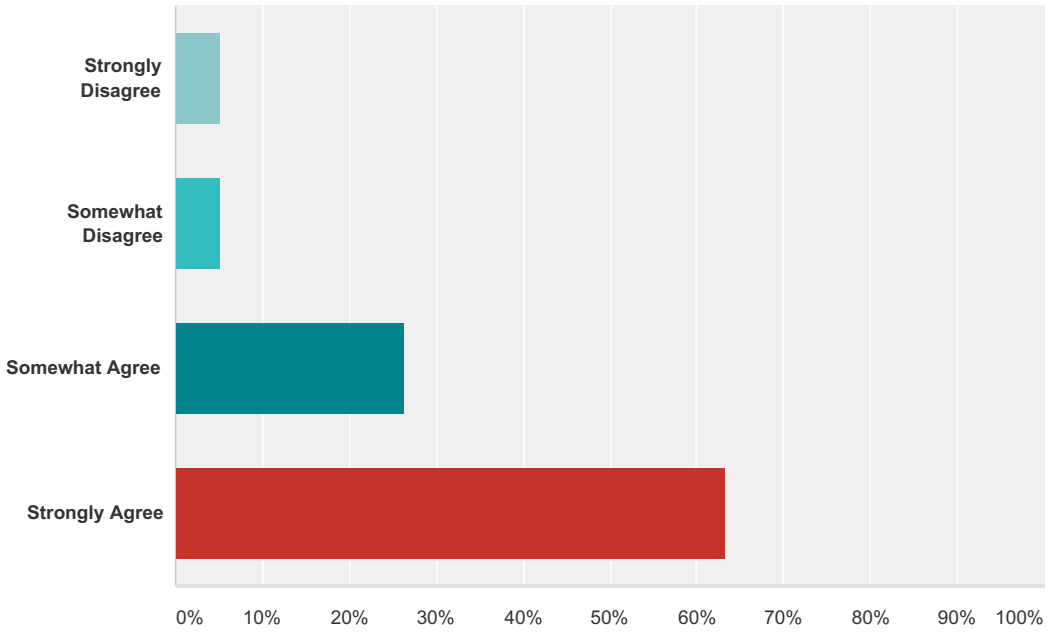
Dr. Tobin Bellamy
Chair, Sedation & General Anaesthetic Services Committee

Tobin began volunteering with the College in 2005 when he joined the Sedation & General Anaesthetic Services Committee (formerly Accreditation), of which he is currently the chair. He is a specialist in Oral and Maxillofacial Surgery and practises in Coquitlam. Toby is also a clinical associate professor at UBC's Faculty of Dentistry, past president of the Dental Specialists Society of BC, and current president of the BC Association of Oral and Maxillofacial Surgeons.

Appendix F: Participant Evaluations

Q1 I had adequate opportunities to express my views.

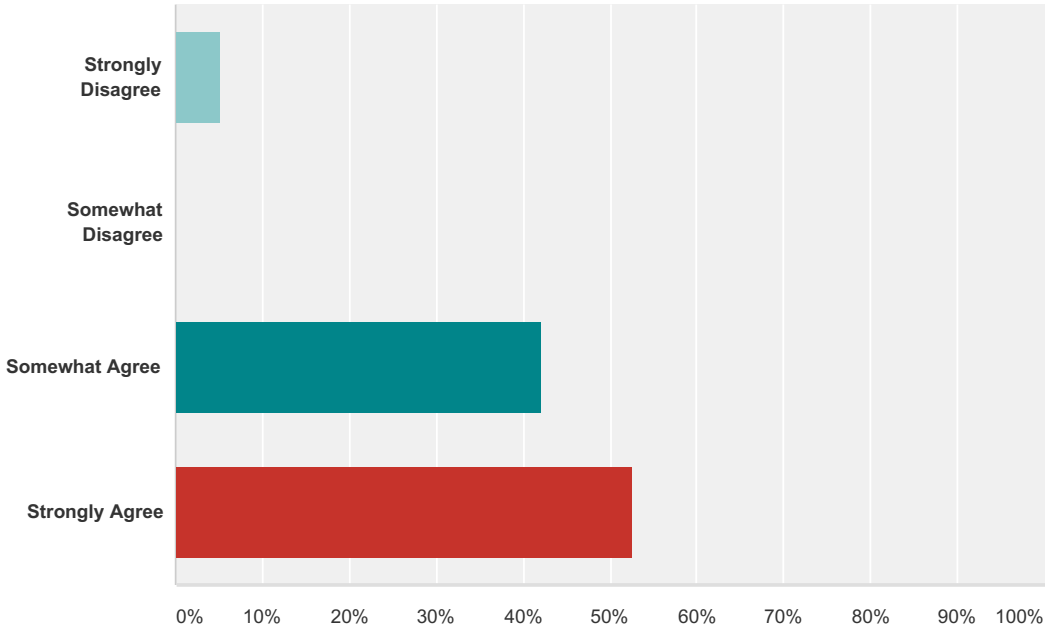
Answered: 19 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	**5.26%**	1
Somewhat Disagree	**5.26%**	1
Somewhat Agree	**26.32%**	5
Strongly Agree	**63.16%**	12
Total		**19**

Q2 There was adequate opportunity for participants to exchange views and learn from each other.

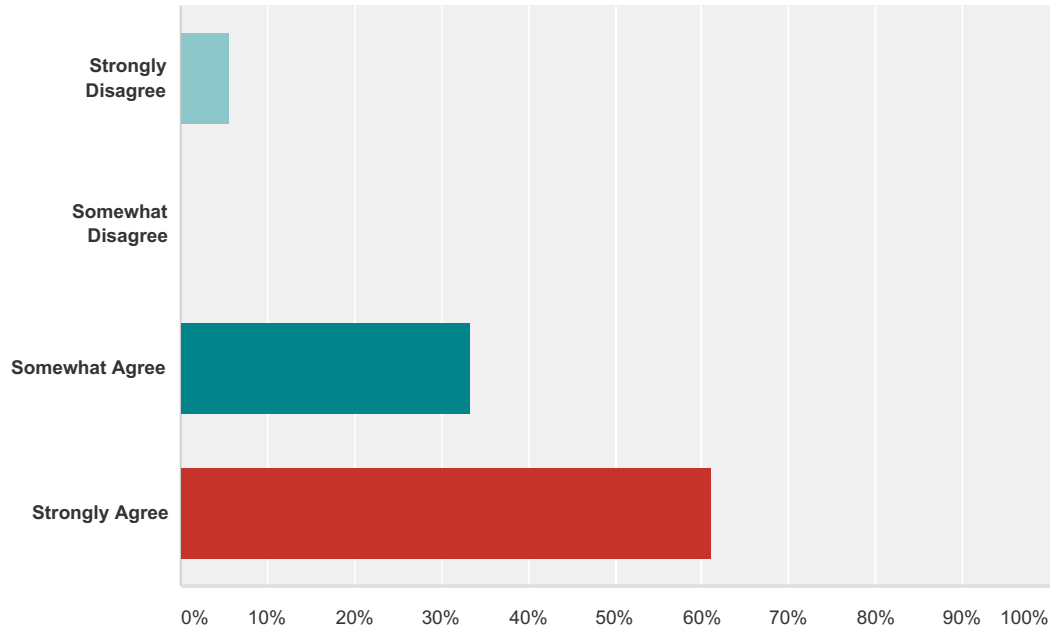
Answered: 19 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	**5.26%**	1
Somewhat Disagree	**0.00%**	0
Somewhat Agree	**42.11%**	8
Strongly Agree	**52.63%**	10
Total		**19**

Q3 CDSBC demonstrated a commitment to listening.

Answered: 18 Skipped: 1



Answer Choices	Responses	
Strongly Disagree	**5.56%**	1
Somewhat Disagree	**0.00%**	0
Somewhat Agree	**33.33%**	6
Strongly Agree	**61.11%**	11
Total		**18**

Q4 Additional comments on the Quality Assurance Program review?

Answered: 9 Skipped: 10

#	Responses	Date
1	Difficult to deal with each aspect of the dental team - so many challenges - need to affect new grads - seasoned practitioners, and everyone in between. Need to be affordable, interesting, informative and effective.	3/31/2017 10:31 AM
2	A liaison between the College and the dental school so important! Easier affordable study clubs.	3/31/2017 10:23 AM
3	Great beginning in discourse and inclusion.	3/31/2017 10:20 AM
4	Paramount for better and safer care Worried about cost/time/stress involved and hands-on requirements Target who cause the problems (and don't punish those who don't!) New grads have a ton of stress - don't push them off the edge! CDAs don't have $/time etc. for hands on anyways!	3/31/2017 10:15 AM
5	Ask optometry to give suggestions to members (theirs and ours) to make sure DDS and CDA can see well intraoral.	3/31/2017 10:00 AM
6	I will write a letter to your group.	3/30/2017 4:26 PM
7	Graduated licensing. Experienced and continued practice hours important. Bad dentists will always be a problem and changes to the existing QA program may create resistance.	3/30/2017 4:18 PM
8	Great conversation - needs to be longer. Loved the interaction between DDS and CDA over the planning.	3/30/2017 4:10 PM
9	Well put together, split groups interaction was great.	3/30/2017 4:05 PM

Q5 Additional comments on Business of dentistry and corporate structures?

Answered: 6 Skipped: 13

#	Responses	Date
1	Corporate dentistry may need to be regulated but so does all dentistry - need to make it affordable to stay ethical, make a profit without doing unnecessary treatment. Make sure that all codes are well identified so that it is obvious which one to use at the time of treatment.	3/31/2017 10:31 AM
2	Comes down to ethics. Continuity of care #1 issue in my experience of why brave/informed pts. leave these practices.	3/31/2017 10:15 AM
3	Doesn't seem to be an "Island" issue.	3/31/2017 10:02 AM
4	Stats - now - future.	3/31/2017 10:00 AM
5	Continuity of care a challenge and a real problem. Revolving door with regards to staff.	3/30/2017 4:18 PM
6	Yes dentistry is a business but it should be patient first. Ethics is of course paramount.	3/30/2017 4:05 PM

Q6 Additional comments on Sedation Dentistry?

Answered: 5 Skipped: 14

#	Responses	Date
1	Educate everyone as to what is appropriate sedation for ages and risks - what needs to be on hand for emergencies.	3/31/2017 10:31 AM
2	Clear guidelines. How to rescue 1 level above. PharmaNet would be so good.	3/31/2017 10:15 AM
3	To gov't: more or time.	3/31/2017 10:00 AM
4	Try to establish dental hospitalists in major hospitals to provide alternative for pts. needing sedation ie. young, special needs, geriatric. Hospital time available to dentists to provide sedation/GA. in safest environment.	3/30/2017 4:18 PM
5	Inform patients.	3/30/2017 4:05 PM

Q7 What worked well at the Listening Session?

Answered: 12 Skipped: 7

#	Responses	Date
1	Prompted questions to keep us on track and time.	3/31/2017 10:31 AM
2	Good format.	3/31/2017 10:23 AM
3	Small groups -> summaries & someone guiding discussion Having this for personal feedback if you weren't able to voice your concerns.	3/31/2017 10:15 AM
4	Small groups. Easier to talk than in front of a large group.	3/31/2017 10:04 AM
5	Small group discussion worked well. A worthwhile evening!	3/31/2017 10:03 AM
6	Constant interaction very good workshop.	3/31/2017 10:02 AM
7	Felt there was some personal bias of conversation leaders pushing the conversation in their direction. Good experience - feel that the separation of groups artificial - conversations would probably be more free flowing if groups were just people that were compatible with each other.	3/31/2017 9:59 AM
8	College people had pre-set agenda and had people skills to draw people out.	3/30/2017 4:26 PM
9	Everyone had an opportunity in my group at least to express opinion and brainstorm solutions. I learned a lot.	3/30/2017 4:20 PM
10	Moving from topic to topic as a group. Facilitation keeping groups on track.	3/30/2017 4:10 PM
11	The rotation through different areas and the guidance of the moderators.	3/30/2017 4:07 PM
12	Splitting into groups, good mandate, well run.	3/30/2017 4:05 PM

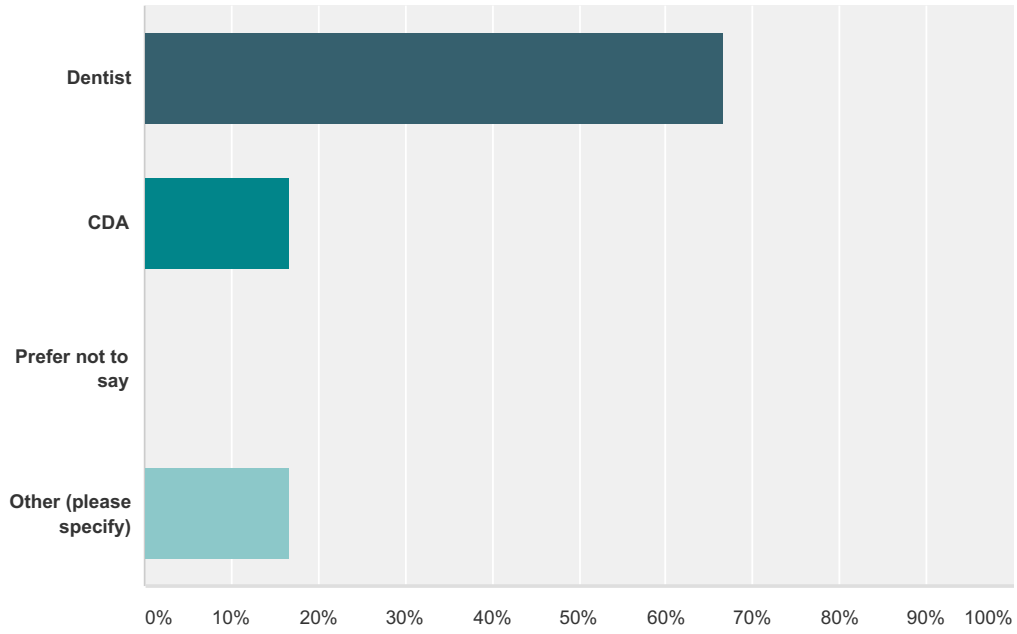
Q8 What could have been improved about the Listening Session?

Answered: 6 Skipped: 13

#	Responses	Date
1	More people attending because many complain and want changes.	3/31/2017 10:31 AM
2	I think Chris did a great job in getting us involved and on time.	3/31/2017 10:20 AM
3	One drink per person.	3/31/2017 10:02 AM
4	Nanaimo and district dentists let the College down by having low numbers. But past College has not set it up to bring us out.	3/30/2017 4:26 PM
5	A little longer sessions by 10 min each.	3/30/2017 4:20 PM
6	Let participants know the format before the session. More time to bring the conversation back to the larger group.	3/30/2017 4:10 PM

Q9 To which of the following groups do you belong?

Answered: 18 Skipped: 1



Answer Choices	Responses	
Dentist	**66.67%**	12
CDA	**16.67%**	3
Prefer not to say	**0.00%**	0
Other (please specify)	**16.67%**	3
Total		**18**

#	Other (please specify)	Date
1	Educator (CDA)	3/30/2017 4:10 PM
2	Educator (CDA)	3/30/2017 4:07 PM
3	CDA/reception	3/30/2017 4:05 PM

CDSBC | College of Dental Surgeons of British Columbia

We're All Ears: Nelson Listening Session

28 April 2017

Participant Input Summary Report

31 May 2017

Table of Contents

INTRODUCTION

The College's policy development process emphasizes engagement with registrants and other stakeholders. CDSBC is building on this commitment by hosting a series of listening sessions, where registrants can learn about and engage with key topics and share their views with College representatives. The listening sessions are a province-wide opportunity to engage registrants in current policy development initiatives.

Purpose

To strengthen the College's relationship with registrants and enhance the quality of its work being done on key topics by hosting an in-person event that presents information and emphasizes registrant discussion and CDSBC listening.

About this report

This report is a summary of the college's fourth listening session, held in Nelson, B.C. on 28 April 2017. It describes the session, participants and topics; it also includes a complete list of participant input and feedback compiled during the session.

A note about participant comments

The appendices contain all participant comments recorded at the listening session. Comments representative of a theme are included in the participant input summary for each topic. Where appropriate, some comments have text in blue to indicate additional comments made by the discussion hosts to clarify the comment's meaning and/or theme. Corrections have been made to address spelling or other errors that did not change the meaning of the comment.

SESSION AGENDA

5:00 pm	Welcome
5:15 pm	Opening discussion
5:40 pm	Five-minute presentations on three topics
6:05 pm	Group discussion based on topics
6:55 pm	Evaluation and closing
7:00 pm	Adjourn

SESSION FORMAT

Dr. Chris Hacker, CDSBC's Director of Professional Practice, facilitated the listening session. After a welcome and introductory remarks, participants discussed an opening question with the group. They recorded their individual thoughts on sticky-notes and took turns sharing some of their best ideas with the entire group.

This session did not follow the format of previous Listening Sessions (where break-out groups rotated through three topics). Due to the smaller number of participants, the three topics presented by College representatives were discussed with the entire group.

SESSION OVERVIEW

Topic	Presenter	Discussion hosts	How participant input will be used
Opening Question		Various	Participant input will be considered by the Board.
Quality Assurance Program	**Ash Varma** *Chair, Quality Assurance Committee*	Ash Varma Róisín O'Neill *Director of Registration and HR*	Participant input will be considered by the QA Committee working group.
Business of dentistry and corporate structures	**Greg Cavouras** *Legal Counsel*	Greg Cavouras Carmel Wiseman *Deputy Registrar*	Participant input will be considered by the Board.
Sedation dentistry and public protection	**Jerome Marburg** *CEO/Registrar*	Jerome Marburg Dr. Chris Hacker *Dental Policy & Practice Advisor*	Participant input will be considered by the Sedation & General Anaesthetic Services Committee.

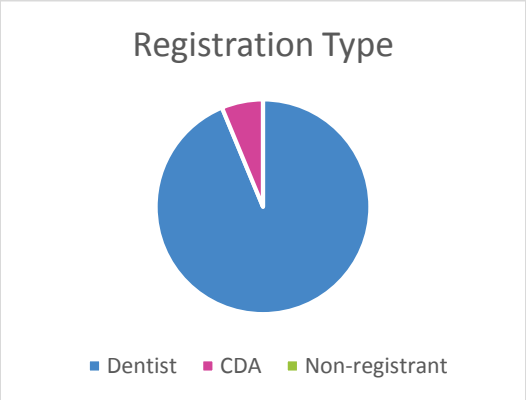
WHO PARTICIPATED IN THE SESSION

The listening session was held in Nelson, B.C. and 16 participants attended.

Registration type

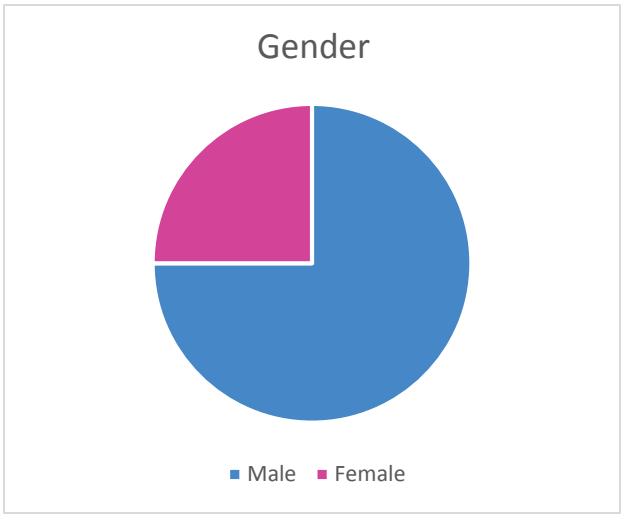
Of the 16 participants, 15 were dentists and 1 was a certified dental assistant (CDA). All of the participants hold practising status.

The ratio of dentists to CDAs at the listening session is not representative of the actual makeup of the College's registrants (there are almost twice as many CDAs as dentists).



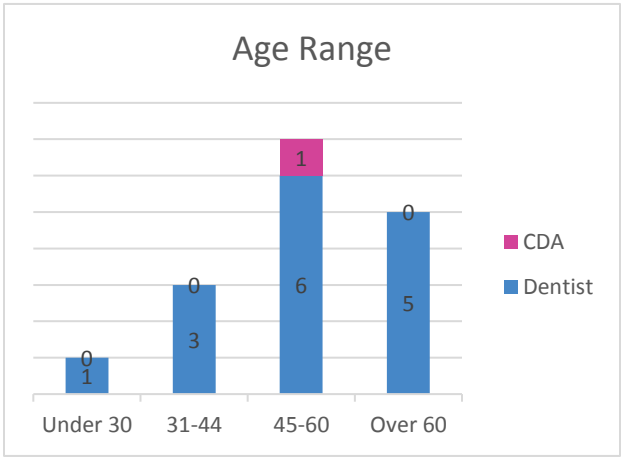
Gender

Overall, the listening session was representative of the College registrants. The single CDA participant was female, which reflects the College's CDA registrants overall (99% female). Dentists at the session strayed from the College's overall gender split (1/3 female, 2/3 male) with a higher representation of males.



Age

Participants at the listening session were generally representative of the College's overall registrant makeup.



OPENING DISCUSSION

To open the listening session, participants answered the question below, first by writing down their responses and then sharing their ideas with the rest of the room. Examples of participant comments are found in the table below, organized by theme.

The purpose of this question was to allow the participants to share some general concerns early on in the session, and to allow items to be raised that may not fall within the three discussion topics on the agenda. We designed this question to give attendees the opportunity to be heard on the issues that matter to them, without limiting their responses by way of the session's structure.

Discussion question

- Thinking about your own practice and what you are seeing in the profession, what would you like your regulator to know?

Participant input

General themes	What participants said
"Corporate Dentistry"	"Corporate dentistry and potential for forcing over treatment by associates" "Problems/challenges facing dentistry: saturation of the dental market, increasing competition driving down quality of care and patient confidence, research in this area?"
Concerns related to Quality Assurance	"Evidence must support any rule or regulation" "Implementing a more effective Quality Assurance program. I suggest mandating study clubs for all registrants, minimum 4 days per year"
Public protection, access to care	"How/who do we as dentists, seeing overtreatment and poor quality coming from an office, convey that information and how is it handled (anonymously?)" "Patients often have issues accessing care, often due to financial circumstances"

See **Appendix A** for a full list of participants' answers to the opening discussion question.

TOPIC 1: QUALITY ASSURANCE PROGRAM

Topic overview

The College Board has directed the Quality Assurance (QA) Committee to establish a working group to begin the process of enhancing CDSBC's QA Program. The working group will research and develop a comprehensive plan that will:

- promote career-long hands-on learning
- encourage collaborative discourse amongst colleagues
- improve treatment outcomes for patients

This initiative will require a high level of engagement with registrants and stakeholders, with a particular focus on two main topics: continuing education (CE) requirements and continuing practice hours.

Discussion question

- What do you think are the best ways to maintain and improve clinical skills and dental knowledge?

Participant input

Participants offered feedback on challenges within the current system of CE and suggested ways in which they might grow their dental knowledge and skills. The group identified course accessibility to be an overarching barrier and were interested in exploring peer review, mandatory subject areas, and hands-on learning (as well as other topics).

General themes	What participants said
Accessibility	"CDA – path back to practice, look at making easier and more accessible" "Refresher course for CDAs is only available at VCC"
Mandatory courses and study club	"Current system – we are self-selecting subject areas for CE – missing out on other important areas" "Implementing a more effective Quality Assurance program, I suggest mandating study clubs with a minimum of 4 days per year"
Peer reviews as part of QA	"Study clubs (peer review)" "Peer to peer (individual basis)"

See **Appendix B** for a full list of participants' comments.

TOPIC 2: BUSINESS OF DENTISTRY AND CORPORATE STRUCTURES

Topic overview

The "corporatization" of dentistry, as an ownership structure, continues to be a topic creating a lot of discussion within the profession. Subject to the ownership rules and accountability, the College is primarily concerned with patient care, but does recognize that there are inherent challenges for dentists as both a business person and a healthcare professional. The College has tools addressing both quality of care and ownership to ensure that appropriate care is being delivered by the appropriate people. The College wants to hear from registrants about what problems/challenges they see, so that any gaps in the tools that we do have can be identified and addressed.

Discussion questions

- What aspects of corporate dentistry are affecting patient-dentist interactions, and how do you know this?
- What could CDSBC do to address these challenges?

Participant input

Participants discussed several aspects of "corporate dentistry" including multi-office clinics and corporate dictation. They also provided potential solutions such producing evidence of quotas to the College for further action, and identifying control to be with the individual dentist. Some of these answers built upon comments from the initial discussion (see Appendix A for these comments).

General themes	What participants said
Concerns	"Chain dental clinics" "Corporation dictates type of restoration" "Saturation of the dental market, increasing competition driving down quality of care and patient confidence. Is there research in this area?"
Solutions	"Quotas – inform registrants that they can provide evidence on quotas and then the college can act. At the moment we have no evidence of quotas" "Control is with the dentists making ethical decisions and educating dentists"

See **Appendix C** for a full list of participants' comments.

TOPIC 3: SEDATION DENTISTRY AND PUBLIC PROTECTION

Topic overview

The Sedation & General Anaesthetic Services Committee's work includes reviewing and modifying CDSBC's sedation regulations to ensure they are consistent with, or exceed, best practice recommendations, and that they are based on current medical/dental literature. In 2016, the Sedation Committee made several changes to the standards and guidelines for minimal and moderate sedation, deep sedation, and general anaesthesia, to better protect the public. Also in 2016, the College placed a one-year moratorium on new applications to register credentials to provide moderate pediatric sedation for dentists who have learned the modality in a short-course format. Against the backdrop of these changes and some tragic incidents where patients were seriously harmed, the College wants to know what further changes registrants think are needed.

Discussion question

- What additional changes should CDSBC make to the requirements for dental sedation to further protect the public?

Participant input

Participants had questions about uncertain areas of current sedation practice. They also noted accessibility issues for the Kootenay Region, and the makeup of the Sedation Committee.

General themes	What participants said
Access	- Inspection of N_2O (nitrous oxide) equipment not available in the Kootenays (shortage of biomedical technicians)
Questions about current requirement	- Is there any liability issue with service >1 year • Is it necessary? - Is there requirement for continuing Advanced Cardiovascular Life Support (ACLS)?
Rationale for policy changes	- Evidence must support any rule or regulation

See **Appendix D** for a full list of participants' comments.

EVALUATION AND NEXT STEPS

Registrants were asked to complete an evaluation form at the end of the session. Overall, registrants indicated that they had adequate opportunities to express their views and learn from each other. They also felt the College demonstrated a commitment to listening.

Due to the low number of responses (2), these findings are not representative of the entire group.

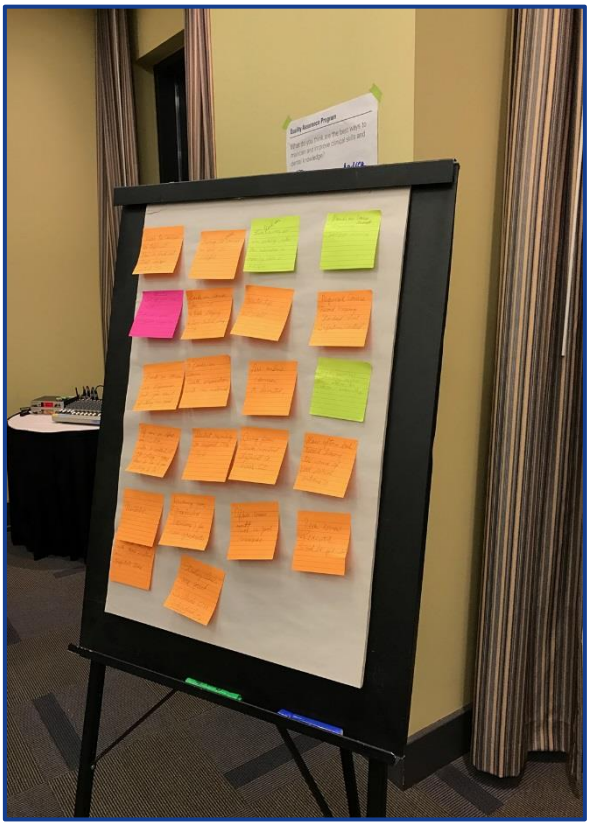
What happens next?

This report will be shared with the Board and relevant committees for their consideration as outlined in the session overview.

Additional sessions will be scheduled for the fall; these will be promoted and details posted to the events page of the College website.

APPENDICES

- Appendix A – Opening discussion
- Appendix B – Topic 1: Quality Assurance Program
- Appendix C – Topic 2: Business of dentistry and corporate structures
- Appendix D – Topic 3: Sedation dentistry and public protection
- Appendix E – Speaker Bios



Appendix A: Opening discussion

Discussion question: Thinking about your own practice and what you are seeing in the profession, what would you like your regulator to know?

- Treatment focus is moving away from dentistry i.e. Snoring and Botox. It is outside the scope of practice (misleading to the public)
- Evidence must support any rule or regulation
- Corporate dentistry and potential for forcing over treatment of associates
- Open doorway for entry of foreign dentists has potential for causing over saturation and over treatment
- There is no evidence for Continued practice hours
- I have concerns about the Smile Care Club which is promoting DIY orthodontics at home in the USA which I feel has potential for some significant problems especially unmonitored and unscreened
- How far will advertising go? I see large billboards in the USA that are very cheap looking
- Problems/challenges facing dentistry: saturation of the dental market, increasing competition driving down quality of care and patient confidence. Is there research in this area?
- In dental regulation can/has the College considered removing 'assignment' thereby encouraging patients to 'own' their coverage and possibly ease other problems e.g. time front desk spend
- How/who do we as dentists, seeing overtreatment and poor quality coming from an office, how do we convey that information and how is it handled (anonymously?)
- CE for volunteers not making money - can't afford – many years of practice
- Patients have issues accessing care often due to financial circumstances
- Some registration requirement cannot be met
- Implementing a more effective Quality Assurance program. I suggest mandating study clubs for all registrants, minimum 4 days per year
- Materials on internet
- Foreign trained
- Scope and practice
- Advertising
- Scope & Dr. Botox
- QA mandate Study Club and include specialization?
- CP volunteer don't think there's evidence of it *(illegible writing)*
- EE (excavate and evaluate) for volume *(illegible writing)*
- Hands on study club should be required as QA

Appendix B: Quality Assurance Program

Discussion question: What do you think are the best ways to maintain and improve clinical skills and dental knowledge?

Discussion hosts: Ash Varma, Róisín O'Neill

- Hands-on learning
- Distance learning for CDA refresher course
- Study clubs (peer review)
- Current system – as we are self-selecting subject areas for CE – we are missing out on other important areas and find skill set CE difficulties
- Peer to peer (individual basis)
- Could we have CE recognized as Continuous Practice hours?
- CDA – path back to practice, look at making this process easier and more accessible
    - Refresher course for CDAs is only available at VCC
- CE should include fundamental skill sets otherwise registrants self-select skills they already know/share philosophy with.

Appendix C: Business of dentistry and corporate structures

Discussion questions: What aspects of corporate dentistry are affecting patient-dentist interactions, and how do you know this? What could CDSBC do to address these challenges?

Discussion hosts: Greg Cavouras, Carmel Wiseman

- Chain dental clinics
- Quotas – inform registrants that they can provide evidence on quotas and then the college can act. At the moment we have no evidence of quotas
- Sliding pay scale (if you make ___ you will be paid ____)
- Corporation dictates the type of restoration
- Control is with the dentists making ethical decision and educating dentists

Appendix D: Sedation dentistry and public protection

Discussion question: What additional changes should CDSBC make to the requirements for dental sedation to further protect the public?

Discussion host: Jerome Marburg, Dr. Chris Hacker

- What are exceptions in deep sedation to capnography
- Is there a requirement for continuing ACLS?
- Inspection of N_2O equipment is not available in the Kootenays (shortage of biomedical technicians/) access
- Is there any liability issue with service>1 year
    - Is it necessary?
- Oral surgeons driving agenda
- Is there evidence of requirement for the 3 month mock trial – same concerns for Nitrous Oxide.
- Makeup of sedation committee

Appendix E: Speaker Biographies

Dr. Ash Varma
Chair, Quality Assurance Committee

Ash has been a volunteer with the College since 1989. He has served on many committees, and chairs the QA committee and the CE subcommittee. He served as both President and Vice-President of the College Board. Prior to that, he was the Upper Island board member for several years. Ash practises in Powell River.

Greg Cavouras
Legal Counsel

Greg is Legal Counsel for the College. He acts for the College in a wide range of legal proceedings, including discipline cases, unauthorized practice and complaints review before the Health Professions Review Board. Prior to joining the College, Greg was a litigator for a leading national law firm.

Jerome Marburg
CEO/Registrar

Jerome directs all administrative and operational matters at the College, including the regulatory and policy responsibilities set out in the *Health Professions Act*, regulations and CDSBC Bylaws. Jerome has extensive experience as a regulator, executive manager and general counsel for professional regulatory bodies, with a strong background in board governance, policy analysis and practical business administration.

CDSBC | College of Dental Surgeons of British Columbia

We're All Ears:
Surrey Listening Session

23 February 2017

Participant Input Summary Report

31 March 2017

Table of Contents

INTRODUCTION

The College's policy development process emphasizes engagement with registrants and other stakeholders. CDSBC is building on this commitment by hosting a series of listening sessions, where registrants can learn about and engage with key topics and share their views with College representatives. The listening sessions are a province-wide opportunity to engage registrants in current policy development initiatives. Sessions will continue to be held over the coming months.

Purpose

To strengthen the College's relationship with registrants and enhance the quality of its work being done on key topics by hosting an in-person event that presents information and emphasizes registrant discussion and CDSBC listening.

About this report

This report is a summary of the listening session held in Surrey, B.C. on 23 February 2017. It describes the session, participants and topics; it also includes a complete list of participant input and feedback compiled during the session.

A note about participant comments

The appendices contain all participant comments recorded at the listening session. Comments representative of a theme are included in the participant input summary for each topic. Where appropriate, some comments have text in blue to indicate additional comments made by the discussion hosts for the purpose of clarifying the comment's meaning and/or for theming purposes. Corrections have been made to address spelling or other errors that did not change the meaning of the comment.

SESSION AGENDA

6:00 pm	Welcome
6:15 pm	Opening discussion
6:40 pm	Five-minute presentations on three topics
7:05 pm	Rotate through discussion stations for each topic
7:55 pm	Evaluation and closing
8:00 pm	Adjourn

SESSION FORMAT

Dr. Chris Hacker, CDSBC's Dental Policy & Practice Advisor, facilitated the listening session. After a welcome and introductory remarks, participants discussed an opening question with each other at their tables. They recorded their individual thoughts on sticky-notes and each table took turns sharing some of their best ideas with the entire group.

College representatives then gave short presentations on three topics. Participants broke into groups (two per topic), each with its own discussion host. The groups answered questions about each topic and recorded their discussion on flip charts. The groups rotated through all three topics over the course of the evening. They had 15 minutes to discuss the first topic and 10 minutes for each subsequent topic to build on the previous groups' ideas.

SESSION OVERVIEW

Topic	Presenter	Discussion hosts	How participant input will be used
Opening Question		Various	Participant input will be considered by the Board.
Topic 1: Quality Assurance Program	**Dr. Ash Varma** *Chair, Quality Assurance Committee*	Dr. Ash Varma Dr. Alex Hird *Member, Quality Assurance Committee*	Participant input will be considered by the QA Committee working group that is tasked with reviewing and updating the QA program.
Topic 2: Business of dentistry and corporate structures	**Greg Cavouras** *Legal Counsel*	Dr. Don Anderson *President* Dr. Patricia Hunter *Treasurer*	Participant input will be considered by the Board.
Topic 3: Sedation dentistry and public protection	**Dr. Tobin Bellamy** *Chair, Sedation & General Anaesthetic Services Committee*	Dr. Jason Chen *Member, Sedation & General Anaesthetic Services Committee* Dr. Mehdi Oonchi *Member, Sedation & General Anaesthetic Services Committee*	Participant input will be considered by the Sedation & General Anaesthetic Services Committee.

The following individuals also helped to support the listening session:

- Leslie Riva, Senior Manager, CDA Certification and Quality Assurance
- Natasha Tibbo, Sedation Program Coordinator
- Anita Wilks, Director of Communications

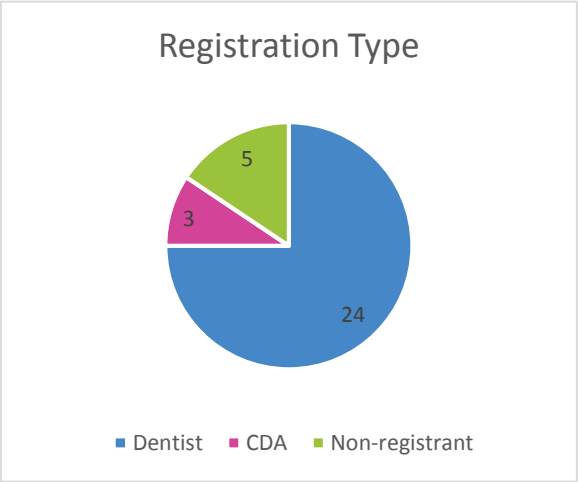
WHO PARTICIPATED IN THE SESSION

The listening session was held in Surrey, B.C. and 32 participants attended from the Fraser Valley and Vancouver districts.

Registration type

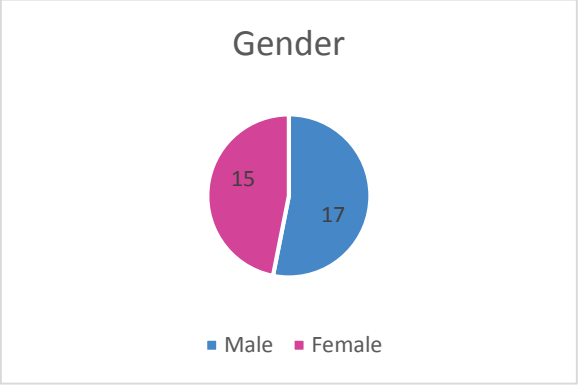
Of the 32 participants, 24 were dentists, 3 were certified dental assistants (CDAs), and 5 were non-registrants (other members of the dental team, dentists/CDAs not registered to practice in B.C., or other interested parties). All of the registrant participants hold practising status.

The ratio of dentists to CDAs at the listening session is not representative of the actual makeup of the College's registrants (there are almost twice as many CDAs as dentists).



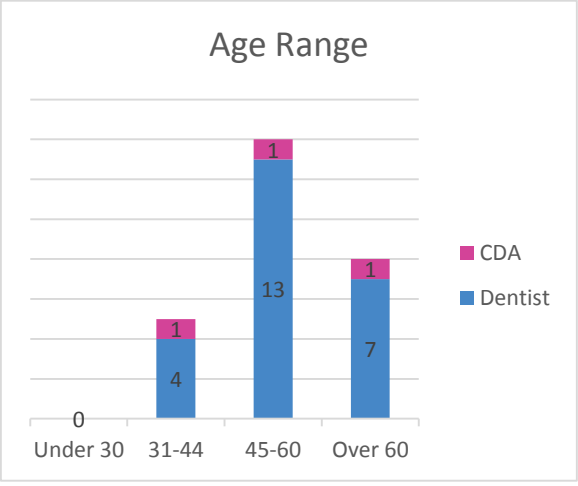
Gender

Overall, the listening session was evenly represented by both male and female registrants. All of the CDA participants were female, which reflects the College's CDA registrants overall (99% female). Dentists at the session were representative of the College's overall gender split (1/3 female, 2/3 male).



Age

Participants at the listening session were generally representative of the College's overall makeup. Participants at the session skewed older overall, with no attendees in the youngest age bracket, and more attendees in the oldest bracket.



OPENING DISCUSSION

To open the listening session, participants answered the question below, first by writing down their responses and then sharing their ideas with the rest of their table. Examples of these comments from participants are found in the table below. Comments have been themed into general categories, though there is significant interconnectedness among the first four topics.

The purpose of this question was to allow the participants to share some general concerns early on in the session, and to allow items to be raised that may not fall within the three discussion topics on the agenda. We designed this question to give attendees the opportunity to be heard on the issues that matter to them, without limiting their responses by way of the session's structure.

Discussion question

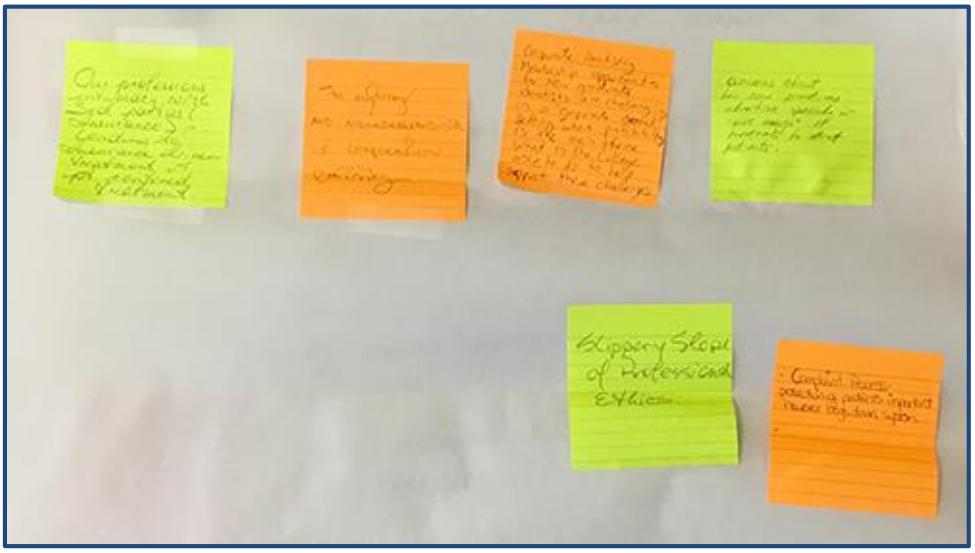
- Thinking about your own practice and what you are seeing in the profession, what would you like your regulator to know?

Participant input

General themes	What participants said
"Corporate Dentistry"	"Quotas for associates – they do exist! (target production)" "Are small practices becoming extinct (in near future) due to larger "Corp" ← Global companies taking over" "Mentorship opportunities for new graduate dentists are challenging in a 'corporate dental' setting where profitability is the main theme. What is the College able to do to help support these challenges?" "$ only driver for corporate dentistry"
Business/Financial Concerns	"Practice overheads continue to increase" "More competition with so many more dentists" "High graduate debt load and the need / pressure to produce" "I feel the patients in some offices are getting used to not paying insurance co-payment and that hinders our growth"
Reputation of the profession & ethical concerns	"Increased competition / decreased professionalism → no phone call" "Our profession's intimacy with 3rd parties (insurance) – leading to insurance driven treatment vs. patient centred treatment" "Not enough testing within recertification" (QA)
Advertising concerns	"False advertising – patient over treatment. Patient care has gone down tremendously" "Advertising – needs more control and regulation by the College"

	"Concerns about how some practices advertise specials or 'give aways' or treatments to attract patients" "Advertising cheapening the profession"
Concerns related to new dentists	"Future of dentistry – technically incompetent graduates. Solution: 1-2 year internship. Problem based learning is technically inadequate" "Number of registrants challenging exams and license vs. going to school" "New grads should have to do 2 years in hospital practice before working privately" "Not enough clinical experience in dental school training – quality of graduates poor" "Direct licensing international dental graduates have very poor skills"
Volunteer recognition	"#CE Points when dentist, CDA, and hyg. volunteer their time to provide service to the underprivileged at a recognized facility"
Complaints process	"Protecting patients is important however it bogs down system" "Why is the dentist required to respond? Rather, the complaint should be assessed for merit and then a decision made to pursue or not." "What does the College do if they encounter a situation where a specialist bad mouths the work of a general practitioner and pushes the patient to complain? Do they even make a call to the specialist?"

See **Appendix A** for a full list of participants' answers to the opening discussion question.



TOPIC 1: QUALITY ASSURANCE PROGRAM

Topic overview

The College Board has directed the Quality Assurance (QA) Committee to establish a working group to begin the process of enhancing CDSBC's QA Program. The working group will research and develop a comprehensive plan that will:

- promote career-long hands-on learning
- encourage collaborative discourse amongst colleagues
- improve treatment outcomes for patients

This initiative will require a high level of engagement with registrants and stakeholders, with a particular focus on two main topics: continuing education (CE) requirements and continuing practice hours.

Discussion question

- What do you think are the best ways to maintain and improve clinical skills and dental knowledge?

Participant input

Participants offered feedback on the current system of CE and suggested ways in which they might grow their dental knowledge and skills. Participants also had a particular focus on new graduates / new registrants.

General themes	What participants said
Support for existing continuing education modes, with a preference for hands-on and group mentoring/support	"Hands on – radiographs/impressions – CDA specific – learn by doing" "To be in a mentorship (increase hours)" "Study clubs: case studies – peers – interactive" "More CE hours (increase from 90)"
Opportunities for improvement	"Early intervention" "Scrutiny → higher quality" "CDAs – feedback from dentists Dentists – feedback from? (peers)" "Online programs – further developed for those not in lower mainland – BCDA"

	"Teaching – ops – good way to learn by teaching"

New Registrants / New Grads	"Post-graduation internship
	- Immersion in an education environment
	  ○ University
	  ○ Limitation/Restriction of practise"
	
	"Change graduation competencies
	- Requirements standards → quantify"
	
	"Initial entry QA requirements"
	
	"Regulating more strictly entry requirements for new registrants vs. "checking" existing dentists. Foreign graduates."
	
	"There should be more requirements from new grad students"

Mixed opinions on Continuing Practice Hours	"CPH → not a good measure" "Some measure of practice hours" "Maintain active practice (increase hours)"

See **Appendix B** for a full list of participants' comments.

TOPIC 2: BUSINESS OF DENTISTRY AND CORPORATE STRUCTURES

Topic overview

The "corporatization" of dentistry, as an ownership structure, continues to be a topic creating a lot of discussion within the profession. Subject to the ownership rules and accountability, the College is primarily concerned with patient care and not corporate structures, but does recognize that there are inherent challenges for dentists as both a business person and a healthcare professional. The College has tools addressing both quality of care and ownership to ensure that appropriate care is being delivered by the appropriate people. The College wants to hear from registrants about what problems/challenges they see, so that any gaps in the tools that we do have can be identified and addressed.

Discussion questions

- What aspects of corporate dentistry are affecting patient-dentist interactions, and how do you know this?
- What could CDSBC do to address these challenges?

Participant input

Participants discussed several aspects of "corporate dentistry", including anecdotal feedback, and provided potential solutions to the concerns they raised. One lengthy "firsthand account" is found in **Appendix C**.

General themes	What participants said
Financial needs of the business taking priority over patient care	"Cash flow pressure affects patient care" "Corporate dentistry USA – preferred provider status is a big concern" "% profit looks good to business oriented person" "Unfair competitive advantage bully smaller practices, which affects patient care" "Not collecting co-payment [practices die in Surey if co-payments are collected by small practice]" "Negative stigma with corps/'bad publicity' impact on public. Solo practitioners may not be able to compete with corps. for practice purchases - less cash and financial resources. Corps overpaying for practices."
Autonomy and staff concerns	"Pressure to only refer to in-house specialists" "Huge restrictive covenants" "Quotas exist – office managers increased pressure" "Also quotas for retiring dentists who have sold to keep production of presale values"
Ownership/structure solutions	"Impress on individual dentists' their responsibilities to patient and quality care" "Can CDSBC limit # of practices someone owns?"
Ethical concerns	"It is not a matter of structure it has to do with the ethics (and expertise of practitioners) of the person/dentist running the practice • i.e. their capability to perform the procedures and their willingness to refer" "More effort on ethical training → mandatory CE credits more promotion of ethics courses"

See **Appendix C** for a full list of participants' comments.

TOPIC 3: SEDATION DENTISTRY AND PUBLIC PROTECTION

Topic overview

The Sedation & General Anaesthetic Services Committee's work is a necessary and continual process of reviewing and modifying guidelines to ensure they are consistent with, or exceed, best practice recommendations, and that they are based on current medical/dental literature. In 2016,

the Sedation Committee made several changes to the standards and guidelines for minimal and moderate sedation, deep sedation, and general anaesthesia, to better protect the public. Also in 2016, a moratorium was placed on new applications to register credentials to provide moderate pediatric sedation for dentists who have learned the modality in a short-course format. Against the backdrop of these changes and some tragic incidents where patients were seriously harmed, the Sedation Committee wants to hear from registrants about the further changes they think need to be made to further enhance protection of the public.

Discussion question

- What additional changes should CDSBC make to the requirements for dental sedation to further protect the public?

Participant input

Participants were generally focused on the public protection aspect of the question. As this is an area of dentistry that not everyone was equally experienced in, there were some questions posed of the discussion hosts (not listed below). This may support the general theme below regarding the need for more communication.

General themes	What participants said
Changes to the standards & guidelines	"Multiple oral sedation drugs in past. Now unable to meet the current standards." "Guidelines min-mod very strict. DDS resistant. Over regulation can hurt office /patient access." "The guideline is too safe for minimal sedation"
Sedation roles within/outside of the dental team	"Operator model – anesthetist" "Fully qualified medical anesthesiologist" "Having a responsible person come to the office to escort the sedated patient"
Need for more clarity / communications	"Clear definition between mild and moderate" "Patients are confused about sedation / the 'levels'– important to have good communication. Patients think they will be "out" and won't need freezing when undergoing moderate or IV sedation. There is a need to inform patients that minimal and moderation sedation are conscious sedation and it is different than deep or general anesthesia."

See **Appendix D** for a full list of participants' comments.

EVALUATION AND NEXT STEPS

Registrants were asked to complete an evaluation form at the end of the session. Overall, registrants indicated that they had adequate opportunities to express their views and learn from each other. Comments supported the format of the event, though some would have liked more time for discussion. Other comments focused on making sure that there is follow-up on these sessions that reports out on the solutions identified.

Survey responses

General themes	What participants said
What worked well	"Openness. Willing to listen." "The station rounds were effective at providing an opportunity to share ideas." "It was very interesting listening to the other dentists at the stations. There was much common thought."
What could be improved	"It's a good idea to send the topics in advance so that people can think and prepare their ideas." "More time for discussion groups." "Identify specific topics of concern and provide 3 hour session devoted to identify issues and potential solutions."

See **Appendix F** for all of the registrant evaluations.

What happens next?

This report will be shared with the Board and relevant committees for their consideration as outlined in the session overview.

The College will continue to host more listening sessions throughout the province in 2017. Upcoming listening session dates are posted to the events page of the College website.

APPENDICES

- Appendix A – Opening discussion
- Appendix B – Topic 1: Quality Assurance Program
- Appendix C – Topic 2: Business of dentistry and corporate structures
- Appendix D – Topic 3: Sedation dentistry and public protection
- Appendix E – Speaker Bios
- Appendix F – Participant evaluations

Appendix A: Opening discussion

Discussion question: Thinking about your own practice and what you are seeing in the profession, what would you like your regulator to know?

- As a CDA, I am happy with how we are regulated.
- As a CDA, I am happy that we have the 60-day rule. Therefore, we have more independence on providing care to the patients.
- Fee guide – regular / ministry
- Insurance companies are dictating % coverage and dentist accepting coverage and not copay
- Sedation – 150 cases in 3 years for single drug is unreasonable. → Alberta and dual drug immediately. If you miss it, retake tabs & costs!! Full committee meeting for accreditation
- Are small practices becoming extinct (in near future) due to larger "Corp" ← Global companies taking over
- Increased competition / decreased professional → no phone call
- Too many dentists?
- Quotas for associates – they do exist! (target producton)
- Botox – fillers – rationale?!?

- Communication difficulties between patients and doctor
- OMFS Dentist access to hospital
- Scope of G.P. Discouraged to practice to your full potential.
- [illegible comment re: minimal and moderate sedation]

- What does the College do if they encounter a situation where a specialist bad mouths the work of a general practitioner and pushes the patient to complain? Do they even make a call to the specialist?
- I don't know enough about (understand) corporate dentistry
- Issues affected dentistry, corporatization, access to care, affordability and how they will affect the autonomy of our profession.
- I don't like corporate dentistry advertising to the public, specifically with pricing e.g. implant for $1999!
- I feel the patients in some offices are getting used to not paying insurance co-payment and that hinders our growth
- Number of registrants challenging exams and license vs. going to school
- Practice overheads continue to increase
- More competition with so many more dentists
- Internet savvy patients
- Reg - # clinics?
- Advertising – radio etc.
- Structure – education DDS
- Public not protected – what college can do? Advertise – etc.
- #CE Points when dentist, CDA, and hyg. volunteer their time to service to recognized facility

- What can be done about dentists that do not follow the "best practice code"
- New grads should have to do 2 years in hospital practise before working privately
- False advertising – patient over treatment. Patient care has gone down tremendously
- At what point does advertising cross the line? E.g. massive billboard at peace arch border crossing?
- High graduate debt load and the need / pressure to produce
- Not enough clinical experience in dental school training – quality of graduates poor
- Direct licensing international dental graduates have very poor skills
- Advertising – needs more control and regulation by the College

- Future of dentistry – technically incompetent graduates. Solution: 1-2 year internship. Problem based learning is technically inadequate

- Our profession's intimacy with 3rd parties (insurance) – leading to insurance driven treatment vs. patient centred treatment
- The mystery and misunderstandings of corporate dentistry
- Corporate dentistry mentorship opportunities for new graduate dentists are challenging in a "corporate dental" setting where profitability is the main theme. What is the College able to do to help support these challenges?
- Concerns about how some practices advertise specials or "give aways" or treatments to attract patients
- Slippery slope of professional ethics
- Complaint process – protecting patients important however bogs down system

- How is the College protecting the public vs. profit driven practices?
- False advertising
- Patient overtreatment patient care has tremendously gone down.
- Having a really hard time finding good quality dentist
    - Money is their main focus
- Not enough testing within recertification
- Complaints process
    - Why is the dentist required to respond rather, the complaint should be assessed for merit and then a decision made to pursue or not.
- Volunteer credits for professionals when dentist, CDA, hygienist gives service to underprivileged
- Slippery slope of professional ethics
    - 3rd party intimacy
    - $ only driver for corporate dentistry
    - Advertising cheapening the profession
    - Litigious society & complaint process

Appendix B: Quality Assurance Program

Discussion question: What do you think are the best ways to maintain and improve clinical skills and dental knowledge?

Discussion host: Dr. Ash Varma

- Study club membership
- Attending courses (Quality)
- Hands on – radiographs/impressions – CDA specific – learn by doing
- Increased frequency
- To be in a mentorship (increase hours)
- Maintain active practice (increase hours)
- CDAs – feedback from dentists
- Dentists – feedback from? (peers)
- Volunteering – CE hours – clinical practice
- Study clubs
    - case studies – peers – interactive
- Online programs – further developed for those not in lower mainland – BCDA
- Teaching – ops – good way to learn by teaching
- Mentorships
- More CE hours (increase from 90)
- Study clubs

Discussion host: Dr. Alex Hird

- Post-graduation internship
    - Immersion in an education environment
        - University
        - Limitation/Restriction of practice
- Change graduation competencies
    - Requirements standards → quantify
- Early intervention
- Initial entry QA requirements
- CPH → not a good measure
- Group / peer review and learning – register groups
- Scrutiny → higher quality
- Inspection problem / auditing
- ? Yes / No - mandatory topics / hours
- Hands-on
- Online group / dental town-ish
- Good as is.
- Need more study clubs – hands on
- CPH /CEH not a measure
- Recognized accreditation/s qualifications
    - Create accreditation pathways for contemporary areas of practice
    - "Diplomates" / "fellows"
- Hands-on →
- Case review
- Some measure of practice hours

Appendix C: Business of dentistry and corporate structures

Discussion questions: What aspects of corporate dentistry are affecting patient-dentist interactions, and how do you know this? What could CDSBC do to address these challenges?

Discussion host: Dr. Don Anderson

- Cash flow pressure affects patient care
- Largely anecdotal (lower reputation)
    - From dental suppliers
    - Affects their profit margins
    - Patients
- Patient care – patient well being
- Loss of autonomy – i.e. self-regulation
- ? Open Contracts
- Training in dental schools
- Interests of the corporation and insurance companies vs. dentist and patient
- Corporate dentistry USA – preferred provider status is a big concern
- Another concern is when the principals of the larger corporation clinics get older and want to sell (80 offices) who can purchase them? I believe dental insurance companies step up quickly this is an American model. Ownership needs to be 51% or more by the DDS at the clinic not 5 % owned by the shareholders.

One dentist's firsthand experience:

- Many unoccupied hours: no follow through with own diagnosis
- If don't agree to provide other dentists treatment plan → fired
- Loss of patient/dentist rapport
- Lots of dentist turnover
- Decreased comprehensive treatment plans
- Fired for being too conservative
- Office manager problems
- Unfair competitive advantage bully smaller practices, whichs affects patient care
- All five dental offices in one area owned by 1 corporation
- Leads to financial and psychological stress and bad decision making which affects patient care.
- Not collecting co-payment [practices die in Surey if co-payments are collected by small practice]
- Inconsistent patient care
- Corporate make-up of treatment bills
- Pressure to only refer to in-house specialists

Discussion host: Dr. Patricia Hunter

- It is not a matter of structure it has to do with the ethics (and expertise of practitioners) of the person/dentist running the practice
    - i.e. their capability to perform the procedures and their willingness to refer
- Why corporate dentistry:
    - Quotas → money
    - % profit looks good to business oriented person
    - Fill a need for new grads and international grads → offering positions
- Problems:
    - Huge restrictive covenants
    - Quotas exist – office managers increased pressure
    - Also quotas for retiring dentists who have sold to keep production of presale values
- College:
    - Impress on individual dentists' their responsibilities to patient and quality care
    - Can CDSBC limit # of practices someone owns?
    - Lack of information because no one wants to talk
    - Watch and wait – people will eventually come forward
    - More effort on ethical training → mandatory CE credits more promotion of ethics courses

Appendix D: Sedation dentistry and public protection

Discussion question: What additional changes should CDSBC make to the requirements for dental sedation to further protect the public?

Discussion host: Dr. Jason Chen

- Clear definition between mild and moderate
- guideline – zero pre-med before office arrival
    - Impact on patient anxiety pre-arrival / arrival to office
- Control of associate practising sedation
- Risk increases with level of sedation
- Guidelines cannot protect someone who decides to go rogue
- Multiple oral sedation drugs in past
    - Now unable to meet the current standards

- Guidelines min-mod very strict
    - DDS resistant
    - Over regulation can hurt office /patient access
- If dentist doesn't follow rules needs to have "repercussions"?
- Done in hospital facility
- Operator model – anesthetist
- Fully qualified medical anesthesiologist
- Qualification / training
- Proper equipment / proper inspection

Discussion host: Dr. Mehdi Oonchi

- Having a responsible person come to the office to escort the sedated patient
- Patients are confused about sedation / the "levels"– important to have good communication
- Patients think they will be "out" and won't need freezing when undergoing moderate or IV sedation.
- There is a need to inform patients that minimal and moderation sedation are conscious sedation and it is different than deep or general anesthesia
- Questions:
    - Are there updates on minimal sedation guidelines?
    - Can dentists prescribe oral sedation medications for nervous patients the night before treatment?
    - Can a dentist replace a sedation certified staff for administration of IV sedation?
    - If they don't have ride – how should we dismiss a sedated patient?
    - What types of CPR are appropriate for minimal and moderate sedation team members?
    - In mild oral sedation should we continuously monitor the patient using a Pulse Oximeter?

Appendix E: Speaker Biographies

Dr. Ash Varma
Chair, Quality Assurance Committee

Ash has been a volunteer with the College since 1989. He has served on many committees, and chairs the Quality Assurance Committee and the CE subcommittee. He served as both President and Vice-President of the College Board. Prior to that, he was the Upper Island board member for several years. Ash practises in Powell River.

Greg Cavouras
Legal Counsel

Greg acts for the College in a wide range of legal proceedings, including discipline cases, unauthorized practice and complaints review before the Health Professions Review Board. Prior to joining the College, Greg was a litigator for a leading national law firm.

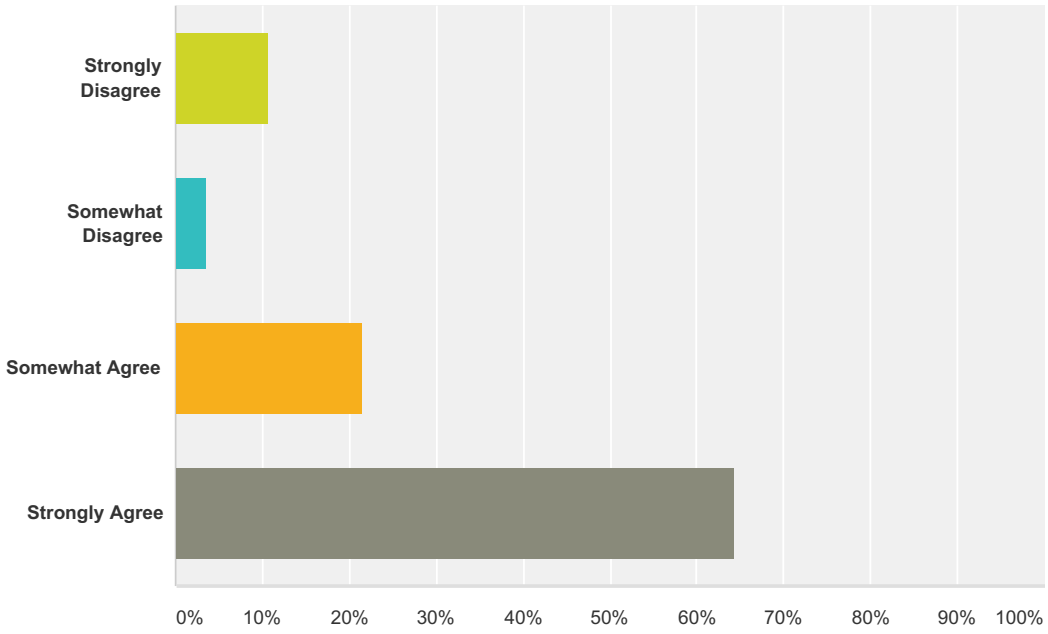
Dr. Tobin Bellamy
Chair, Sedation & General Anaesthetic Services Committee

Tobin has volunteered with the College since 2005. He served on the Accreditation Committee before serving on Sedation & General Anaesthetic Services Committee, of which he is currently the chair. He is a specialist in Oral and Maxillofacial Surgery and practices in Coquitlam.

Appendix F: Participant Evaluations

Q1 I had adequate opportunities to express my views.

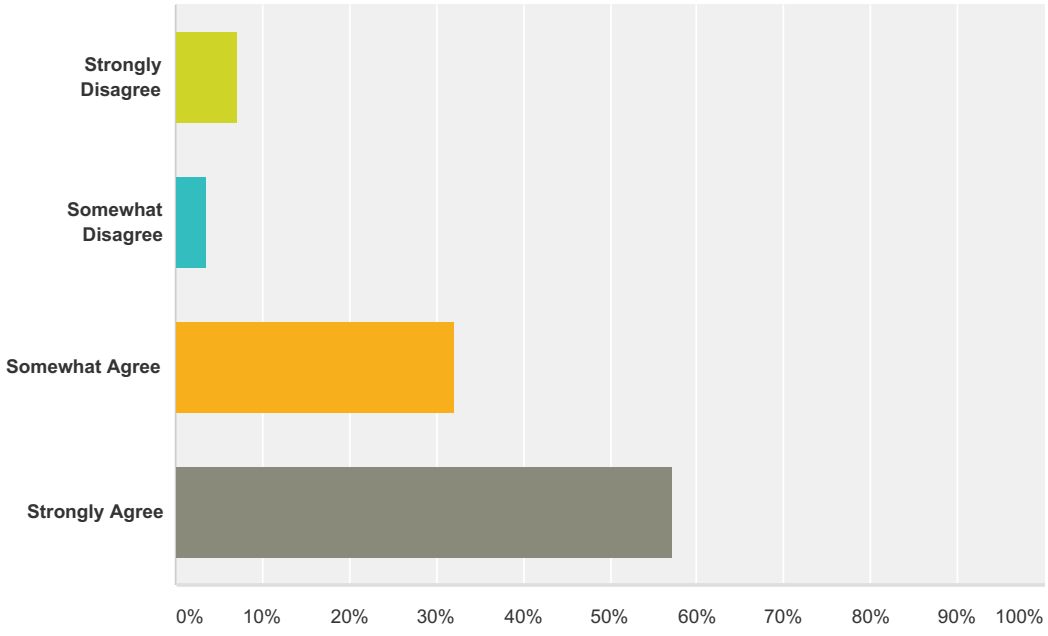
Answered: 28 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	**10.71%**	3
Somewhat Disagree	**3.57%**	1
Somewhat Agree	**21.43%**	6
Strongly Agree	**64.29%**	18
Total		**28**

Q2 There was adequate opportunity for participants to exchange views and learn from each other.

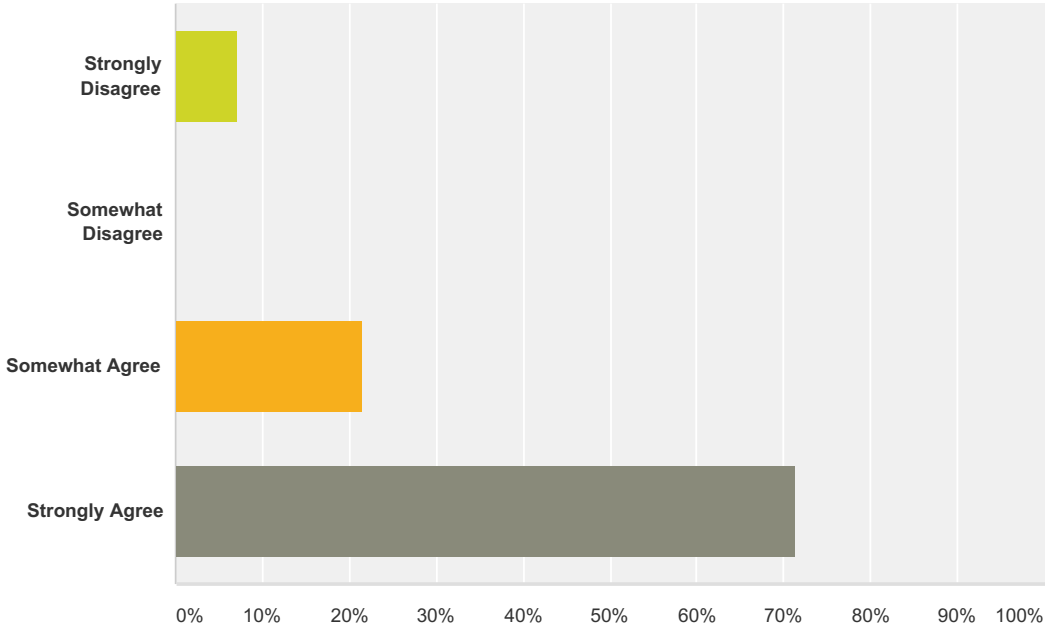
Answered: 28 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	**7.14%**	2
Somewhat Disagree	**3.57%**	1
Somewhat Agree	**32.14%**	9
Strongly Agree	**57.14%**	16
Total		**28**

Q3 CDSBC demonstrated a commitment to listening.

Answered: 28 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	**7.14%**	2
Somewhat Disagree	**0.00%**	0
Somewhat Agree	**21.43%**	6
Strongly Agree	**71.43%**	20
Total		**28**

Q4 Additional comments on the Quality Assurance Program review?

Answered: 5 Skipped: 23

#	Responses	Date
1	Significantly need to improve for CDAs - perhaps more advocacy with CDABC	3/2/2017 9:35 AM
2	Ample opportunity to exchange information.	3/2/2017 9:32 AM
3	Regulating more strictly entry requirements for new registrants vs. "checking" existing dentists. Foreign graduates	3/1/2017 4:23 PM
4	There should be more requirements from New Grad students.	3/1/2017 4:11 PM
5	Covered well at station.	3/1/2017 4:08 PM

Q5 Additional comments on Business of dentistry and corporate structures?

Answered: 4 Skipped: 24

#	Responses	Date
1	Negative stigma with corps/"bad publicity" impact on public. Solo practitioners may not be able to compete with corps. for practice purchases - less cash and financial resources. Corps overpaying for practices.	3/2/2017 9:35 AM
2	Business models as they evolve will affect care of patients so can't separate both.	3/1/2017 4:23 PM
3	Very good dialogue. could become a huge problem. Keep talking!	3/1/2017 4:21 PM
4	Covered well at station.	3/1/2017 4:08 PM

Q6 Additional comments on Sedation Dentistry?

Answered: 2 Skipped: 26

#	Responses	Date
1	Do not do this for a reason. GA hospital only with Anesthetist	3/1/2017 4:21 PM
2	The guideline is too safe for minimal sedation	3/1/2017 4:11 PM

Q7 What worked well at the Listening Session?

Answered: 12 Skipped: 16

#	Responses	Date
1	Format.	3/2/2017 9:35 AM
2	One to one sessions with College staff.	3/2/2017 9:32 AM
3	Large group input. Well organized.	3/2/2017 9:30 AM
4	Well done.	3/2/2017 9:28 AM
5	Most.	3/1/2017 4:23 PM
6	College reaching out to the membership on important issues.I felt the door was open.	3/1/2017 4:21 PM
7	Openness. Willing to listen	3/1/2017 4:19 PM
8	More dentists and CDAs attended the course. Worked well to meet other professionals and hear them.	3/1/2017 4:17 PM
9	The station rounds effective with providing opportunity to share ideas.	3/1/2017 4:16 PM
10	Discussion on hearing others views.	3/1/2017 4:15 PM
11	Understood the responsibility of the dentist and also the obligation of the College towards the public.	3/1/2017 4:13 PM
12	Was very interesting listening to the other dentists at the stations. Much common thought.	3/1/2017 4:08 PM

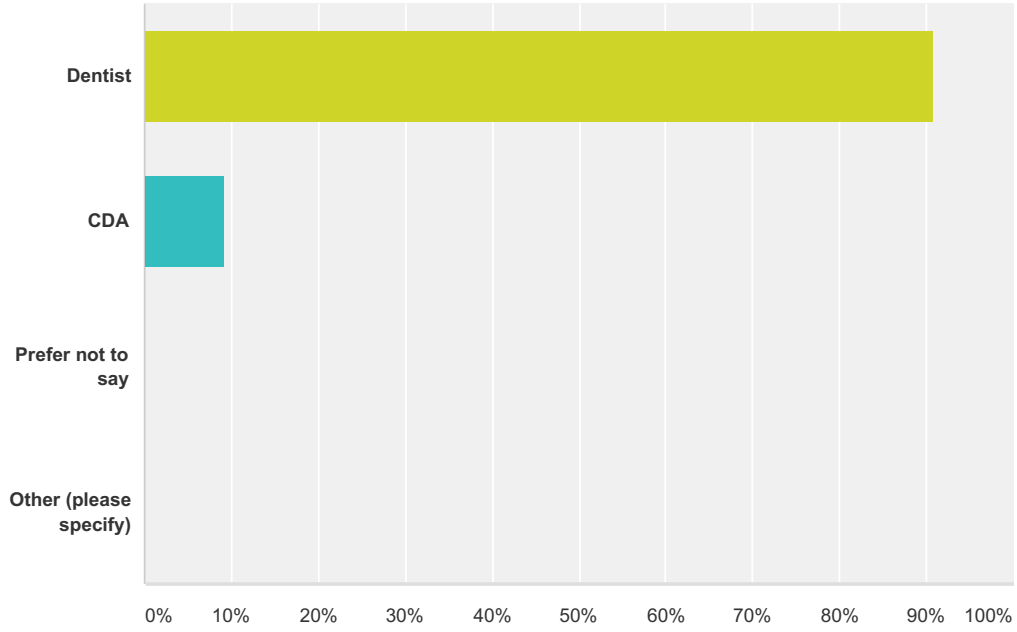
Q8 What could have been improved about the Listening Session?

Answered: 9 Skipped: 19

#	Responses	Date
1	Identify specific topics of concern and provide 3 hour session devoted to identify issues and potential solutions.	3/2/2017 9:37 AM
2	Nothing. I liked it.	3/1/2017 4:21 PM
3	Provide a follow up - email/message that speaks to possible solutions or direction form these sessions.	3/1/2017 4:19 PM
4	More time please.	3/1/2017 4:15 PM
5	It's a good idea to send the topics in advance so that people can think and prepare their ideas.	3/1/2017 4:14 PM
6	Probably some more time.	3/1/2017 4:13 PM
7	Aware of issues in dental community.	3/1/2017 4:08 PM
8	I think it was well played out indeed!	3/1/2017 4:08 PM
9	More time discussion groups.	3/1/2017 4:05 PM

Q9 To which of the following groups do you belong?

Answered: 22 Skipped: 6



Answer Choices	Responses	
Dentist	**90.91%**	20
CDA	**9.09%**	2
Prefer not to say	**0.00%**	0
Other (please specify)	**0.00%**	0
Total		**22**

#	Other (please specify)	Date
	There are no responses.	

CDSBC | College of Dental Surgeons of British Columbia

Complaints Team Report

01 February 2017 – 31 May 2017

Overview

As at 31 May 2017, the Complaints Team was handling **171** active files. The Chart at Tab A captures the breakdown by age of the open complaint files as of that date.

In this reporting period the number of files older than a year has decreased. The following table compares the number of files that are over one year of age:

31 May 2017	**40** files
31 January 2017	**51** files

The number of files two years or older has also decreased for this report. The following table compares files over two years of age:

31 May 2017	**2** files
31 January 2017	**11** files

The Chart at Tab A indicates the average file age of the open files is **239** days. The following table compares the average file age of open files:

31 May 2017	**239** days
31 January 2017	**273** days

This is significant progress – the average file age of open complaints is under 8 months. This is the lowest yet reported to the Board.

Telephone Calls

Between 01 February 2017 and 31 May 2017, the complaints support staff received:

- 188 calls from members of the public inquiring about making a complaint regarding their dentist;
- 58 calls from dentists and dental office staff regarding complaint issues;
- 100 calls from registrants and complainants regarding their open files; and

- 76 miscellaneous inquiries.

Long-standing Complaints

There are many reasons a file may take an extended period of time to resolve, including:

- difficulty in obtaining reports and records;
- multiple patients involved;
- complexity of the issues;
- the registrant's health;
- staff resources available;
- the involvement of legal counsel; and
- legal proceedings.

Complaints Received

Between 01 February 2017 and 31 May 2017, the College opened 62 complaints.

The Chart at Tab B includes the number of complaint files opened and closed by month for 01 February 2017 to 31 May 2017.

The Charts at Tab C include files opened by month so far this fiscal year over last fiscal year as well as last fiscal year over the previous year.

Of the 62 complaints received between 01 February 2017 and 31 May 2017, 24 (84%) were from patients or family members of a patient.

Closed Complaints

The Complaints Team continues to target the older files in the system.

The Chart at Tab D sets out the age of files on closing between 01 February 2017 and 31 May 2017. The College closed 69 files during that period. 34 files were closed in under a year.

The majority of files are closed because the allegations are unsubstantiated or can be resolved by agreement. The most common treatment issues found on closing are:

- diagnosis and treatment planning (23%)

- informed consent (12%)
- orthodontics (8%)

Complaints to the Ombudsperson

The Ombudsperson for the Province of British Columbia accepts complaints/inquiries regarding professional associations and regulators, including the College of Dental Surgeons.

Between 01 January 2017 and 31 May 2017, there were 2 complaints or inquiries which did not require investigation.

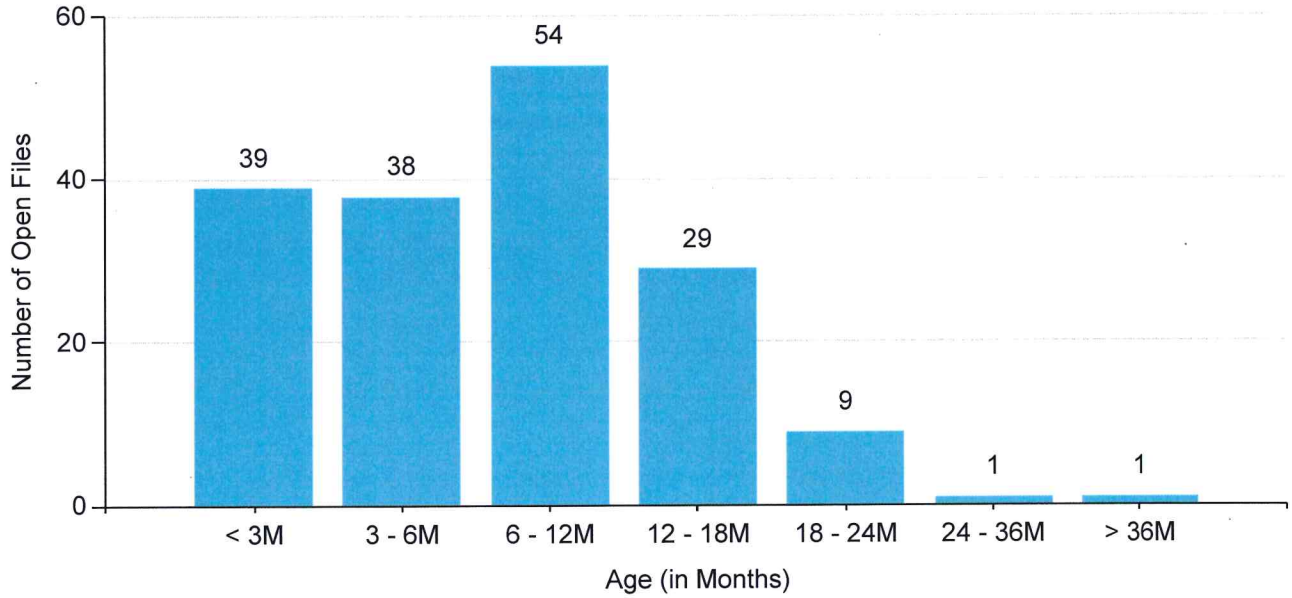
TAB A

Open Files Aging Report

As of May 31, 2017
Average File Age (days): **239**

Age	File #	Opened	Days	Dentist/CDA	Complainant	Investigator	Count
< 3M							39
3 - 6M							38
6 - 12M							54
12 - 18M							29
18 - 24M							9
24 - 36M							1
> 36M							1
Total							**171**

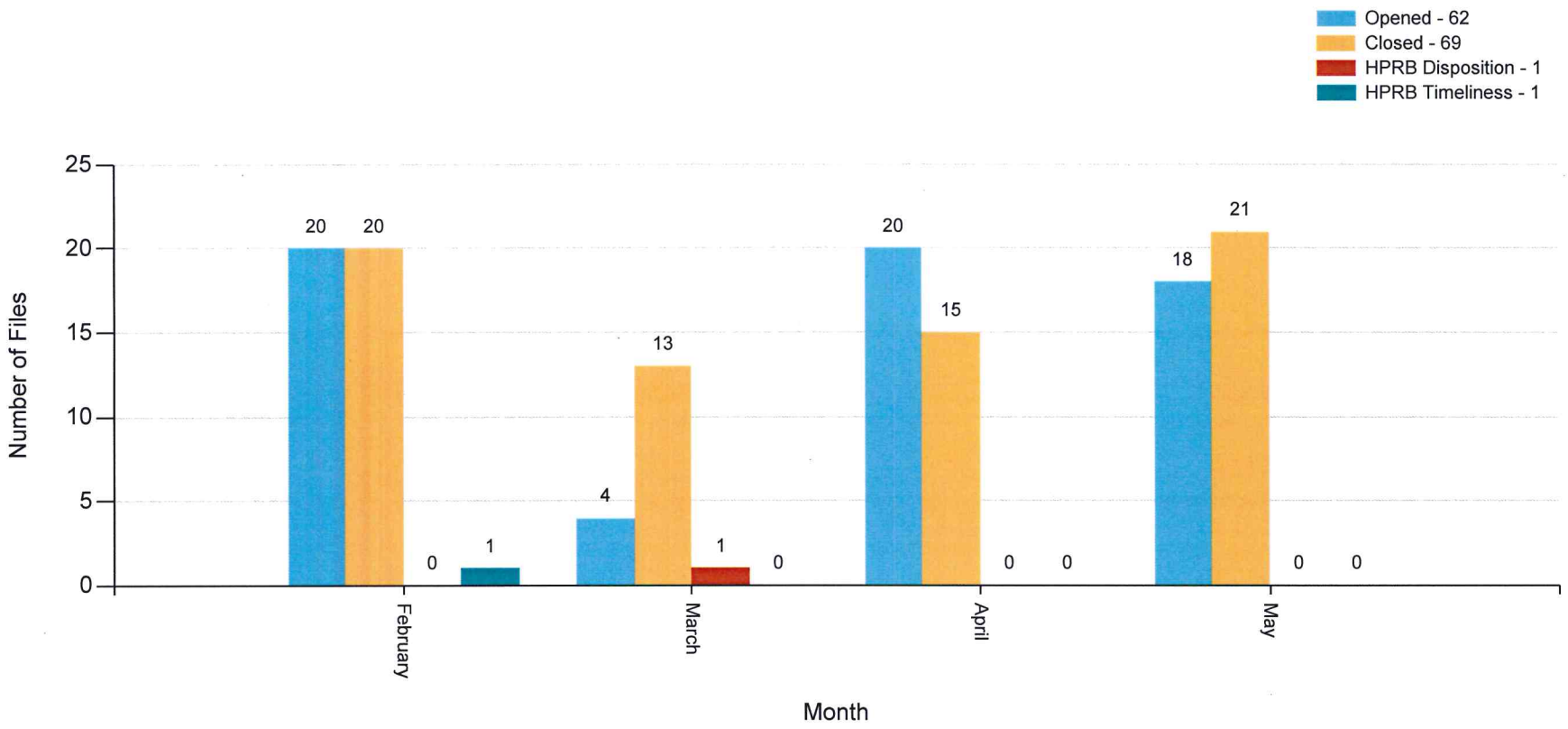
Open Complaint Files



TAB B

File Breakdown By Month

01-Feb-2017 to 31-May-2017

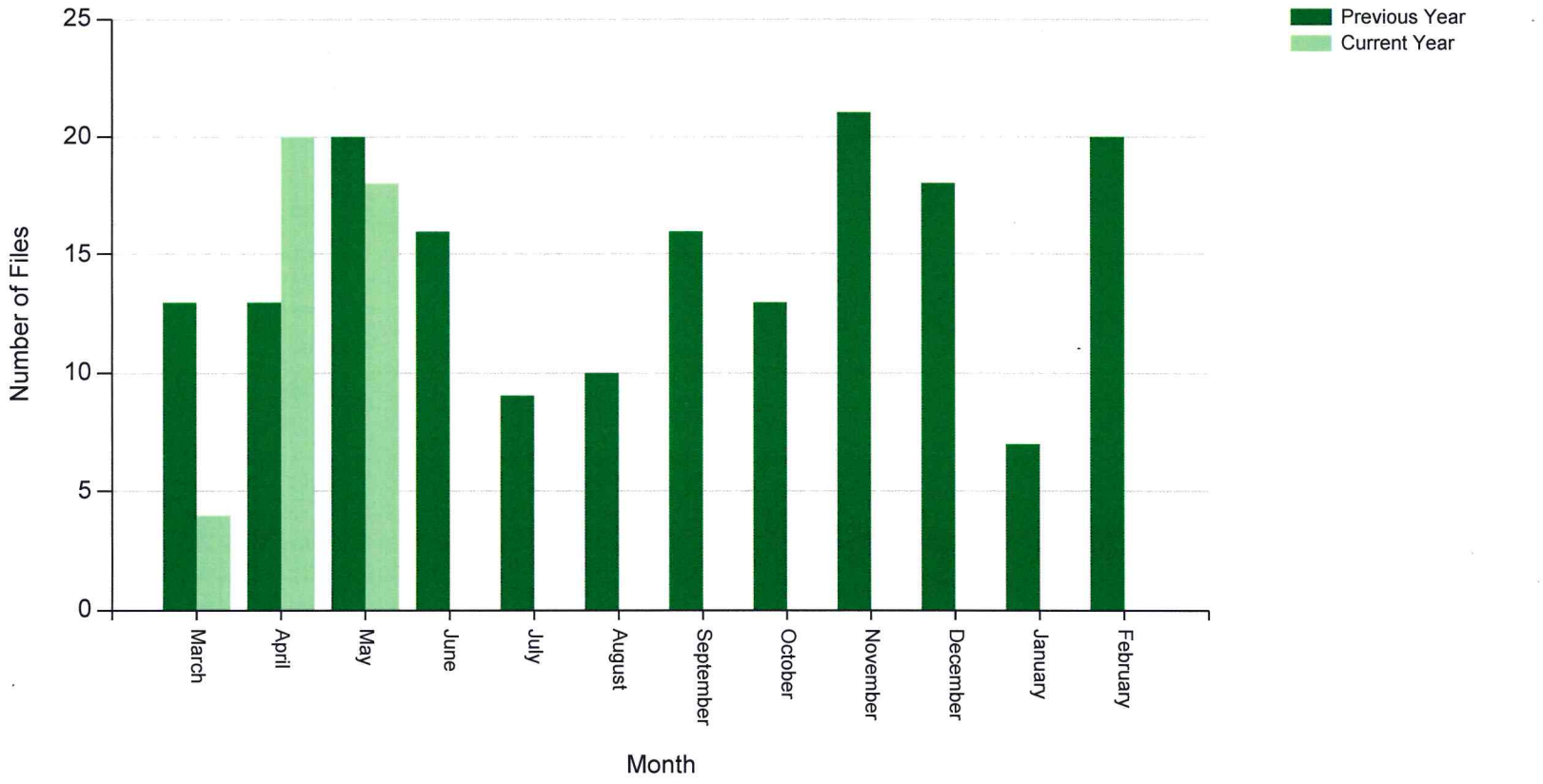


Printed: Wednesday, May 31, 2017

TAB C

Opened Files By Month -2017

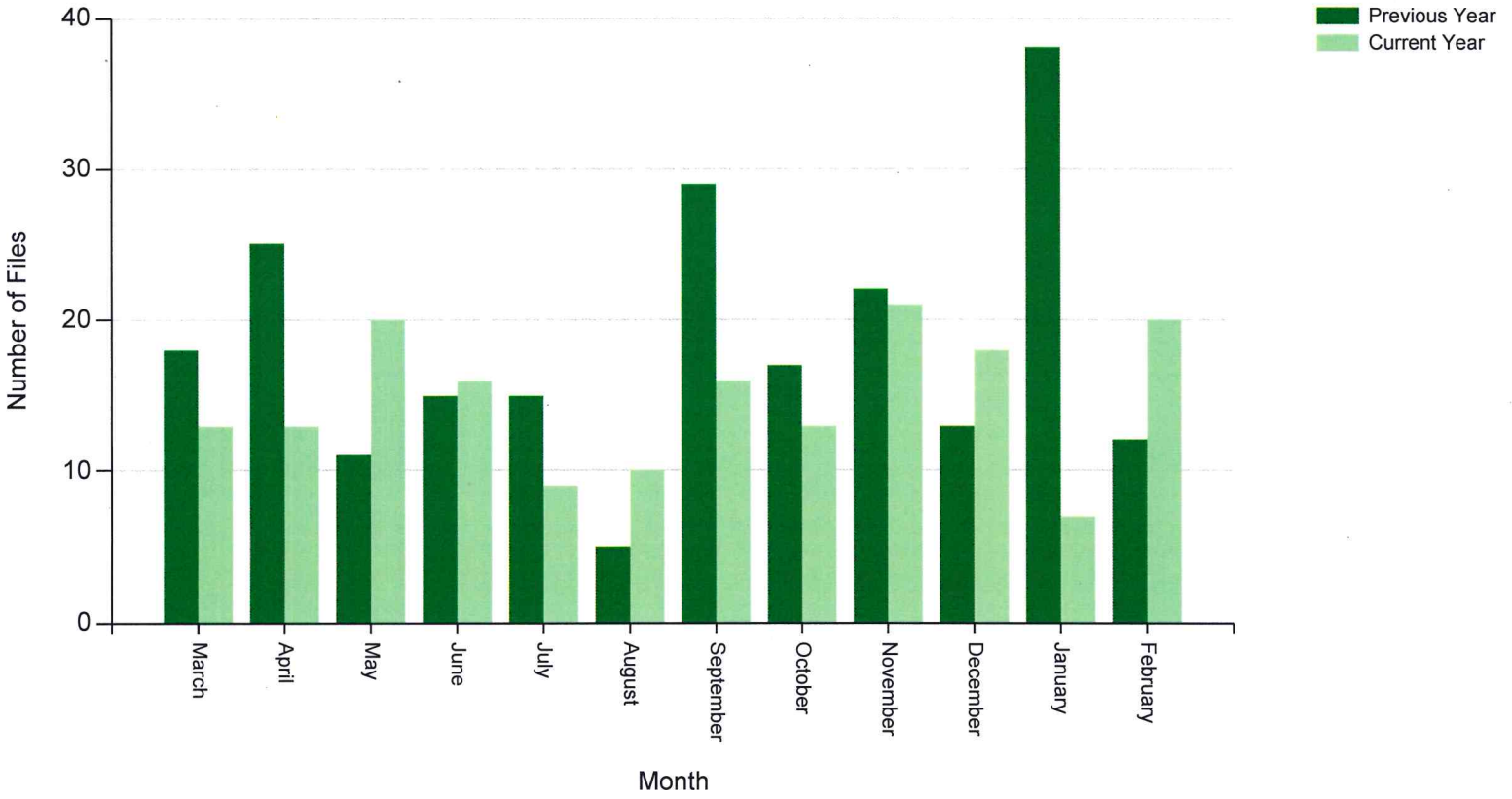
Current Year to Previous Year Comparison



Printed: Wednesday, May 31, 2017

Opened Files By Month - 2016

Current Year to Previous Year Comparison



Printed: Wednesday, May 31, 2017

TAB D

Age of Files on Closing

Files Closed between 01-Feb-2017 and 31-May-2017

Age of Files (Days)	Number of Files
0 - 90	4
91 - 225	11
226 - 365	20
365+	34