COLLEGE OF CHIROPODISTS OF ONTARIO
QUALITY ASSURANCE COMMITTEE
PRACTICE ASSESSMENT PROGRAM

Practitioner Name_____ Date_____

Assessor Letter of Identification

(Date)
_____

Practitioner participating in the Practice Assessment process

_____

Clinic premises

_____

_____

Date & time of assessment

_____

Name of Assessor

_____

Under the regulatory authority granted by the ***Regulated Health Professions Act*** 1991, the Registrar of the College of Chiropodists of Ontario confirms _____(Assessor)
is the appointed Assessor who will complete the College's Practice Assessment Program in cooperation with

_____ _____ (Practitioner), a member in good standing with the College.

In order to expedite the process, your availability is requested for approximately 45 minutes. You will be asked to accompany the assessor around your clinic, to help identify specific items listed on the assessment tools pertaining to your physical work environment and administration.

Felecia Smith,
Registrar, College of Chiropodists of Ontario

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Practitioner Name_____ Date_____

(Date)

(Letter to member selected for peer review)

Dear (member)

You have been randomly selected to participate in the Peer Review component of the Quality Assurance program. Section 81 of the Health Professions Procedural Code grants authority to the Quality Assurance Committee to appoint assessors for the purposes of a quality assurance program. This is a mandated program under the ***Regulated Health Professions Act,*** 1991 that is directed towards assisting members to enhance their practice. The program clearly recognizes that continuous quality improvement is a partnership between the College, the member and the assessor. Regulation 203/94 made pursuant to ***The Chiropody Act***, 1991 deals with Quality Assurance. Section 26 (1) of the Regulation says that the Committee ***shall*** administer the quality assurance program, which ***shall*** include, amongst others, a Practice assessment (referred to by the College as peer review). The language is mandatory. Section 26(2) states that: Every member ***shall*** comply with the requirements of the quality assurance program that apply to him or her**.**

The peer review program is meant to be a positive educational experience that identifies your practice strengths and weaknesses and globally identifies trends amongst members. It is not meant to be a punitive process. Every practice can be improved and no practitioner is perfect.
It is not surprising that most practitioners do not like an outsider reviewing their practice and asking about patient care. However, it is important to remember that the outsider or assessor is a fellow practitioner who works in a practice setting similar to yours with similar patient demands, diagnostic mysteries and practice pressures. Assessors must undergo the peer review process before becoming part of the program.

We hope that the results of the peer review program will help promote the development of continuing education courses, College programs and policies that are directed to improving the daily practice of our members.

Your Assessor is _____. He/she will be contacting you directly to arrange a convenient time for a site visit.

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Practitioner Name_____ Date_____

Pre-Assessment Tool Section One

Practitioner's name & Registration no. _____

Practice address _____

_____

Telephone Number _____

Designation (DCh, SRCh, DPM, D.Pod..M) _____

Year of Graduation _____

Date of Birth _____

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Pre-Assessment Tool Section Two

Is this a general practice **q** or Are there areas of practice NOT performed here? **q**
If so, please detail:

Is there a limitation to your certificate of registration? **q**
If so, please detail:

Please indicate the one best description of your primary practice.

- **q** Solo practitioner.
- **q** Group practice with more than one other practitioner.
- **q** Sole practitioner in a multidisciplinary team.
- **q** Hospital setting.
- **q** Not directly involved with clinical patient care - Go directly to section three.

How many years of practice at this site?

What is the approximate number of patient encountered per week?

	YES	NO	N/A
Do you perform procedures requiring the administration of local anaesthetics at least once per week?	**q**	**q**	**q**
Do you prescribe topical medications at least once per week?	**q**	**q**	**q**
Do you prescribe oral medications at least once per week?	**q**	**q**	**q**

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Pre-Assessment Tool Section Three

Are your records maintained in
- **q** French
- **q** English

Please indicate the best three time slots for the Peer Review process.
For example: AM on Monday, PM on a Thursday, AM on a Friday.

Would you be available for an AM Saturday or Sunday time slot?
- **q** Yes
- **q** No