Follow up consultation on a proposed oral health therapy scope of practice – feedback from Samuel Carrington (BOH)

26th May 2016

To whom it may concern,

Firstly I would like to thank the Council and the Sub-Committee involved in drafting this document for all stakeholders. The time and energy would have been huge and being a 'dual graduate', I cannot thank you enough.

Secondly, my responses to the questions outlines are as follows:

Q1. Do you agree with the proposed changes to the oral health therapy scope of practice? If not, please explain.

A1. I had the pleasure of attending a webinar facilitated by the Council, and a presentation shortly after the NZDOHTA AGM on these proposed changes. Attending these sessions gave me an opportunity to voice concerns and seek clarification. One thing that I enquired about in the webinar was University of Otago Faculty of Dentistry concerns 'in its submission regarding the ability of its oral health graduates to diagnose "complex carious lesions for all ages"'. I enquired about AUT's position and was told AUT's submission stated they were fine with their graduates working up to the age of 30 years and, any age older than that, they recommended completing modules.

At the presentation, this was reiterated and a frank discussion was had. We were told that AUT did not submit a formal submission to the consultation round, rather their feedback coming from an informal request from the Oral Health Working Party set up to help draft the scope. There seemed to be a lack of confidence from those present on Otago's comments (especially the Bachelor of Oral Health programme) stating that it seemed Otago had a lack of confidence in their graduates performance on diagnosis and treatment of carious lesions.

"The BOH programme confirmed that, at this point, its graduates did not have the necessary clinical experience and competence to perform restorative procedures on patients 18 years and over". I would like to seek clarification on the stance of Auckland University of Technology on their graduates to practice on patients over the age of 18 years and believe this should be added into the consultation document as they have an accredited oral health course and I believe the stakeholders have every right to hear their feedback, whether positive or negative.

Being an oral health graduate, I personally have no problem in diagnosing complex carious lesions on patients under the age of 18 years. Permanent dentition starts erupting into the mouth at approximately age 6. A P4 lesion on tooth 16 in a 9 year old requires the same degree of complexity

to diagnose as a P4 lesion on a 22 year old within the dental therapy scope of practice, of which I practice daily. I would like to seek clarification from the Council as to what is the justification for having an age limit on the same degree of complexity.

The scope of adult care in dental therapy needs to be revised to reflect that an oral health degree is a prescribed qualification. The fact that it was discussed in the first consultation and subsequently being consulted for removal means that oral health graduates do have the necessary skills to complete these tasks under the current outline for the scope. An example of how this could be reworded would be:

'The provision of oral health assessment, treatment, management and prevention services; within the general dental therapy scope of practice or oral health therapy scope of practice; for adult patients aged 18 years and older that, depending on the dental therapist's and/or oral health therapists qualifications, is provided in a team situation under direct clinical supervision or the clinical guidance of a practising dentist/s or dental specialist/s. Disease prevention and oral health promotion and maintenance are core activities'

I believe the detailed point in the proposed oral health therapy scope about local anaesthetic administration should remain the same - "administering local anaesthetic using dentoalveolar infiltration and inferior dental nerve block techniques". I challenge the Council to look into removing the "under direct clinical supervision" restriction on the dental hygiene scope of practice.

Q2. Do you agree with the proposed consultative professional relationship between an oral health therapist and one, or more, dentist/dental specialists, without the need for a signed agreement? If not, please explain.

A1. I believe a consultative professional relationship is the best way to go. There have been instances where I have had to have my professional working relationship documents for both dental hygiene and dental therapy (two individual ones for each scope).

The dental therapy working relationship document took some months to get back to me as the Principal Dental Officer was 'too busy' or it had 'been misplaced' many times.

In private practice where I was working in my capacity as a dental hygienist, I needed multiple dentists to sign my agreement which took time to get back to me and even then, there was no guaranteeing I would be able to get in contact with them when I was working and they were away at a conference or sick or away due to unforeseen circumstances etc....

Personally, I find a written working relationship document has its merits but the best way to support better care for patients is maintaining collegiality and supporting peer learning and I find a consultative professional relationship is better for this.

I urge the council to consider removing the same for the scopes of general dental hygiene and general dental therapy as well.

Q3. Do you agree that the following orthodontic activities from the oral health therapy scope of practice be moved from direct clinical supervision to being performed with the consultative professional relationship?

a. **Tracing cephalometric radiographs**
b. **Fabricating retainers and undertaking simple laboratory procedures of an orthodontic nature**

If not, please explain?

A3. Yes I strongly support the move from direct clinical supervision to consultative professional relationship for these activities.

Q4. Do you agree with the proposal to end-date the two oral health programmes as prescribed qualifications for the orthodontic auxiliary scope of practice? Consequently, oral health graduates that register as an oral health therapist will be removed from the orthodontic scope of practice – if registered in the orthodontic auxiliary scope of practice.

A4. I agree with the current proposal and agree that oral health therapists may choose to limit their scopes of practice without the need to register as an orthodontic auxiliary as it is already part of their training programme.

Q5. Do you agree with the proposed competency standards for oral health therapists? If not, why?

A5. I agree with the competency standards and support credible process of maintaining professional standards to keep the public, practitioner and profession safe.

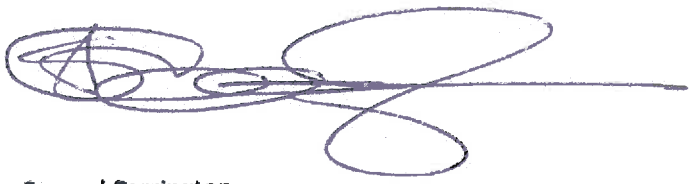
Q6. Do you agree with the proposed registration transition for oral health graduates? If not, why?

A6. I agree with the proposed registration transition and would urge the council to hold and facilitate consumer engagement and information sessions aimed at informing the public and employers and potential employers of the positive change.

While I understand the Council is not mandated to be concerned about employment relations; the current dental therapy workforce (of those holding both scopes) is largely employed by district health boards (DHBs) and their Multi Employer Collective Agreement (MECA) or Single Employer Collective Agreement (SECA) do not have the provisions for employment of Oral Health Therapists or

a relative salary scale. I would like to Council to formally advise the Public Services Association (PSA) and the DHBs of this change so that they may progress with their own processes to facilitate the future needs of the emerging workforce.

Kind regards,



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