

Peer & Practice Assessment Report

Demographic & Practice Information	
Practitioner Name:	Registration Number:
Type of Practice: (e.g., Sole Proprietor, Incorporation, Associate)	
Assessment Information	
Practice Name:	Contact Information (phone/email):
Assessment Address:	
Assessor Name:	Assessment Date: _____

ASSESSMENT COMMUNICATION LOG		
Date Practitioner Contacted	Purpose of Communication	Outcome of Communication

Assessor Signature:	Total Time to Complete the Assessment: _____
	Total Time for Post-Assessment Reporting: _____

INSTRUCTIONS

For each assessment category, please check the box that best reflects your assessment of the identified statement. If you select **Incomplete or N/A**, you are required to document the specific suggestions and/or clarify your concerns in the **Details/Comments** section.



Record Keeping

COLLECTION & DOCUMENTATION OF PATIENT INFORMATION	Complete	Incomplete	N/A
1. The record system allows for ready retrieval of the patient file. (Assessor Note: Use visual demonstration submission or discuss filing system during discussion section).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Each page and/or part of the patient record contains a unique identifier.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The record is legible and written in English or French.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The record contains the patient's necessary personal and contact information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The record contains the patient's dental history, medical history, allergies, medications/supplement use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The record contains evidence of intraoral and extraoral examinations, noting clinical findings and professional opinions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Notation of any referrals made by the denturist.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Information and advice provided to the patient and any necessary follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Date and nature of all patient interactions, including patient services related to repairs and/or adjustments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Financial records are kept as part of the patient record or linked with a unique identifier; maintains an account of all charges for services including notation of refunds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INFORMED CONSENT & CONFIDENTIALITY/PRIVACY	Complete	Incomplete	N/A
11. Treatment options are recorded and the record reflects that informed consent was obtained, including the patient's acceptance of the treatment plan, costs and any modifications, withdrawal and/or refusal of consent, in accordance with the Standard of Practice: Informed Consent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Notation of any substitute decision makers, their relationship to the patient and any documentation provided (i.e. Power of Attorney).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. The record contains consent to collect, use and disclose personal health information, signed by the patient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Measures are in place to ensure the security of patient records in accordance with the Standard of Practice: Confidentiality & Privacy. (Assessor Note: Use visual demonstration submission or discuss during discussion section).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EQUIPMENT & INSTRUMENTS	Complete	Incomplete	N/A
15. All services to, maintenance for and inspection of equipment or instruments is tracked using a record of service.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Paper records <input type="checkbox"/> Electronic Records			

Details/Comments:



Assessment and Interpretation of Patient Needs and Requirements

ASSESSMENT & INTERPRETATION OF PATIENT NEEDS & REQUIREMENTS	Complete	Incomplete	N/A
1. There is evidence of the assessment of existing prostheses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The practitioner has:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. considered factors that may affect the provision of denturist services;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. determined viable treatment options appropriate to the patient's oral and general health status and needs; and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. communicated viable treatment options and the prognosis to the patient to enable the patient to make an informed decision.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details/Comments:

Post-Insertion Patient Education and Continuity of Care

POST-INSERTION PATIENT EDUCATION AND CONTINUITY OF CARE	Complete	Incomplete	N/A
1. There is evidence that patients are being provided patient education regarding the use, care and maintenance and follow-up of dental prostheses and oral appliances.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. There is an indication that the practitioner has made adequate arrangements for ongoing care where warranted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details/Comments:



Infection Prevention and Control (IPAC)

INFECTION CONTROL	Complete	Incomplete	N/A
1. Proper hand hygiene protocol maintained.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OPERATORY			
2. There is evidence of surface and equipment disinfection and cleaning in between patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. There is evidence of barrier protection (e.g., gloves, masks, headrest covers, barrier tape).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STERILIZATION AREA			
4. There is evidence of instrument cleaning, disinfection, sterilization, and safe storage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. There is an established process for monitoring sterilization including record keeping logs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LABORATORY			
6. There is evidence of IPAC protocols in place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Surface cleaning and disinfection are appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. There is an area dedicated to the fabrication of prostheses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. There is a system in place for adequate asepsis control for work entering and exiting the laboratory area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details/Comments:

Self-Assessment & Continuing Professional Development (CPD) Activities

Self-Assessment & CPD Activities	Complete	Incomplete	N/A
1. The evidence provided supports a minimum of 10 CPD credits for the previous renewal period.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Member has completed the Self-Assessment Tool and selected their CPD goals for the cycle.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details/Comments:

GENERAL COMMENTS

**Summary:**

Rating 1	Meets criteria
Rating 2	No safety concerns noted. Minor improvements are needed when most elements of quality are evident and deficiencies, if any, are minimal.
Rating 3	One or more areas are identified as a risk or a safety/quality concern for patients. Moderate ongoing learning and improvement activity is needed.
Rating 4	Caution is needed; issues or risky patterns are identified, or patient outcomes might be adversely affected. Major improvement is needed.

	Rating 1	Rating 2	Rating 3	Rating 4	N/A
Summary Report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IPAC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CPD/SAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Record Keeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSR #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSR #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSR #3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSR #4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide any additional comments that are relevant to the assessment but are not covered in any of the preceding categories.