



College of
Dental Hygienists
of Ontario

Protecting your health and your smile

CDHO Peer Mentorship Program

Updated May 2013

CDHO Peer Mentorship Program

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CDHO Peer Mentorship Program

Introduction

Mentorship is recognized as a viable strategy for professional growth and leadership in health professions. Formal mentorship programs are becoming increasingly popular in institutions educating health care professionals and in workplaces inside and outside the health care field.

The CDHO recognizes that mentoring relationships can be especially meaningful to new registrants. An experienced dental hygienist who qualifies as a CDHO Peer Mentor can give personal support to a new practitioner who is adjusting to the fast-paced, high-stress work of caring for clients. Dental hygienists who complete the mentorship program gain experience in seeking and participating in collective decision making, develop a habit for a collaborative approach to client care and gain confidence in practice.

Benefits of the Program

Mentees:

- Expanded perspectives, deepened self-knowledge and self-understanding through shared experiences with a trusted colleague.
- Support and guidance during their integration into clinical practice.
- Access to an informed second opinion, aids critical thinking.
- Authorization to self-initiate scaling teeth, root planing and curettage of surrounding tissue for duration of mentorship.
- Exposure to additional resources and professional networks.
- Professional socialization.

Mentors:

- Recognition for influencing the professional growth of another dental hygienist.
- Exposure to new ideas, other perspectives, and intellectual stimulation.
- Contributes to the professional portfolio as a continuing competency activity.

Public of Ontario:

- Increased access to dental hygiene services provided by dental hygienists who are authorized by the College to self-initiate.
- Dental hygienists participate in, and promote intra- and inter-professional collaboration.

Qualifications of the Mentor

For the purpose of the CDHO Peer Mentorship Program, a mentor is a registered dental hygienist who has been approved by the College and has met the following criteria:

- Good standing with the College;
- A minimum of 5 years in clinical dental hygiene practice;
- Currently practising dental hygiene;
- Authorized to self-initiate for a minimum of 2 years; and
- The professional experience to facilitate the professional development of a colleague.

The dental hygienist peer mentor facilitates professional development by adopting a role of confidante, advisor, role model and sounding board. The mentoring relationship is deliberate, conscious and voluntary, aimed at assisting in the growth and ability of another colleague. A peer mentor should limit the number of mentees one is responsible for to a maximum of three in a given time period. A mentor under the CDHO Peer Mentorship Program may not receive financial consideration for mentoring.

Responsibilities of the Mentor

Identify through co-discovery the areas of practice that involve uncertainty, and/or ethical dilemmas that may not be solved simply from a technical problem-solving approach.

1. Develop a plan with the mentee that will establish learning objectives, resources, communication strategies and evaluation of outcomes.
2. Facilitate learning opportunities and advise the mentee of appropriate resources.
3. Give insight, advice, encouragement and support as needed.
4. Promote and facilitate professional relationships aimed at collaborative client-centered care.
5. Assess the mentee's progress and submit written reports to the CDHO as required.

The mentor is **not** responsible for the clients under the care of the mentee. The mentee has the ultimate responsibility for all dental hygiene care provided.

Mentee

For the purpose of the CDHO Peer Mentorship Program, a mentee is a registered dental hygienist requiring guidance and support in developing their competence to self-initiate the authorized act of "scaling teeth and root planing, including curetting surrounding tissue."

Responsibilities of the Mentee

1. Share through discussion his/her needs and expectations of the mentorship.
2. Develop a plan with the mentor that will establish learning objectives, resources, communication strategies and evaluation of learning outcomes.
3. Be open and receptive to the advice and suggestions offered by the mentor and respond accordingly.
4. Respect the time and opportunities provided by your mentor and acknowledge the contributions your mentor makes to your professional practice.

Be aware that as a registered dental hygienist, you are responsible for all dental hygiene services you provide to your clients.

Choosing a Mentor

Your search for a mentor may begin while you are a student if you seek out opportunities to meet and introduce yourself to dental hygienists within your community. Look for opportunities to join the professional associations, attend local society meetings, and volunteer for events that dental hygienists in your community are organizing or participating in. The College maintains a list of peer mentors on its website. Introducing yourself will be easier if you have a point of reference such as a common acquaintance or an event you both attended. Remember that mentors volunteer their services and have no obligation to take you on as a mentee. The mentor you select for the purposes of the CDHO Peer Mentorship Program must be currently listed as CDHO peer mentor. If you are considering a non-traditional practice setting in your immediate future, it would be advisable to seek out a mentor who currently practises in that type of setting. For example, if you would like to practise in a long-term care facility, it would make good sense to mentor with someone who has hands-on experience in that type of practice setting.

Qualities of a Good Mentor

- ☺ Is involved in continuous learning and pursues professional growth through a variety of sources.
- ☺ Voluntarily accepts your invitation to mentor, is enthusiastic about mentoring.
- ☺ Is **not** your supervisor or your employer.
- ☺ Is respectful, empathetic and non-judgmental.
- ☺ Is a positive role model and knowledgeable about clinical dental hygiene practice.
- ☺ Is transparent about his/her own search for better answers and more effective solutions to his/her own professional practice.
- ☺ Is open to new ideas and learning from colleagues, including new practitioners.
- ☺ Listens to the whole story before commenting.
- ☺ Is comfortable having his/her views challenged.

- ☺ Sees the new practitioner as an equal.
- ☺ Gives advice but expects the mentee to make their own decisions.
- ☺ Has a genuine desire to empower.

Duration of the Mentorship

To be considered eligible under **Stream Two or Three**, a registrant must be mentored for a minimum period of six (6) months in which the new registrant has provided a minimum of 500 hours of direct client care and the mentor establishes that the new registrant has the skills, knowledge and attitudes required to self-initiate the authorized act of “scaling teeth and root planing, including curetting surrounding tissue.” Prior to starting the mentorship, the mentee must apply for authorization with condition and is required to submit to the College with that application, a copy of the mentorship contract.

Methods of Guidance

The mentor and mentee will establish through co-discovery what methods of guidance will be most appropriate for the efficiency and effectiveness of the mentorship. The following is a list of recommended opportunities for learning, aimed at professional growth and practice enhancement. The mentorship is not limited to the suggestions on this list.

- Administrative management discussions.
- Clinical management discussions.
- Reviewing mentee's client records (**mandatory**) (suggested minimum: 20 client records).
- Reviewing mentee's professional portfolio.
- Telephone/e-mail conferences (as per mentorship contract).
- Review and discussion of mentee's daily practice journal.

Note: The minimum mentor/mentee contact time is 24 hours of direct and indirect mentoring over the six-month period, averaging 4 contact hours per month. More time may be required and participants are encouraged to use the 24 hours as a minimal requirement with the attitude that additional time invested will enhance the mentorship experience.

Documentation

Both the mentor and mentee should document their activities so that a record of the activities performed, issues covered and time spent in the mentorship, are available for scrutiny if required.

Evaluation by the Mentor

The mentor should evaluate the performance of the mentee to enable the mentor to issue the Mentor's Declaration and Statement of Confidence. No particular method of evaluation is required (e.g., written questions, structured verbal discussion, assessment of client interactions). Assessment can occur throughout the mentorship or it can be a stand-alone activity towards the end of the mentorship. However, the evaluation should be structured and based on specific questioning and not just on general impressions.

The evaluation would cover the following areas:

- Application of the dental hygiene process of care to the authorized act.
- Familiarity with the indications for performing the controlled act.
- Relevant client management skills.
- Appreciation of the contraindications for performing the controlled act, the ability to assess and recognize them, applying critical thinking for managing a client with a contraindication and the ability to implement an appropriate strategy.
- Knowledge of when and how to refer a client with a condition beyond his or her competence to an appropriate regulated health practitioner.
- Judgment in managing ethical situations related to the controlled act.
- Understanding related legislation, standards of practice, guidelines and Code of Ethics.

Mentor's Declaration and Statement of Confidence

At the end of the mentorship period and once the mentor has established sufficient evidence of the mentee's ability to self-initiate, the mentor will complete the Mentor's Declaration and Statement of Confidence and send it directly to the CDHO with a copy of the mentorship contract.

Applying for Certification to Self-initiate

Upon successful completion of the requirements to apply for self-initiation under **Stream Two or Three**, the mentee will be eligible to apply for authorization to self-initiate without the additional condition of a mentorship. An application must be made using the appropriate application form, the application fee and the required documentation.

CDHO Peer Mentorship Program Guidelines

Introduction

Mentoring relationships and formal mentoring programs are used in many industries, including health care, to provide a supportive learning environment for professional growth and development. The dental hygienist mentor facilitates professional development by adopting a role of confidante, advisor, role model and sounding board. The mentoring relationship is deliberate, conscious and voluntary, aimed at assisting in the growth and ability of another colleague. The Quality Assurance Committee recognizes that a mentorship arrangement is mutually beneficial to the mentor and the mentee. For that reason, the mentor and the mentee can use the mentorship contract as evidence of a learning activity in their professional portfolios.

Mentor

For the purpose of the CDHO Peer Mentorship Program, a mentor is a registered dental hygienist who has been authorized to self-initiate, who is in good standing with the College, who possesses the professional experience to facilitate the professional development of a colleague.

Mentee

For the purpose of the CDHO Peer Mentorship Program, a mentee is a registered dental hygienist requiring guidance and support in developing their competence to self-initiate the authorized act of "scaling teeth and root planing, including curetting surrounding tissue."

Role of Mentor

1. Identify through co-discovery the needs of the mentee.
2. Develop a plan with the mentee that will establish learning objectives, resources, communication strategies and evaluation of learning outcomes.
3. Facilitate learning opportunities and advise the mentee of appropriate resources.
4. Give insight, advice, encouragement and support as needed.
5. Assess the mentee's progress and submit written reports to the CDHO as required.
6. Promote and facilitate professional relationships aimed at collaborative client-centered care.

The mentor is **not** responsible for the clients under the care of the mentee. The mentee has the ultimate responsibility for all dental hygiene care provided.

Role of Mentee

1. Share through discussion your needs and expectations of the mentorship.
2. Develop a plan with the mentor that will establish learning objectives, resources, communication strategies and evaluation of learning outcomes.
3. Be open and receptive to the advice and suggestions offered by the mentor and respond accordingly.
4. Respect the time and opportunities provided by your mentor and acknowledge the contributions your mentor makes to your professional practice.

Be aware that as a registered dental hygienist, you are responsible for all dental hygiene services you provide to your clients. In accordance with professional standards and College expectations, you are authorized to self-initiate the scaling of teeth, root planing including curettage of surrounding tissue with the condition that you practise under the mentorship of an approved CDHO mentor until you have received full approval to self-initiate from the CDHO.

CDHO Peer Mentorship Program Contract

Mentee Information

First Name		Last Name													
Telephone (Res.)	Telephone (Bus.)	CDHO Registration Number													
Primary Employment Setting: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Hospital</td> <td><input type="checkbox"/> Long-Term Care</td> <td><input type="checkbox"/> Periodontal Practice</td> </tr> <tr> <td><input type="checkbox"/> Education</td> <td><input type="checkbox"/> Supportive Living</td> <td><input type="checkbox"/> Other (Please specify)</td> </tr> <tr> <td><input type="checkbox"/> Home Care</td> <td><input type="checkbox"/> General Dental Office</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Public Health</td> <td><input type="checkbox"/> Private Dental Hygiene Practice</td> <td>_____</td> </tr> </table>				<input type="checkbox"/> Hospital	<input type="checkbox"/> Long-Term Care	<input type="checkbox"/> Periodontal Practice	<input type="checkbox"/> Education	<input type="checkbox"/> Supportive Living	<input type="checkbox"/> Other (Please specify)	<input type="checkbox"/> Home Care	<input type="checkbox"/> General Dental Office		<input type="checkbox"/> Public Health	<input type="checkbox"/> Private Dental Hygiene Practice	_____
<input type="checkbox"/> Hospital	<input type="checkbox"/> Long-Term Care	<input type="checkbox"/> Periodontal Practice													
<input type="checkbox"/> Education	<input type="checkbox"/> Supportive Living	<input type="checkbox"/> Other (Please specify)													
<input type="checkbox"/> Home Care	<input type="checkbox"/> General Dental Office														
<input type="checkbox"/> Public Health	<input type="checkbox"/> Private Dental Hygiene Practice	_____													
Client Age Range: (Please check all that apply) <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> 0-5 years</td> <td><input type="checkbox"/> 6-11 years</td> <td><input type="checkbox"/> 12-17 years</td> </tr> <tr> <td><input type="checkbox"/> 18-64 years</td> <td><input type="checkbox"/> 65 plus years</td> <td></td> </tr> </table>		<input type="checkbox"/> 0-5 years	<input type="checkbox"/> 6-11 years	<input type="checkbox"/> 12-17 years	<input type="checkbox"/> 18-64 years	<input type="checkbox"/> 65 plus years		Practice Hours Per Week: I work _____ hours a week. I work _____ hours at my primary practice.							
<input type="checkbox"/> 0-5 years	<input type="checkbox"/> 6-11 years	<input type="checkbox"/> 12-17 years													
<input type="checkbox"/> 18-64 years	<input type="checkbox"/> 65 plus years														

Mentor Information

First Name		Last Name	
Telephone (Res.)	Telephone (Bus.)	CDHO Registration Number	

Mentorship Period

Contract Start Date: ____/____/_____ <small>DD MM YYYY</small>	Contract End Date: ____/____/_____ <small>DD MM YYYY</small>	Duration of Contract: <input type="checkbox"/> 6 months <input type="checkbox"/> Other (Please specify) _____
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Time Allocation

Number of mentored hours per week or per month: (Please indicate if guidance is provided weekly or monthly.)
 The mentee will be mentored _____ hours per week / per month. (Min: 1 hrs/wk, 4 hrs/mth)

Method of Mentorship Guidance

Check all that apply:

<input type="checkbox"/> Observation of mentee with clients	<input type="checkbox"/> Administrative management discussions
<input type="checkbox"/> Clinical management discussions	<input type="checkbox"/> Observation of mentor with clients
<input type="checkbox"/> Reviewing mentee's client records (mandatory)	<input type="checkbox"/> Telephone conferences
<input type="checkbox"/> Other (Please specify) _____	

Method of Feedback

Check all that apply:

<input type="checkbox"/> Face-to-face meetings	<input type="checkbox"/> Telephone conferences	<input type="checkbox"/> Other (Please specify)
<input type="checkbox"/> Written communication	<input type="checkbox"/> E-mail	_____

CDHO Peer Mentorship Program Contract (cont'd)

Mentee's Declaration

1. I understand that I will be assessed with respect to my compliance with the CDHO Standards of Practice and will undertake to acquire the skills, knowledge and behaviour to demonstrate my competence to self-initiate the authorized act of "scaling teeth and root planing, including curetting surrounding tissue."
2. I acknowledge my role as a mentee in the CDHO Peer Mentorship Program.
3. I agree to collect evidence of compliance for my mentor's review.

Signature of the mentee

Date

Mentor's Declaration

1. I am a CDHO Peer Mentor.
2. I agree to assess the mentee's practice to determine if s/he has the required skills, knowledge and behaviour to meet the CDHO Standards of Practice.
3. I agree to mentor the above named mentee in accordance with the CDHO Peer Mentorship Program Guidelines.
4. I agree to notify the mentee and the College immediately if I am no longer able or willing to continue to fulfill my responsibilities as a mentor.
5. I agree to review the mentee's progress and submit a Final Assessment Report at the end of the mentorship term.
6. I agree, subject to the above, to respect the mentee's right to privacy and confidentiality at all times.

Signature of the Mentor

Date

Mentee and Mentor Agreement

We agree to the following process:

1. To review the CDHO Regulations and Standards of Practice, and identify areas requiring specific attention.
2. To develop an action plan to ensure that the mentee gets advice and guidance in the areas of need to acquire the necessary skills, knowledge and behaviours for compliance.

Signature of the Mentor

Date

Signature of the Mentee

Date

For Office Use Only

Approval of this contract grants authorization to self-initiate with conditions. This permits a registrant to decide, based on a comprehensive health assessment, to proceed with the controlled act of scaling teeth, root planing and curettage of the surrounding tissue without the order requirement, while under the mentorship of a CDHO Peer Mentor.

Date Approved:

____/____/_____
DD MM YYYY

Signature:

Expiry Date:

____/____/_____
DD MM YYYY

Mentor's Declaration and Statement of Confidence

Mentee's Full Name

has completed his/her mentorship period with me as per the terms of the CDHO Peer Mentorship Program. I am confident that this registrant has the knowledge, skills and attitudes required to self-initiate the authorized act of "scaling teeth and root planing, including curetting surrounding tissue."

Mentor's Signature

Registration Number

Date



Application for Authorization – Self-Initiation (effective August 1, 2013)

Please refer to the **Standard for Authorization to Self-Initiate Profession-Specific Acts** included in this package before completing this application.

Please print in block letters and/or check the appropriate box.

Name: CDHO Registration No.:

Self-Initiation Streams (Please select the Stream option that you are applying under.)

Stream One

Registrants who hold a General/Specialty certificate of registration with the CDHO and meet ONE of the following criteria options:

Supporting Documents:
(to be submitted with application)

Option a) I have practised clinically under a “standing order/protocol” in Ontario for at least two (2) years (minimum 3200 hours) immediately preceding this application; AND I can provide a copy of a “standing order/protocol” that authorizes me to perform the controlled act of “scaling teeth and root planning, including curetting surrounding tissue”.
Written statement not accepted in lieu of “standing order/protocol.”

Declaration of clinical practice for at least two (2) years; AND
 Copy of “standing order/protocol” for previous two (2) years (3200-hour equivalent)

Option b) I have practised clinically for at least two (2) years (minimum 3200 hours); AND
I have completed a CDHO-approved clinical refresher course OR the CDHA Self-Initiation course during the 24 months immediately preceding this application.

Declaration of clinical practice for at least two (2) years; AND
 Proof of successful completion of a CDHO-approved clinical refresher course OR the CDHA Self-Initiation course

Option c) I have practised clinically in Alberta or British Columbia for at least two (2) years (minimum 3200 hours) immediately preceding this application.

Declaration of clinical practice for at least two (2) years; AND
 Certificate of Professional Conduct (Form B) OR Letter of Standing, to be sent directly from the CRDHA or the CDHBC

Option d) I have practised clinically in Nova Scotia and I was authorized by the CDHNS to self-initiate during that time.

Proof of authorization to self-initiate in Nova Scotia to be sent directly from the CDHNS; AND
 Certificate of Professional Conduct (Form B) OR Letter of Standing to be sent directly from the CDHNS

I have completed the requirements of **Stream Two**

I have completed the requirements of **Stream Three**

Proof of successful completion of Mentorship Program (Mentor’s Declaration)

FOR OFFICE USE ONLY

Date application received:

Date self-initiation approval was issued:

With condition

Stream Two / Conditional Authorization

Registrants who hold a General/Specialty certificate of registration with the CDHO, who do not satisfy any of the criteria in **Stream One**, and meet ALL of the following criteria:

Supporting Documents:
(to be submitted with application)

- I graduated from an accredited or non-accredited Dental Hygiene program before January 1, 2013, or non-accredited program after January 1, 2013; AND
- I completed a CDHO-approved clinical refresher course OR the CDHA Self-Initiation course within the 24 months preceding this application; AND
- I have entered into a mentorship contract with a CDHO peer mentor.

- Proof of successful completion of a CDHO approved clinical refresher course OR the CDHA Self-Initiation course; AND
- Copy of mentorship contract

Note: This conditional authorization is for a minimum of six (6) months to a maximum of twelve (12) months, and can be renewed. Once the mentorship period has been completed, the registrant can apply under Stream One.

Stream Three / Conditional Authorization

Registrants who hold a General/Specialty certificate of registration with the CDHO, who do not satisfy any of the criteria in **Stream One or Two**, and meet ALL of the following criteria:

Supporting Documents:
(to be submitted with application)

- I graduated from an accredited Dental Hygiene program after January 1, 2013; AND
- I have entered into a mentorship contract with a CDHO peer mentor.

- Copy of mentorship contract

Note: This conditional authorization is for a minimum of six (6) months to a maximum of twelve (12) months, and can be renewed. Once the mentorship period has been completed, the registrant can apply under Stream One.

- I have reviewed the [**Standard for Authorization to Self-Initiate Profession-Specific Acts**](#) included in this package.

I am applying for authorization to self-initiate under the following:

- Stream One** — Please see payment instructions below
- Stream Two / Conditional Authorization** (*fee waived*) **Stream Three / Conditional Authorization** (*fee waived*)

Payment Instructions: STREAM ONE (CDN \$75.00—Processing Fee)

Offline Payment:

Amount: CAN \$75.00 **Payment Type:** Certified Cheque Money order

Online Payment:

An email with payment instructions will be sent to you once your application has been approved.

Registrant's Declaration

I certify that the statements made by me in this application are complete and correct to the best of my knowledge and belief. I understand that making a false or misleading statement on this application is considered professional misconduct and could be subject to disciplinary action. I have enclosed or made arrangements to have supporting documentation sent directly to the CDHO.

Signature

Date