Peer & Practice Assessment Program

Handbook

Enhancing Learning Opportunities & Ensuring Compliance

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Introduction

This handbook contains the information about the Peer & Practice Assessment Program of the College of Chiropractors of Ontario (CCO), and how to prepare for the assessment.

Background Information & Legislative Context

CCO's Quality Assurance (QA) Committee developed the Peer & Practice Assessment Program to enhance your learning opportunities and ensure your compliance with the regulations, standards of practice, policies and guidelines.

On becoming registered with CCO, you have the right to call yourself a chiropractor and to practise chiropractic within the scope of practice identified in the *Chiropractic Act, 1991*. In assuming the right to practise, you also assume the responsibilities associated with this right, including the responsibility to maintain competence.

The public must feel confident that you, who demonstrated entry-level competencies when you registered with CCO, continue to be competent for as long as you are in practice. The public should reasonably expect some level of consistency of experience, such as a thorough history, pertinent examination, diagnosis/clinical impression, plan of care, and outcome evaluations.

Participation is Mandatory

You are required to participate in the Peer & Practice Assessment Program if you hold a General Certificate of Registration.

If you are registered as General, and actively practise chiropractic, your assessment will entail a review of 10 current patient files and your knowledge of CCO regulations, standards of practice, policies and guidelines (all posted on CCO's website – www.cco.on.ca).

If you are registered as General, and do not actively practise chiropractic, you will undergo a ***modified assessment***. For example, if you do not actively see patients, your assessment would entail a review of your knowledge of CCO regulations, standards of practice, policies and guidelines.

Peer & Practice Assessment Program

Member Selection

CCO randomly selects members to participate in the program and matches the selected member with an assessor. A colleague trained to identify areas of improvement and encourage members to strive for continuous quality improvement will conduct your assessment, designed to be educational, not punitive.

If you have any concerns and/or conflict with the assigned assessor, please contact Dr. J. Bruce Walton, Director of Professional Practice, CCO, at 416-922-6355, ext. 106. You may request another peer assessor to conduct your assessment.

Preparing for the Assessment

Action Steps

1. Review this handbook, along with all the relevant assessment materials. These can be found on the CCO website at www.cco.on.ca. There you will find a link to the Peer and Practice Assessment materials. In particular, you should review the Peer & Practice 1.0 Assessment Checklist, and the Record Keeping Worksheet.

2. Complete the Action Steps chart attached to the selection letter, which includes the following:

   Send the following items to CCO within 15 days of receiving the assessment notification **(Please do not use any staples when assembling the material):**
   - pre-visit questionnaire
   - one current sterilized patient file (name/other identifying information removed)
   - blank sample of clinical charts/forms
   - list of abbreviations and short forms used (if any)

3. Review CCO's regulations, standards of practice, policies and guidelines (posted on CCO's website – www.cco.on.ca – in the "Members of CCO" section).

4. Prepare your professional portfolio for the assessor's review. Your portfolio should include the following information:

   - Self-Assessment Plan of Action Summary Sheet (when completed)
   - materials gathered while fulfilling requirements (e.g., course outlines, brochures from conventions/conferences, etc.)
   - samples of recent advertisements (if applicable)

When CCO receives your completed materials, the materials will be forwarded to your assessor, who will contact you (telephone or e-mail) to arrange a mutually convenient time to conduct the assessment. **(This may take up to several weeks, depending on how many assessments are assigned to your assessor)**

The assessment does not have to occur during office hours. A convenient time will be scheduled by you and the assessor.

The Assessment

Plan your schedule to allow for two meetings with your peer assessor – before and after the assessment – and identify key staff to help the assessor select patient files for review.

Your assessor will provide you with a copy of the report form at the conclusion of your assessment. Prepare to discuss any issue or clarify any information you may have regarding the report.

After the Assessment

The assessor forwards the report form, the checklist, the record keeping worksheet, and any comments you may have, to the QA Committee for review. The QA Committee then makes one of four dispositions regarding your assessment provides you with a written report, the Quality Assurance Disposition Report **(This may take several weeks to finalize, depending on the number of assessments being processed).**

The four options are as follows:

- no further action is required;
- you correct a significant deficiency in the area(s) identified by the assessor and/or QA Committee;
- you correct a minor deficiency in the area(s) identified by the assessor and/or QA Committee;
- you participate in a remediation process, such as submitting two sterilized patient files to the QA Committee).

Making changes and improvements

Deficiencies will be noted as “needs improvement” by the assessor and reviewed at CCO. The Disposition Report will summarize any areas in need of improvement. For example, it will be noted, in the disposition, if any one of the following items is missing in a patient file (even if it is missing in one file):

- written diagnosis
- documented consent (including orthotics and acupuncture)
- comparative assessments completed at the appropriate time

Confidentiality of Information

Pursuant to the *Regulated Health Professions Act, 1991*, any information regarding peer and practice assessment is confidential and will be shared only with the QA Committee. No other committee will have access to this information.

The QA Committee requires assessors to sign a confidentiality agreement and will consider a breach of this agreement a serious offence.

For Additional Information

Please contact Dr. J. Bruce Walton, Director of Professional Practice, CCO, at:

- 416-922-6355, ext. 106, or
- bwalton@cco.on.ca

Materials you should review

Self-Evaluation (The next section of this Handbook)

This document is for your personal use only. You are not required to submit it to CCO.

Auditing your own chiropractic records can help you identify strengths and weaknesses of your current system, including identifying opportunities for improvement with your record keeping.

Peer & Practice Assessment 1.0 Checklist (Found in the Peer and Practice Assessment section on CCO's webpage at www.cco.on.ca)

This is the checklist your assessor will use to gage your knowledge of CCO's regulations, standards of practice, policies and guidelines. We encourage you to review the checklist and the various regulations, standards, policies and guidelines on which the checklist is derived.

Please note: if you do not provide a particular service (e.g., orthotics, chiropractic care of animals) you are still required to know/be familiar with the standard of practice.

Record Keeping Worksheet (Found in the Peer and Practice Assessment section on CCO's webpage at www.cco.on.ca)

This is the checklist your assessor will use to review 10 current patient files and your compliance with standard of practice S-002: Record Keeping

Self-Evaluation

	Always	Needs Improvement	Not Applicable
My record keeping system allows for ready retrieval of an individual patient file.			
My records are legible.			
I have an up to date short-form legend/abbreviation guide to accompany my records			
The patient's identity is clearly evident on each component of the file.			
Each patient file clearly shows full name, address, date of birth and gender.			
The date of each visit or consultation is recorded and included in the SOAP format or another equivalent format.			
My record keeping system includes a daily appointment record and a financial record for each patient.			
Each patient file includes the history, examination, diagnosis or clinical impression, therapeutic management and prognosis for each patient.			
Each patient file includes reasonable information on treatment and advice given, with an appropriate record of consent to examination and care or plan of care			
Each patient file includes evidence of re-assessment/ progress evaluations at appropriate times in the care of a patient or, at the very minimum, on or before each 24th visit.			
My records contain sufficient detail so that others can understand where the patient started, where they are now and where they are going			