

Working in Aotearoa New Zealand

A handbook for oral health professionals

May 2021

Dental Council
Te Kaunihera Tiaki Niho

Message from the Chief Executive

Ka pū te ruha, ka hao te rangatahi
The old net is cast aside and the new net goes fishing

Tēnā koutou katoa

The aim of this handbook is to provide information about Aotearoa New Zealand to oral health practitioners seeking registration in New Zealand. This is not a definitive or complete resource but an introduction to the history and culture of our country and the practising environment you will be working in here.

I encourage you to take the time to explore and understand our unique cultural landscape.

As the Māori proverb states, the old net is set aside and the new net goes fishing, an appropriate metaphor to reflect new ways of learning and working in Aotearoa New Zealand.

Ngā mihi



Marie Warner
Tumu Whakarae (Chief Executive)
Dental Council – Te Kaunihera Tiaki Niho

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Introduction

The information in this handbook will prepare you for working as an oral health practitioner¹ in Aotearoa New Zealand (New Zealand). You may be a new graduate starting to practise in New Zealand or you may have already worked overseas as an oral health professional.

Working as an oral health practitioner in New Zealand may be new or different from what you are used to. It can take time to adjust to working in a new country. This handbook will help you understand what it is like to work in the New Zealand oral health setting, and where to get advice and support if you need it.

The handbook may also be a useful resource for oral health practitioners already practising in New Zealand.

The handbook aims to give you an overview of the things you need to know as an oral health practitioner in New Zealand, including:

- the New Zealand practice environment – cultural context, Te Tiriti o Waitangi / The Treaty of Waitangi, key health sector organisations and their roles
- the legal and regulatory framework in New Zealand that governs your work here
- your obligations under the Health Practitioners Competence Assurance Act 2003
- the Code of Health and Disability Services Consumers' Rights
- standards you need to comply with
- your other legal obligations related to oral health practice
- the support network that is available to you.

If you want to work as an oral health practitioner in New Zealand, you **must** be registered with the Dental Council and have a current practising certificate.



We are available to help.

You can find more information on our website:
www.dcnz.org.nz

If you have further questions, please contact us:

Email: inquiries@dcnz.org.nz

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¹ Dentist, dental specialist, oral health therapist, dental hygienist, dental therapist, orthodontic auxiliary, dental technician, clinical dental technician.

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SECTION 1:

Overview of New Zealand society and your working environment

- Overview and context
- New Zealand is a culturally diverse society
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Overview and context

Population

The population of New Zealand exceeded five million in early 2020. Most of the population lives in the North Island, with 85% concentrated in urban areas. The main ethnic groups are indigenous Māori, Europeans, Pacific peoples and Asians.

Although the percentage of people aged 65 or over is increasing, (22% projected by 2031, compared to only 12% in 1998), the reverse is true for Māori and Pacific peoples, who comparatively have almost twice the proportion of children under 15 years of age.

Socio-political structures

Māori settled New Zealand from the Pacific over 1,000 years before European explorers came this far south. Te Tiriti o Waitangi / The Treaty of Waitangi (Te Tiriti o Waitangi) was intended to assure protection of certain rights and responsibilities for both cultures, as part of the British Commonwealth.

However, the intent and provisions of Te Tiriti o Waitangi went largely unheeded until the 1970s, when legislation was introduced requiring statutory bodies and government departments to act consistently with the founding promises of Te Tiriti o Waitangi, thus recognising the bicultural nature of the country's history.

Constitutionally, New Zealand is a Westminster-based democracy with a mixed-member proportional representation process of electing members to the single House of Representatives (Parliament). In addition, city or regional councils administer local government services.

Economy

Historically, the New Zealand economy has been heavily dependent on overseas trade. In the 1980s the country experienced a prolonged period of low economic growth, with severe overseas debt and budget deficit burdens.

Since that time, New Zealand has diversified by developing its agriculture and manufacturing industries to suit the needs of niche markets. It moved away from the previous reliance on dairy, meat, and wool exports to a greater focus on forestry, tourism, horticulture, fisheries, and manufacturing. More recently, the COVID-19 pandemic has severely impacted tourism.

New Zealand's largest export markets are currently China, Australia, Japan, USA, the UK and Korea.

Health status

Life expectancy at birth has improved during the last four decades in New Zealand. From 2017 to 2019, women lived to an average age of 83.5 years, and men to 80 years of age.

Although Māori life expectancy has increased significantly and infant mortality rates have declined over the past two decades, these rates are still worse than those of non-Māori. Māori also experience disproportionately high rates of diseases such as diabetes, lung cancer and hypertension, and mental health issues.

The health status of Pacific peoples is poorer than that of others, but generally occupies an intermediate position between Māori and non-Māori. Pacific peoples perceive their health status has deteriorated because of their changing socio-economic patterns, and loss of their traditional ways of life in New Zealand.

New Zealand is a culturally diverse society

New Zealand society is culturally diverse. Culture is not restricted to ethnicity. It can include gender, spiritual beliefs, sexual orientation, lifestyle, beliefs, age, social status, or perceived economic worth.

Our cultural diversity is reflected in the many ethnic groups and in other groups that people may identify within our population, for example, LGBTQ+² communities, or religious groups.

New Zealanders of Māori ancestry have a special place as tangata whenua – the first people of the land. Te Reo Māori is an official language of New Zealand, along with English and New Zealand sign language.

Other sources of information about New Zealand society:

- [History, culture and heritage](#) (New Zealand Government website)
- [Te Ara – The Encyclopedia of New Zealand](#) (the complete guide to our peoples, environment, history, culture and society)
- [Kia ora Discover New Zealand](#) (the official guides to exploring, living and working, studying and doing business in New Zealand)

Te Tiriti o Waitangi / The Treaty of Waitangi

Te Tiriti o Waitangi is New Zealand's founding document. It is a treaty signed in 1840 by Māori with the British Crown.

After being substantially ignored for over 150 years, Te Tiriti o Waitangi now pervades every aspect of New Zealand society. An understanding of the principles of Te Tiriti o Waitangi is crucial for all health practitioners.

As a health practitioner it is important you understand Te Tiriti o Waitangi, and that Māori are tangata whenua – the people of the land – who have a unique place in New Zealand society. This is important because:

- you will be working in a health and disability sector that recognises its role to uphold the principles of Te Tiriti o Waitangi
- if you work for or receive government funding, then you are an agent of the Crown and you have responsibilities to uphold and apply the principles of Te Tiriti o Waitangi
- understanding Māori culture affects your clinical environment
- understanding Te Tiriti o Waitangi and Māori culture is part of the professional and practice standards we expect of you as set out in the Dental Council *Standards framework for Oral Health Practitioners, Cultural competence practice standard*, and the *Best practices when providing care to Māori practice standard*.

² Lesbian, gay, bisexual, transgender, queer or questioning and other gender communities.

History

Early contact between Māori and tauīwi (foreigners) began with the explorers and navigators who came to New Zealand. Early in the 19th century, they were followed by the whalers and sealers, and later by the traders. The missionaries followed them. Most of these enterprises and interests spread from Australia.

During this early period, Māori culture was dominant and Māori people managed the land and the resources. They began to lose some control as contact with British settlers increased. Diseases and the musket wars over 30 years decimated the Māori population. Lawlessness and disagreement among the new arrivals and between them and Māori grew.

Responding to the increased lawlessness of the settlers, a group of rangatira (chiefs), the Confederation of the United Tribes, met in October 1835 and drafted and signed He Whakaputanga o te Rangatiratanga o Nu Tirenī (the Declaration of Independence of the United Tribes of New Zealand) with the help of James Busby, the British Resident. As well as adopting a flag, this Confederation was the first indication that Māori saw themselves as an independent nation.

On the advice of the missionaries, Britain was asked to intervene to provide law and order for both the settlers and the Māori. There was concern too, at the interest shown by France and other nations, in colonising the country. This led to the signing of Te Tiriti o Waitangi at Waitangi, in the Bay of Islands on 6 February 1840 by representatives of the British Crown and Māori rangatira.

About 40 rangatira signed the Māori version of Te Tiriti o Waitangi on 6 February, and by September 1840, another 500 had signed copies that were sent around the country. Almost all rangatira signed the Māori version. Some signed even though they remained uncertain as to the effects of Te Tiriti o Waitangi, while others refused or had no chance to sign.

British sovereignty over the country was proclaimed on 21 May 1840, with Te Tiriti o Waitangi to apply equally to Māori tribes whose rangatira had not signed.

While Te Tiriti o Waitangi had potential for a fair and even arrangement, inequalities between the partners quickly developed. Control, power, and decision-making passed from one partner to the other and by 1852, administration of New Zealand effectively lay with the European settlers. The Anglo-Saxon traditions of individual effort and industry and the promise of full citizenship to male settlers left little room for traditions and values of other origins. By 1860 the population of European settlers exceeded the dwindling Māori numbers.

Te Tiriti o Waitangi and the differences between the Māori and the English versions

Te Tiriti o Waitangi has three articles and is a broad statement of principles on which the British and Māori people agreed to found and build a nation state and government in New Zealand. A nation state implies that its population is united and constitutes a nation.

In summary, in the English version of Te Tiriti o Waitangi:

- Māori give up the sovereignty of New Zealand to Britain (Article the first)
- Māori give the Crown exclusive rights to buy lands they wish to sell, and in return, are guaranteed full rights of ownership of their lands, forests, fisheries, and other possessions (Article the second)
- Māori are given the rights and privileges of British subjects (Article the third).

Te Tiriti o Waitangi in Māori was deemed to convey the meaning of the English version, but there are important differences which have led to differing understandings, tensions, and grievances. For example, the Crown was granted 'kāwanatanga' (governmental authority), while Māori were guaranteed 'tino rangatiratanga' (absolute chieftainship). The Crown has not always recognised this, being focused on the former to the extent that Māori rights and interests became virtually invisible.

Grievances

Grievances from the past have lingered on, including issues about land, language, authority and self-determination. Today these grievances still underpin much of the tension in Māori and tauwi (foreigners) relations, although the situation has been considerably complicated by other problems, such as unemployment, inflation, and disparities in living standards.

Inequalities in fact, occur in all major economic and social areas of New Zealand society and dissatisfaction has led to calls for a re-examination of the basic values on which our social policies are based. A Māori cultural and political revival has reiterated the need for cultural perspectives to be part of that examination.

Te Rōpū Whakamana I Te Tiriti o Waitangi / Waitangi Tribunal

Historically, Māori have not been central to core decision-making, whether from within relevant government agencies or other agencies.

This was inconsistent with the mutual recognition of authority that is the foundation of the relationship between kāwanatanga and tino rangatiratanga.

During the early 1970s, the government acknowledged that previous government actions had resulted in the acquisition of Māori land, water, and other resources from their owners, generally without proper consent or compensation.

Accordingly, in 1975 the government established Te Rōpū Whakamana I Te Tiriti o Waitangi / Waitangi Tribunal (the Tribunal) to consider claims by Māori against the Crown for breaches of the principles of Te Tiriti o Waitangi and make recommendations to the government for recompense. The Tribunal was given the exclusive right to determine the meaning of Te Tiriti o Waitangi.

Through the work of the Tribunal and the courts, the three original Articles of Te Tiriti o Waitangi have been refined to a few principles, which provide the framework for how those working in the health sector will meet their obligations under Te Tiriti o Waitangi in their day-to-day work.

Te Tiriti o Waitangi principles in health

In 2019, the Waitangi Tribunal released [Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry](#). The report recommends the following principles for the primary health care system:

- **Tino rangatiratanga:** The guarantee of tino rangatiratanga (the fullest expression of rangatiratanga, autonomy, self-determination, sovereignty, self-government), which provides for Māori self-determination and mana motuhake (autonomy, self-determination, sovereignty, self-government) in the design, delivery, and monitoring of health and disability services.
- **Equity:** The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
- **Active protection:** The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents, and its Te Tiriti o Waitangi partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.

- **Options:** The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora (holistic health and wellbeing) Māori models of care.
- **Partnership:** The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

At a practitioner level, healthcare professionals employed by or contracted to a government-funded agency are Crown agents and as such are bound by and need to understand how to uphold the principles of Te Tiriti o Waitangi. This includes those employed by government, government agencies, DHBs, and to practitioners providing care under the Combined Dental Agreement³ or other government agency funded care.

These principles also apply to the wider health and disability sector and provide the framework for how non-government funded health providers will meet their obligations under Te Tiriti o Waitangi in their day-to-day work.

As well, the principles apply in the oral health clinical environment at an individual patient level. Practitioners work in partnership with their patients, enabling their patients to participate in determining their oral health, and protecting them by putting their interests' first and practicing safely and competently.

Te Tiriti o Waitangi is a significant part of the day-to-day clinical, funding and governance practices in the health and disability system. Māori are tangata whenua and all New Zealanders have obligations under Te Tiriti o Waitangi to understand, respect and recognise the importance of Māori and their culture.

As a health professional working in the health and disability system you have particular obligations. You must also meet the Dental Council's professional standards and competencies for your scope of practice, which all require you to know about Māori health and provide your care and treatment in a way that recognises and celebrates Māori culture.

³ See page 14 of this handbook for more information about the *Combined Dental Agreement*.

Understanding Māori health from a Te Ao Māori (Māori world view) perspective

- Te Whare Tapa Whā is the model for understanding Māori health that is used by the Ministry of Health / Manatū Hauora (the Ministry). There are also other Māori health models available that you could explore to learn more.
- The Ministry's Māori health strategy He Korowai Oranga recognises the holistic care approach that is needed when working with Māori by describing Pae Ora / Healthy Futures for Māori, Whānau Ora / Healthy Families, Wai Ora / Healthy environments, and Mauri Ora / Healthy individuals.
- The Dental Council's professional standards (set out in our Standards framework for Oral Health Practitioners) also expect that you will provide a holistic care approach, which has a different emphasis for Māori.

Professional Standard 19 provides: *You must take a holistic approach to care appropriate to the individual patient.*

Professional Standard 4 is also highly relevant and provides: *You must treat patients fairly and without discrimination, respecting cultural values, personal disabilities and individual differences.*

Māori culture is a significant part of New Zealand's identity – you have a professional responsibility to be aware of and have respect for Māori culture.

Oral health of New Zealanders

The oral health of New Zealanders has improved in general over the last few decades. This is mainly attributed to the introduction of fluoride toothpaste and the fluoridation of the water supply in some areas⁴.

However, there are still concerning levels of untreated decay in the adult population and significant inequalities remain for some groups, including children and Māori.

The New Zealand health survey is conducted annually and includes oral health indicators for children (0–14 years) and adults (15+ years). Māori tamariki (children) and adults have consistently poorer oral health outcomes when compared to the total child and adult population.

The 2017–18 oral health indicators for children 0–14 years of age with natural teeth, showed:

- 11.1% of children (1–14 years) had teeth extracted in their lifetime due to decay, an abscess, infection, or gum disease compared with 14.6% (estimated 32,000) of Māori tamariki.
- 58% of children (0–14 years) brushed their teeth twice a day or more with standard fluoride toothpaste compared with 50.1% (estimated 113,000) of Māori tamariki.

⁴ In March 2021, the government announced proposed changes to the Fluoridation Bill that would see decision-making on fluoridation shift from local authorities to the Director-General of Health.

These poorer outcomes are mirrored in the adult population:

- 6.9% of adults had one or more teeth removed in their lifetime due to decay, an abscess, infection or gum disease compared with 10.1% of Māori adults.
- 63.5% of adults brush their teeth twice a day or more with standard fluoride toothpaste compared with 49% of Māori adults.

These poorer outcomes for Māori continue to be a concern for successive governments and for generations of whānau (family), hapū (kinship group collective of whānau), and iwi (extended kinship group) who experience these outcomes.

Māori oral health providers

Māori oral health providers focus on addressing the oral health needs of Māori patients. They were established in response to concerns about the high levels of untreated oral disease in Māori, and their difficulties accessing the oral health care they needed. Māori health providers are indigenous, not-for-profit, Māori owned and governed organisations.

Māori oral health providers deliver oral health care services from fixed and mobile clinics to population groups with high oral health needs, and in high deprivation areas such as Te Taitokerau (Far North) and Te Tairāwhiti (East Coast).

They offer a whānau ora (family health) approach to care – an approach that is culturally authentic and responsive and supports the whole whānau (family) to achieve good oral health throughout life.

Cultural diversity in oral health practice

Oral health practitioners in New Zealand work with a population that is culturally diverse.

The oral health workforce includes many international practitioners and a variety of cultural groups. Interactions with patients and colleagues from different cultures are therefore common. Practitioners need to be competent in dealing with patients whose cultures differ from their own and respect all colleagues and staff irrespective of their cultural identity.

Practitioners also need to recognise the unique place that Māori hold as tangata whenua – the people of the land – in New Zealand and honour Te Tiriti o Waitangi principles in the delivery and promotion of oral healthcare.

An individual patient's cultural values or beliefs can affect the way they view health and illness, and the choices they make about their health.

New Zealand oral health practitioners must treat patients fairly and without discrimination, respecting cultural values, personal disabilities, and individual differences (professional standard 4 of our [Standards framework for Oral Health Practitioners](#)).

As an oral health practitioner in New Zealand, you can demonstrate this at an individual patient level in the way you:

- listen to and consider your patients' preferences and concerns
- encourage your patients to ask questions so they can make informed decisions about their care and give their informed consent
- put your patients' interests first, practising within your professional knowledge, skills, and competence.

Being aware of each individual patient's cultural values can enhance the trust relationship that develops between you and your patient. It can improve communication in the practitioner/patient relationship and, can ultimately lead to better outcomes of care and increased patient satisfaction.

The Dental Council's *Cultural competence practice standard* and *Best practices when providing care to Māori practice standard* provide more details and information.

The New Zealand health system

The **Minister of Health** (the Minister) and the New Zealand government have overall responsibility for the predominantly publicly funded health and disability system, and for setting the sector's strategic direction.

The Minister is supported and advised by the **Ministry of Health – Manatū Hauora** (the Ministry). The Ministry is the government's principal agent and has overall responsibility for the stewardship of the health and disability system.

Most of the day-to-day business of the **public** health system is administered by 20 **district health boards** (DHBs).

The role of DHBs is to:

- plan, manage, provide, and purchase health services for the population of their district
- implement government health and disability policy
- ensure services are arranged effectively and efficiently for all New Zealand.

Public health funding covers primary health care, hospitals, public health, and some aged care. Oral health care for children and adolescents up to the age of 18, and limited, emergency care for adults (primarily low-income earners), is funded publicly in New Zealand.

The health and disability system extends beyond the Ministry and DHBs to other health Crown (government) entities, primary health organisations, public health units, private providers, non-government health providers (including Māori and Pacific providers), and health practitioners. The health and disability system also includes the manufacturing, distribution and supply of medicine and medical devices, and their regulation.

The **Health and Disability Commissioner Te Toihau Hauora, Hauātanga (HDC)** is an independent Crown entity ensuring the rights of health consumers are upheld and encouraging health and disability service providers to improve their performance. This includes making sure that consumer complaints are managed fairly and efficiently.

The **Accident Compensation Corporation (ACC)** is another Crown entity. The ACC (Te Kaporeihana Āwhina Hunga Whara) is responsible for administering New Zealand's no-fault accidental injury compensation scheme, commonly referred to as 'the ACC scheme'. Nobody can sue people or organisations for accidental personal injury in New Zealand.

The ACC scheme helps prevent injuries and get New Zealanders and visitors back to everyday life if they have had an accident or treatment injury. The scheme emphasises prevention, care and recovery.

In New Zealand, everyone who works and owns a business contributes to the ACC scheme by paying ACC levies.

When teeth or associated structures are damaged because of an accident, the ACC will usually contribute to the cost of treatment by dentists and dental specialists for all age groups. It will also contribute to the cost of treating injuries caused by medical misadventure caused by health practitioners or service providers.

[ACC's website](#) has all the information you need to register as an ACC health service provider and to understand your responsibilities under the ACC scheme.

The New Zealand health system includes professional and regulatory bodies for all health professionals, such as the **Dental Council**, and the **Health Practitioners Disciplinary Tribunal (HPDT)**. The HPDT hears and determines disciplinary proceedings brought against health practitioners under the Health Practitioners Competence Assurance Act 2003.

Medsafe is the New Zealand Medicines and Medical Devices Safety Authority. It is a business unit of the Ministry. It is responsible for the regulation of therapeutic products in New Zealand. Therapeutic products include medicines and related products, and medical devices. The regulation of therapeutic products and how they are prescribed are regulated under the Medicines Act and its regulations. More information is available on the [Medsafe website](#).

There are also many non-government organisations and consumer bodies that provide services and advocate for the interests of various groups that fall within our health system.

More detailed information can be found in [The New Zealand Health and Disability System: Handbook of Organisations and Responsibilities](#), October 2017.

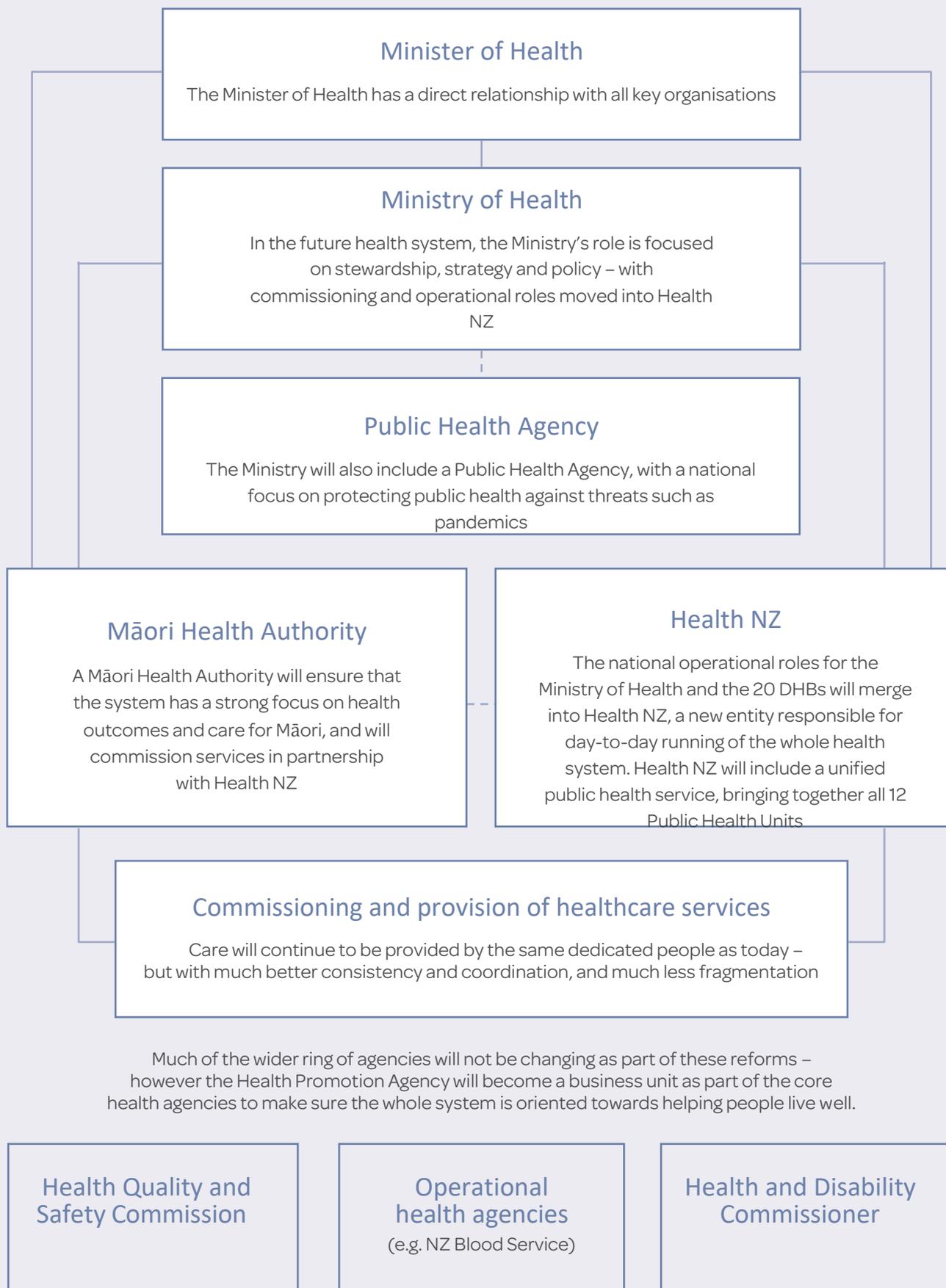
Major reform of New Zealand's health and disability system proposed

In April 2021, the Minister of Health announced plans to strengthen the New Zealand health and disability system to ensure every New Zealander can access the right care at the right time.

The key structural reforms proposed to the current health system are shown on the following page. These changes have been designed to make the system simpler and more co-ordinated allowing for better and more equitable, more consistent care.

At the time of writing, the change programme to achieve this reform was only beginning and we expect the phasing in period to take at least three years. This section will be updated as key changes occur.

The health system of the future (announced by the Minister of Health in April 2021)



Much of the wider ring of agencies will not be changing as part of these reforms – however the Health Promotion Agency will become a business unit as part of the core health agencies to make sure the whole system is oriented towards helping people live well.

Source: Ministry of Health presentation to Responsible Authorities hui, 10 May 2021

Current funding for oral health care in New Zealand

Public funding for oral health comes from the Ministry and is administered by the DHBs located throughout the country.

Privately funded care means the patient is responsible for paying for the care they receive.

In general, patients aged 18 years and over are responsible for paying for the oral health care they receive, typically in private practice.

Publicly funded oral health care is available for:

- children and adolescents from birth up to age 18 years
- low-income adults
- special needs and medically compromised patients when care cannot be provided in private practice.

Children up to age 13 years

Oral health education, preventive and basic treatment services are provided free of charge to pre-school, primary and intermediate age children through the Community Oral Health Service (COHS).

To receive free oral health care, children need to be enrolled in the COHS in their region.

The COHS is provided by the local DHB and funded by the Ministry.

Oral health care under the COHS is mainly provided by dental therapists and oral health therapists in community-based clinics (often located on school sites), or in mobile dental clinics. Patients are referred to a dentist or dental specialist for further treatment if necessary.

Adolescents – up to age 18 years

A range of free basic oral health services is funded for adolescents until their 18th birthday.

Services are usually provided by private dentists who are contracted by the local DHB under a *Combined Dental Agreement* (commonly referred to as 'the CDA') to provide free oral health care for adolescents.

Some COHSs also provide free oral health care for adolescents under the Combined Dental Agreement.

The treatment covered under the *Combined Dental Agreement* includes regular examinations, preventive services (fissure sealants and fluoride treatments), fillings and extractions. Specialised services such as orthodontics and oral surgery are not covered.

Low-income adults

For people who have a Community Services Card, limited funding for health care is available through Work and Income New Zealand. This funding can be used for oral health care.

Some public hospitals provide limited services (pain relief and infection management) for people who are unable to access private care due to their financial circumstances.

In many hospitals, emergency departments only provide dental care if it is trauma related.

Special needs and medically compromised patients

Specialised oral health care is available from hospital-based services for people with medical conditions, intellectual or physical disabilities, mental illness, or severe disease that prevents them from using private dental services.

The oral health workforce

The oral health workforce in New Zealand is made up of:

- dentists
- dental specialists
- oral health therapists
- dental therapists
- dental hygienists
- orthodontic auxiliaries
- dental technicians
- clinical dental technicians
- dental assistants (not registered).

In providing oral health care the Dental Council envisages a team approach where practitioners work collaboratively for the benefit of patients' overall health. Each member of the oral health team has their own unique set of skills and competencies to contribute, within their scope of practice.

The scope of practice for oral health therapists, dental therapists, dental hygienists, and orthodontic auxiliaries requires they have a professional relationship with one (or more) dentist or dental specialist. These relationships are called 'working relationships' or 'consultative working relationships', depending on the scope of practice.

All these relationships provide a clear and reliable way for practitioners to seek and provide professional advice about treating and managing patients, and a potential pathway for referral.

Dental hygienists and oral health therapists practise some specified orthodontic activities with the dentist or dental specialist who is responsible for the patient's clinical care outcomes on-site at the time. Orthodontic auxiliaries practise all their scope activities under these same conditions.

Dental assistants can support oral health practitioners in providing care. No formal training is necessary to become a dental assistant in New Zealand, and they are not required to be registered.

The New Zealand Dental Association (NZDA) offers a course in dental assisting. You can find more information about the NZDA dental assisting course on their [website](#).

The number and type of practitioners that make up the oral health team in each practice varies. It depends largely on where the practice is located and the kind of care offered.

Practice environments where oral health practitioners typically practise include:

- **Private practice** – usually owned by a practitioner or a corporate entity. In general, a private practice provides a broad range of general or specialist oral health care.
- **Community oral health clinics** – DHB funded, typically offering oral health care to children up to 13 years of age. Services for adolescents up to 18 years of age may also be offered.
- **Mobile dental clinics** – mainly DHB funded with a small number privately/corporate owned mobile units, mainly offering oral health care to children up to 13 years of age. Services for adolescents up to 18 years of age may also be offered.

- **The hospital** – DHB funded. Primarily offering specialised treatment for children (such as procedures under general anaesthesia), emergency treatment for adults with low income, and patients with special needs or who are medically compromised and cannot be treated in private practice
- **University of Otago and AUT University** – provide education and clinical supervision of oral health students
- **Māori oral health providers** – deliver oral health services primarily for Māori communities.

Some private practices provide oral health care to patients on behalf of the Ministry under contract agreements.

Ministry of Health information about fluoride

Water fluoridation

The World Health Organization (WHO) and other international and national health and scientific experts endorse water fluoridation as the most effective public health measure for the prevention of dental decay.

The Ministry endorses the adjustment of the natural level of fluoride in community water supplies in New Zealand to between 0.7 ppm and 1.0 ppm. This is the optimal level that provides protection against tooth decay and is recommended by the WHO.

At these carefully monitored levels, fluoride is safe and within the guidelines of the WHO and other international public health agencies.

Based on the findings from the most recent NZ Oral Health Survey (2009), it is estimated that children and adolescents living in a fluoridated area have a 40% lower lifetime incidence of dental decay.

While around 60% of New Zealand's population live in areas that have a fluoridated community water supply, the remainder either live in areas with a non-fluoridated community water supply, or areas that rely on rainwater.

The Ministry provides 'Fluoride Facts' about community water fluoridation, which it describes as 'safe, effective and affordable'.

Most recently, in March 2021, the government announced proposed changes to the Fluoridation Bill that would see decision-making on fluoridation shift from local authorities (DHBs) to the Director-General of Health.

Use of topical fluorides

The Ministry sets the guidelines for the topical use of fluorides in New Zealand.

The Ministry's Guidelines for the Use of Fluorides covers the use of topical fluoride treatments including fluoride toothpastes, fluoride varnishes, fluoride mouth rinses, fluoride gels and foams and also for the use of fluoride tablets.

2



SECTION 2:

Health regulation in New Zealand

- Health Practitioners Competence Assurance Act 2003
- The Dental Council
- Patient's Rights – The Code of Health and Disability Services Consumers' Rights

The law and health regulation in New Zealand

Understanding the legal and regulatory framework for oral health services in New Zealand will help you develop work practices that comply with the standards required in New Zealand.

Regulation of our health system helps provide assurance to New Zealanders that they can trust the services they receive and that the health service providers are safe, and operate in an ethically acceptable way.

Health Practitioners Competence Assurance Act 2003 (the HPCA Act)

The HPCA Act provides the legal framework for the regulation of health practitioners in New Zealand to protect the public from risk of harm.

The HPCA Act applies to all health practitioners regulated under it, including oral health practitioners.

The HPCA Act is about public safety. Its purpose is to protect the health and safety of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise throughout their professional careers.

The various mechanisms the HPCA Act describes to achieve its purpose are administered by ‘responsible authorities’ (also known as regulatory authorities). The HPCA Act gives the authorities responsibility for – and provides them with tools for – ensuring that health practitioners are, and remain, competent and safe to practise their professions.

There are 17 responsible authorities governed by the HPCA Act, regulating 23 health professions. In the future, other professions may also become regulated under the HPCA Act.

The Dental Council (the Council) is the responsible authority for the oral health professions.

The six oral health professions regulated under the HPCA Act are:

- dentistry
- oral health therapy
- dental hygiene
- dental therapy
- dental technology
- clinical dental technology.

These professions are representative of the following oral health practitioners: dentists, dental specialists, oral health therapists, dental therapists, dental hygienists, orthodontic auxiliaries, clinical dental technicians, and dental technicians.

Every health practitioner who practises in a regulated profession in New Zealand must be registered with the relevant responsible authority and hold an annual practising certificate issued by that authority.

Important protections are in place to protect the health and safety of members of the public, with provisions in the HPCA Act to ensure that:

- only registered health practitioners can use the professional titles protected by the HPCA Act, or claim to be practising a profession that is regulated by the HPCA Act
- certain activities are restricted and can only be performed by registered health practitioners as declared in the HPCA Act
- responsible authorities are required to ensure a practitioner is competent to practise in a scope of practice before they issue an annual practising certificate for that scope of practice
- health practitioners are not permitted to perform activities that fall outside their registered scope of practice.

The Dental Council – Te Kaunihera Tiaki Niho

The Dental Council (the Council) is the responsible authority (or regulator) for oral health practitioners, created by the HPCA Act with legislated responsibilities and functions.

Our statutory function is to protect the health and safety of the New Zealand public by regulating the oral health professions.

The Council has no statutory duty or authority to represent the interests of oral health practitioners in the healthcare sector. It is not a professional membership body.⁵

Being registered with the Council is not voluntary – it is a mandatory requirement if you want to practise in New Zealand. Every practitioner must be registered with the Council and hold a current practising certificate to work as an oral health practitioner in New Zealand.

We use the various mechanisms provided for under the HPCA Act, with the aim of ensuring that oral health practitioners are competent and fit to practise their professions – thereby protecting the health and safety of the public.

The Council is a not-for-profit regulatory body. Its legislative functions are funded through the fees obtained from registration applications and annual practising fees from registered oral health practitioners.

The Minister of Health appoints the Council members (governance board). It has ten members, including seven practitioner members from the oral health professions and three lay members who are not from the oral health professions and represent the public view.

Members are appointed for a term of up to three years and may be reappointed for further terms, to a maximum of nine consecutive years. At the first meeting of the Council each year, the Council elects two of its members as the chairperson and the deputy chairperson.

The role of the Council is to oversee the strategic direction of the organisation, monitor management performance and ensure the Council meets the requirements of the HPCA Act.

⁵ Professional associations that represent the interests of oral health practitioners in New Zealand are set out Section 8 of this handbook.

The functions of the Council are set out in the HPCA Act, and include:

- defining scopes of practice for each profession (the health services of each profession – a description of what a practitioner is entitled to do, commensurate with their education, training, experience, and competence)
- prescribing qualifications required for the profession’s scope of practice, and accrediting and monitoring educational institutions that teach and award/confer these qualifications
- authorising the registration of oral health practitioners
- considering applications for annual practising certificates
- reviewing and promoting the competence of oral health practitioners
- recognising, accrediting, and setting programmes to ensure the ongoing competence of oral health practitioners
- receiving and acting on information from concerned parties about the competence of oral health practitioners, and in turn notifying the relevant authorities if a practitioner poses a risk of harm to the public
- considering the case of a practitioner who may be unable to perform the functions required for the practice of their profession
- setting standards of clinical competence, cultural competence, and ethical conduct to be observed by oral health practitioners
- promoting education and training within the profession.

The Council’s functions are administered by a secretariat including the Chief Executive, the Registrar, and other staff.

You must meet the requirements set for you by the Council.

Effectively, these requirements enable you to meet your legal obligations under the HPCA Act.

The Code of Health and Disability Services Consumers' Rights

Patients and other consumers accessing health and disability services, including oral health services in New Zealand, have the protection of the Code of Health and Disability Services Consumer Rights (the Code of Rights). An independent Commissioner, the HDC, promotes and protects these rights under a New Zealand law called the Health and Disability Commissioner Act 1994.

The Code of Rights establishes the rights of consumers (your patients), and corresponding obligations and duties of providers (you). These are:

- The right to be treated with respect
- The right to freedom from discrimination, coercion, harassment, and exploitation
- The right to dignity and independence
- The right to services of an appropriate standard
- The right to effective communication
- The right to be fully informed
- The right to make an informed choice and give informed consent
- The right to support
- Rights in respect of teaching or research
- The right to complain

You should familiarise yourself with the complete Code of Rights which you can find on the website of the HDC.

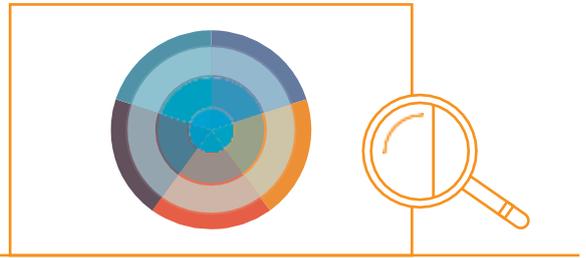
Posters for patients, summarising their rights, are also available on the HDC website. The Council recommends you display this information for your patients in the waiting area of your practice and have complete copies of the Code of Rights available for them.

The Council's Standards framework for oral health practitioners sets the standards of ethical conduct, and clinical and cultural competence that the public can expect from oral health practitioners that practitioners must meet. Our standards enable you to meet your obligations under the Code of Rights.

The law in New Zealand provides that patients have rights as health consumers, and practitioners have corresponding duties to patients.

Patients' rights are described in the Code of Rights.

3



SECTION 3:

Standards

- The Standards framework for oral health practitioners
 - Ethical principles
 - Professional standards
 - Practice standards
- Compliance and monitoring

Standards framework for oral health practitioners

The Council is required by the HPCA Act to set standards for clinical competence, cultural competence, and ethical conduct for oral health practitioners.

The *Standards framework for oral health practitioners* describes the minimum standards of ethical conduct, and clinical and cultural competence that patients and the public can expect from oral health practitioners in New Zealand.

These standards are defined in the ethical principles, professional standards and practice standards of the standards framework that govern all oral health practitioners.

The standards provide the threshold against which practitioners' conduct and performance (competence or fitness to practise) are measured, by:

- the Council
- patients and the public
- the Health and Disability Commissioner
- a professional conduct committee
- the Health Practitioners Disciplinary Tribunal
- the Courts.



All registered oral health practitioners are required to meet the Council's standards.

Components of the standards framework

A) Ethical principles

There are five ethical principles that oral health practitioners must adhere to at all times. These are not listed in any order of priority; they all have equal importance. They are:

- put patients' interests first
- ensure safe practice
- communicate effectively
- provide good care
- maintain public trust and confidence.

B) Professional standards

Professional standards describe what you must do to ensure you achieve the ethical principles.

A professional standard may relate to a number of ethical principles and is aligned to the ethical principle it most strongly relates to.

Guidance is provided in the Council's *Standards framework for oral health practitioners* to help practitioners meet the professional standards. The standards framework is available on the [Dental Council website](#).

C) Practice standards

Practice standards relate to particular areas of oral health practice that require more detailed standards to enable practitioners to meet the professional standards and ethical principles.

The Council's practice standards are:

- *Advertising*
- *Best practices when providing care to Māori patients and their whānau*
- *Cultural competence*
- *Infection prevention and control*
- *Informed consent*
- *Medical emergencies*
- *Patient records and privacy of health information*
- *Professional boundaries*
- *Sedation*
- *Transmissible major viral infections.*

The purpose of each practice standard is detailed in the following table.

Advertising	Sets minimum standards for advertising by oral health practitioners to ensure the public is protected from advertising that is false, deceptive, or misleading.
Best practices when providing care to Māori patients and their whānau	<p>Outlines the attitudes, knowledge, and skills relevant to oral health practitioners in providing advice to and care for Māori patients and their whānau (families). This resource has been developed to enable practitioners to integrate cultural competency for Māori patients within their clinical practice and to achieve better outcomes. It should be read in conjunction with the Council’s practice standard on cultural competence.</p>
Cultural competence	<p>Oral health practitioners in New Zealand work with a population that is culturally diverse. Patients may identify with one or more of the many ethnic groups within our population. They may also identify with other cultural groups such as disability, LGBTQ+ or particular religious groups.</p> <p>The oral health workforce itself includes many international practitioners and a variety of cultural groups. Interactions with patients and colleagues that come from different cultures are common. Practitioners need to be competent in dealing with patients whose cultures differ from their own, and respect colleagues and staff.</p> <p>Individual cultures affect the way people understand health and illness, the choices people make regarding their health care, how they access health care services and how they respond to health care interventions.</p> <p>Cultural competence will improve the quality of oral health care services and outcomes for patients.</p>
Infection prevention and control	<p>Sets minimum standards that must be observed by all practitioners to:</p> <ul style="list-style-type: none"> • eliminate or reduce the number and quality of infectious agents in the oral health practice environment • prevent the transmission of infectious agents from any person within the practice environment to another, and from one item or location to another item, location, or person. <p>The Council’s Transmissible Major Viral Infections (TMVI) practice standard must be read in conjunction with the Infection prevention and control practice standard.</p>
Informed consent	Sets minimum standards for the process of obtaining informed consent in oral health practice.
Medical emergencies	Sets minimum standards for registered oral health practitioners to enable appropriate and effective management of a medical emergency in dental practice, within their training.

<p>Patient records and privacy of health information</p>	<p>Sets minimum standards for oral health practitioners in creating and maintaining patient records and maintaining the privacy of patients’ health information.</p> <p>Patient records assist practitioners in providing safe, effective, and complete care – and enable them to collaborate effectively with their colleagues and other health practitioners, in the interests of good patient care. They may also be used in forensic investigations and complaint resolution, and in quality review and audit processes.</p> <p>These standards apply to patient records and health information regardless of their form or location, and covers paper-based and digital records.</p>
<p>Professional boundaries</p>	<p>Sets minimum standards for practitioners in identifying and maintaining appropriate professional boundaries between themselves and their patients, and those close to them, including their families and whānau.</p> <p>The professional behaviour expected of practitioners in relation to their colleagues and the public is covered in the professional standards of the standards framework.</p> <p>The standards and guidance in the practice standard relate to areas of practice where there are recognised risks of boundary breaches occurring. However, this is not an exhaustive list of scenarios – practitioners should use their professional judgement and be guided by the standards framework’s ethical principles and the standards contained in this practice standard to determine and appropriate response.</p>
<p>Sedation</p>	<p>Sets minimum standards for the practice of minimal and moderate sedation in dentistry.</p> <p>It applies when a practitioner administers a drug or drugs to relieve patient anxiety and/or to provide sedation, and when a practitioner recommends or prescribes a sedative drug that the patient self-administers.</p> <p>It also applies when a practitioner proceeds with treatment knowing at the time of appointment that the patient has self-administered a sedative drug or drugs that the practitioner has not prescribed or recommended.</p> <p>It does not regulate techniques that are intended to induce deep sedation or loss of consciousness (general anaesthesia), where a specialist anaesthetist is required to administer the sedation or general anaesthesia and continuously monitor the patient until recovery.</p> <p>NOTE: General anaesthesia is not in the scope of practice for any oral health practitioner</p>
<p>Transmissible major viral infections (TMVI)</p>	<p>Sets minimum standards that must be observed by all practitioners, to prevent the transmission of TMVIs specifically from practitioner to patient.</p>

Compliance and monitoring

All oral health practitioners are required to meet the Council's professional standards and practice standards and adhere to the ethical principles. It is vitally important that practitioners familiarise themselves with the *Standards framework for oral health practitioners* and the practice standards within it.

Failure to meet the standards and adhere to the ethical principles could result in the Council's involvement and may impact on the practitioner's practice.

No standards framework can capture all expected professional behaviours. Where there is no express standard, you should adhere to the ethical principles and use your professional judgement and insight to determine appropriate behaviour.

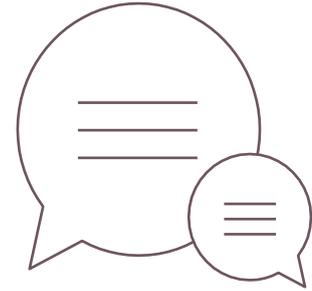
You will declare compliance with the standards when you apply for an annual practising certificate (APC).

Each year up to 10% of practitioners are randomly selected from each profession to complete a questionnaire as the first step in checking compliance with the practice standards.

From this group, a number of practitioners are selected and visited by the Council's professional advisor to confirm they comply with the standards we set.

The *Standards framework for oral health practitioners* and separate practice standards can be found on the Council's website.

4



SECTION 4:

Patient complaints

- Patients' right to complain
- Options for complaint resolution
 - Nationwide Health & Disability Advocacy Service
 - Professional associations
 - Health and Disability Commissioner
 - Dental Council
 - Disputes Tribunal
 - Accident Compensation Corporation

Patients' right to complain

Complaints are common occurrences for health professionals. Patients have the right to complain. Applying goodwill and common sense can solve most problems. If you act quickly and appropriately and, listen to the patient's concerns with the aim of addressing them, you will minimise the negative effects of a complaint.

The Council expects you will 'facilitate the fair, simple, speedy and efficient resolution of complaints' (guidance for Professional Standard 6 of the *Standards framework for oral health practitioners*), in line with the requirements of Right 10(3) of the *Code of Rights*.

You must have a procedure for complaints which you inform the patient of, and follow, if you receive a complaint. That procedure must reflect the requirements of Right 10 (the right to complain) of the Code.

Options for complaint resolution

If you are unable to resolve a patient's complaint, there are other options available to the patient for complaint investigation and resolution including:

- Nationwide Health & Disability Advocacy Service
- Professional associations
- HDC
- Disputes Tribunal
- ACC
- Dental Council

Patients must be made aware of the external organisations they can contact for support.

Nationwide Health & Disability Advocacy Service

A free advocacy service for consumers is offered by the nationwide *Health & Disability Advocacy Service*. The service operates independently from all health and disability service providers, government agencies and the HDC – to help consumers with complaints.

The role of the advocate is to assist consumers to identify what is needed to achieve resolution, and then to support them in their chosen actions. Advocates are not investigators or mediators, nor do they make decisions on whether there has been a breach of the *Code of Rights*.

Professional associations

The professional associations for the various oral health professions can offer profession-specific information, advice, and support to consumers.

The New Zealand Dental Association (NZDA) has a consumer complaints process and a peer review system for the resolution of disputes concerning the quality and appropriateness of dental treatment provided by dentists or dental specialists who are NZDA members.

If a dentist has chosen to be a member of NZDA they are required to abide by any decision reached through its dispute resolution process.

The patient can contact the NZDA's National Consumer Liaison Officer (NCLO) to complain about the standard of work or conduct of a dentist who is an NZDA member. The NCLO acts as an intermediary with the aim of resolving the complaint.

If the NCLO is unable to resolve the complaint, it may be referred to NZDA's system of 'peer review'. The peer review process is free for the public and NZDA members.

The purpose of peer review is to provide fair and independent answers about the quality and appropriateness of dental treatment. It is not a disciplinary system.

Not all cases are suitable for peer review, for example, fees charged for treatment is not a topic that can be considered. The decision on whether a case is suitable is made by the Peer Review chairperson.

The New Zealand Institute of Dental Technologists (NZIDT) runs a dispute mediation service to facilitate the resolution of complaints concerning the conduct or services received from an NZIDT member.

The patient can contact NZIDT's Conflict, Complaints, and Resolution Committee (CCRC) to review their complaint. The CCRC consists of four members.

The CCRC operates as an independent facilitator but does not have any directive power. It cannot compel a practitioner to refund money to the patient, only the Courts have such power.

Health and Disability Commissioner (HDC)

Complaints can be received directly from a member of the public, or indirectly through the Council.

The HDC may (depending on the nature of the complaint):

- refer the complaint to an advocacy service
- decide to investigate – the HDC examines the case and decides what action to take. They may consult with the Council and will keep us up to date with their investigation
- if the HDC determines that a practitioner has breached the Code of Rights, the practitioner may be charged before the HPDT, or the HDC may require the practitioner to undertake changes to the way they practise, for example, a change to their informed consent material and procedures
- refer the matter to the Council to investigate whether the practitioner has breached their professional or legal responsibilities under the HPCA Act.

Disputes Tribunal

The Disputes Tribunal can be used to settle disputes involving claims up to \$30,000.

It is quicker, cheaper, and less formal than court. Its decisions are legally binding. This means you must follow the decisions of the Disputes Tribunal.

There are no judges, and a lawyer cannot represent the person making the claim, they usually represent themselves in the hearing.

Each hearing is run by a referee who will consider whether it is appropriate to help parties reach a settlement on a case-by-case basis. Where this is not considered appropriate, the referee makes a decision on the dispute.

Accident Compensation Corporation (ACC)

If a patient believes they have suffered an injury as a result of the treatment provided by a practitioner, they can contact ACC to make a treatment injury claim. ACC may be able to help provide cover for treatment costs, compensation for lost wages, home help assistance, etc.

Claims must be made as soon as possible after an injury – ACC may not be able to accept claims made more than 12 months afterwards. The date also affects when a patient qualifies for help and what help may be available to them.

Dental Council

We are required to pass all complaints against oral health practitioners made to the Council by members of the public to the HDC for them to consider first. HDC may refer these complaints back to us.

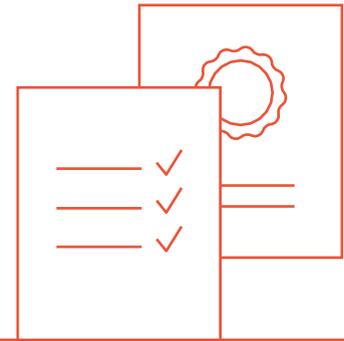
If a complaint is referred to the Council by the HDC, we will act promptly to decide what action should be taken. Public safety is the Council's absolute priority in all cases.

We do not have any powers to award damages or costs, or to impose discipline. The Council decides whether an issue of competence exists and takes appropriate action, including determining whether the practitioner poses a risk of serious harm to the public. Where that is the case, we have the power to restrict a practitioner's scope of practice or suspend their registration on an interim basis, during a review or investigation.

Oral health practitioners must respect patient rights and follow the principles of ethical conduct and professional standards for oral health practitioners. Failing to provide good care or behaving in a way that shows a lack of professional integrity are matters of conduct. These could result in the practitioner facing a disciplinary process.

Complaints about fees charged by a practitioner are not a matter that can be considered by the HDC or the Council.

5



SECTION 5:

Your legal obligations under the Health Practitioners Competence Assurance Act 2003

- Know your obligations:
 - Being competent to practise
 - I am a registered practitioner – what next?
 - Professional support
- Annual practising certificates
- Recertification (your ongoing professional development)
- Public register (your current details)

Know your obligations under the Health Practitioners Competence Assurance Act 2003

The HPCA Act sets out the conditions that a health practitioner must meet to practise in New Zealand. The Council's registration, annual practising certificate, and recertification requirements for practitioners are designed to enable you to meet these conditions.

If you want to provide oral health services in New Zealand, you must first gain registration from the Council. To do this, you must show the Council that you are appropriately qualified, competent, and fit for registration.

Once registered, you will need a current practising certificate to be able to practise your profession. It is your responsibility to have this certificate, and you cannot lawfully practise in New Zealand without it.

As a registered practitioner, you must keep your professional knowledge and skills up to date through ongoing learning and professional interaction. This means you must comply with the requirements of [the recertification programme](#) set by the Council.

Being competent to practise

The Council considers a competent practitioner is one who applies knowledge, skills, attitudes, communication, and judgement to the delivery of appropriate oral health care in accordance with their scope of practice.

We set out the entry level competencies for each of the oral health professions which an applicant for registration must meet before they can be registered.

These entry level competencies are termed 'competency standards' and include criteria against which an individual's performance can be measured. These competency standards are set at an entry level, being at the level of a new graduate of the particular scope of practice.

You can find the competency standards for each oral health profession under the scope of practice information for the relevant profession, on the [I practise in New Zealand](#) page of our website.

I am a registered practitioner – what next?

To comply with the HPCA Act, you must:

- not practise outside of the scope of practice in which you are registered
- not describe yourself or imply that you are a health practitioner of a particular kind unless you are qualified and registered to be a practitioner of that kind. For example, if you are a dentist, you may not describe yourself or imply that you are a dental specialist unless you are registered in a dental specialist scope of practice
- comply with any conditions that the Council may place on your scope of practice
- not perform certain activities restricted to health practitioners unless these activities fall within your scope of practice, and you are competent to perform the activity safely.

Professional support

The Council recommends that newly registered practitioners have a mentoring relationship in place and may impose this as a requirement for some practitioners.

This relationship may be with an immediate supervisor or principal practitioner, or it can be with someone outside your immediate practice environment.

Ideally, the mentor should be a senior and experienced oral health practitioner who is able to provide professional advice and support to you as a newly registered practitioner and discuss any concerns you may have about your professional practice.

Some of the professional associations or some employers run mentoring programmes for new graduates.

If you want to practise as an oral health practitioner in New Zealand, you must be registered with the Council AND hold a current practising certificate.

Application for an annual practising certificate

Registered practitioners who wish to practise in New Zealand must apply to the Council each year for an annual practising certificate (APC).

The issuing of an APC to a registered practitioner certifies to the public that you are competent and fit to practise your registered profession. The Council recommends that your APC is displayed prominently in your place of work.

An APC is issued by the Council Registrar on the understanding that the practitioner:

- has maintained competence in their scope of practice
- remains fit to practise
- is complying with the Council's ethical principles, professional standards, and practice standards, set out in the Council's *Standards framework for oral health practitioners*.

This assurance is based on the declaration you make in your APC application each year on these matters.

Recertification

After registration, the Council needs to ensure that you maintain your competence and fitness to practise in order to protect the health and safety of members of the public.

The recertification process is designed to provide the Council with the assurance it needs to ensure the ongoing competence of practitioners, and to assist practitioners in maintaining competence.

The recertification requirements are the same for full-time and part-time practitioners, and non-practising practitioners.

In 2021, the Council set a [new recertification system](#) for all practitioners effective from October 2021 for dentists and dental specialists, and 1 April 2022 for oral health therapists, dental hygienists, dental therapists, orthodontic auxiliaries, dental technicians and clinical dental technicians.

Practitioners were given until 31 December 2021 to meet the continuing professional development (CPD) requirements under the Council's previous recertification programme.

Information about the [CPD requirements up to 31 December 2021](#) are on the Council's website.

You can also find background information about [development of the new recertification programme](#) on our website.

Key features of the new recertification programme (from October 2021)

Recertification programmes are one of the key tools that the Council has for ensuring practitioners' ongoing competence.

The key features of the new recertification programme that differ from previous programme are:

- flexibility for practitioners to take ownership and actively plan and reflect on their professional development and undertake professional development activities that meet their own needs. This flexibility will remove the previous requirements to meet mandatory hours of activities or for those activities to be verified.
- increased focus on professional peer relationships, including a new requirement for professional peers to provide feedback relevant to the practitioner's professional development and confirm that programme requirements have been met.

All practitioners registered in New Zealand for more than six months will need to meet the new recertification programme requirements, when implemented.

The new recertification programme is an annual programme and has six core components:

1. **CONNECT** and interact regularly throughout your 12-month recertification programme with a professional peer you have nominated online
2. **PLAN** using a professional development plan (PDP) with feedback from your peer
3. **DO** professional development activities (PDAs) that you chose to support your plan and review these with your peer
4. **REFLECT** on your professional development in writing and discuss with your peer
5. Your professional peer will **CONFIRM** that you have engaged with them and met the requirements of your recertification programme
6. **DECLARE** you have completed the requirements of your recertification programme.

Each of the components in this recertification programme encourage you to think proactively about your professional needs, scope of practice, practice setting, your patients, and the [Standards framework for Oral Health Practitioners](#) when choosing PDAs.

We want you to choose meaningful activities that apply to those areas of practice you have identified to maintain, improve or develop.

Each year, you need to assure us that you have met your programme requirements. You do this by:

- having your professional peer confirm that they have discussed your PDP, PDAs and written reflection with you
- declaring that you have met each of the requirements of your recertification programme when you submit your APC application.

We will not routinely ask you to provide evidence of the steps you have taken to complete your recertification programme. But you may be required to produce evidence if:

- you are audited
- we receive a complaint, notification or expression of concern about you
- you or your professional peer declare that you have not met all requirements of your recertification programme.

We expect you to retain evidence supporting your completion of the programme requirements, for at least three years.

Previous recertification programme (until 31 December 2021)

The previous recertification programme required practitioners to complete a minimum number of verifiable CPD hours and peer contact activities. The number was set by the Council for each profession. As noted, this programme ends on 31 December 2021.

New registrants (from March 2020 until 31 December 2020) are required to complete the following minimum number of verifiable CPD hours and peer contact activities by 31 December 2021:

- dentists and dental specialists — 20 CPD hours and 3 peer contact activities
- dental hygienists, dental therapists, and oral health therapists — 15 CPD hours and 2 peer contact activities
- orthodontic auxiliaries — 7 CPD hours and 1 peer contact activity
- dental technicians— 10 CPD hours
- clinical dental technicians — 15 CPD hours.

New registrants after 31 December 2020 will have their CPD requirements adjusted in proportion to the time left of the cycle ending 31 December 2021.

Further details about these [CPD requirements](#) can be found on the Council website.

The public register and keeping your details up-to-date

The Council is required by law to keep a public register naming all registered oral health practitioners.

Anyone can search the public register on the Council website to find out if their oral health practitioner is currently registered and has a current practising certificate, as well as other information about a practitioner such as:

- the practitioner's scope of practice
- the qualifications that gained them registration
- any conditions that may apply to their practice.

If there are any changes to a practitioner's name (for example, due to marriage or divorce, or a registered name change), the practitioner must advise the Council of the changes within one month.

All practitioners are required under the HPCA Act to supply their current postal address and electronic address (email) to the Council, and to promptly advise us if their addresses change.

If a practitioner does not do this, their registration may be cancelled, and this would mean they can no longer practise as an oral health practitioner in New Zealand.

The Council carries out all its communications electronically via email. For this reason, it is vital that practitioners ensure the email address they supply to the Council is accurate and up to date.

It is your responsibility to maintain competence through participation in continuing professional development for the duration of your practising career – and to meet the recertification programme requirements set by the Council.

6



SECTION 6:

Your legal obligations related to practice (other than HPCA Act)

- New Zealand Radiation Protection
- Child protection
- Prescribing
- Privacy of information

You have a professional responsibility to find out about the laws and regulations that affect your work in New Zealand, and to follow them.

The law and regulations may change, and it is your responsibility to keep up to date with those affecting your work. The Council and professional associations update practitioners on key legislative changes that could affect the oral health environment.

This section highlights some key pieces of legislation that impact oral health practitioners.

New Zealand radiation protection legislation

The New Zealand radiation protection legislation consists of the **Radiation Safety Act 2016** and the **Radiation Safety Regulations 2016** which came into force on 7 March 2017, replacing earlier legislation. Radiation safety legislation is administered by the [Ministry of Health's Office of Radiation Safety](#).

The radiation protection legislation aims to facilitate the safe use of ionising radiation with the intent of protecting people and the environment from the harmful effects of ionising radiation and to meet international obligations on radiation protection, safety, security, and nuclear non-proliferation.

It covers the use of radiography equipment in dental practice.

The key requirements of the legislation for oral health practitioners are:

- the entity that manages or controls radiation sources must hold a 'Source licence' authorising them to manage and control those sources
- managing entities must register controlled radiation sources with the Office of Radiation Safety
- individual users of radiation sources must hold a User licence unless their use is otherwise authorised by the Act or regulations. Dentists, dental specialists, dental therapists, oral health therapists, dental hygienists, and orthodontic auxiliaries, where radiography is included in their scope of practice and when they hold a current annual practising certificate, are exempt from needing a user licence.

Two primary codes apply to oral health practice:

- the [Code of Practice for Dental Radiology: ORS C4](#)

The code applies to all activities associated with radiological equipment used for intra-oral, panoramic, and cephalometric dental procedures and provides details necessary to comply with the fundamental requirements in sections 9–12 of the Radiation Safety Act.

It specifies the requirements for managing radiation safety, x-ray machine performance and facility requirements, and occupational and public dose limits.

- activities associated with cone beam computed tomography equipment are covered in [ORS C1: Code of Practice for Diagnostic and Interventional Radiology](#).

Child protection laws

The Children's and Young People's Well-being Act 1989

The Children's and Young People's Well-being Act 1989, also called the Oranga Tamaraki Act 1989, provides for voluntary reporting of suspected cases of child neglect or abuse by anyone in the community. Section 15 of the Act states that:

'Any person who believes that a child or young person has been, or is likely to be, harmed, ill-treated, abused, (whether physically, emotionally or sexually), neglected, or deprived, or who has concerns about the well-being of a child or young person, may report the matter to the chief executive⁶ or a constable.'

It is important that you and any staff understand their reporting responsibilities under the Act. Your role is to observe, document, and report – **not** to investigate suspected abuse. If you are a worried or concerned about the wellbeing of a child, you should contact Oranga Tamariki – Ministry for Children.

You are encouraged to seek out educational opportunities to help you recognise signs of abuse or neglect, and to learn how to adapt dental treatment to meet the specific needs of a young person or child whose behaviour may be affected.

For more information on dealing with suspected child abuse see the Oranga Tamariki – Ministry for Children website.

The Children's Act 2014

The Children's Act 2014 is intended to better protect children from abuse and neglect, improve their physical and mental health and their cultural and emotional well-being, and increase their participation in decision making about them.

The Children's Act 2014 requires practices funded by State Services (such as ACC and DHBs, through the *Combined Dental Agreement*) that employ or contract people to work with children:

- to have child protection policies that contain provisions on the identification and reporting of child abuse and neglect.

(Note: the NZDA Code of Practice – Child Protection meets the child protection policy requirements of the Children's Act 2014)

- to 'safety check' staff.

Safety checking specifically applies to paid children's workers (including contractors).

The Children's Act creates two types of children's worker:

- **Core children's worker** if they work alone with or have primary responsibility or authority over a child. Dentists are considered to be core children's workers by the Ministry
- **Non-core children's worker** if they have regular, but limited, child contact and do not work alone with the child. Dental assistants are generally considered non-core workers.

It is an employer's responsibility to ensure safety checks are completed for the children's workers they employ or contract before they begin work. Safety checks need to be updated every three years after each check is completed.

⁶ Chief executive means the chief executive of Oranga Tamariki – Ministry for Children.

Safety checking requirements

Safety checking requirements are detailed in the [Children's \(Requirements for Safety Checks of Children's Workers\) Regulations 2015](#). This must include confirmation of the identity of the person and an assessment of the risk (including NZ police vetting) that person would pose to the safety of children if employed or engaged as a children's worker. For new employees this should occur before they begin work.

The [Oranga Tamariki – Ministry for Children website](#) contains helpful information on the Children Act's requirements.

Medicines legislation

Dentists and dental specialists are authorised by their scope of practice and by the relevant legislation, to prescribe medicines and controlled drugs.

There are several pieces of legislation that impact upon prescribing. The main two are the [Medicines Act 1981](#) and the [Misuse of Drugs Act 1975](#), along with their regulations.

Prescribing legislation requires that the prescribing of medicines and controlled drugs by dentists should only be in connection with the provision of dental treatment. Examples include medicine prescribed for pain management, and infection prevention or management.

Dentists should not prescribe medicines and controlled drugs for themselves and should not prescribe for family members or friends, unless they are patients, and the medicine or drug is related to dental treatment.

If your patient has an adverse reaction to a medicine or controlled drug, you should report it to the [Centre for Adverse Reactions Monitoring \(CARM\)](#).

Access to medicines

A standing order can be used to authorise non-prescribing oral health practitioners (such as oral health therapists, dental hygienists and dental therapists) to administer and/or supply a number of prescription medicines within their scope of practice, without the need for a prescription. Examples of the medicines they can use or administer within their scope of practice include local anaesthetics, high concentration fluoride and adrenaline.

A standing order is a written instruction issued by the dentist or dental specialist, as a prescriber, to allow these oral health practitioners access to the prescription medicines without the need for a prescription for each patient.

The Ministry provides [guidelines for those who work with standing orders](#), and to those who issue them, to ensure compliance with the regulations. The guidelines describe the nature of these orders and, details the safeguards that must be in place to protect the safety of the public.

Tooth-whitening restrictions

In New Zealand, registered dentists can carry out tooth whitening within their scope of practice. In some circumstances, tooth whitening products can be applied by other registered oral health practitioners or, a non-registered tooth whitening practitioner (in some cases only under the supervision of a dentist) depending on the percentage level of hydrogen peroxide.

The sale and application of tooth whitening products containing hydrogen peroxide (a hazardous substance) is governed by the Environmental Protection Authority (EPA) – the government agency responsible for regulating activities that affect New Zealand’s environment.

The EPA has authorised the supply of tooth whitening products to the public and the commercial application of such products by different practitioners (registered oral health practitioners and unregistered practitioners) according to the strength of hydrogen peroxide.

There are different requirements for the sale and application of products containing more or less than 8% hydrogen peroxide. These rules are captured within two group standards issued by the EPA under the Hazardous Substances and New Organisms Act 1996:

- Dental Products (Subsidiary Hazard) Group Standard 2017
- Dental Products (Oxidising [5.1.1]) Group Standard 2017.

The Dental Council has prepared an information sheet summarising the EPA rules about supplying or applying tooth whitening products.

Privacy laws: The Privacy Act 2020 and the Health Information Privacy Code (updated 2020)

The [Privacy Act 2020](#) aims to promote and protect individual privacy. It contains 13 information privacy principles related to the collection, holding, use and disclosure of personal information and assigning of unique identifiers. The principles also give rights to individuals to access personal information and to request correction of it.

[The Health Information Privacy Code](#) (Privacy Code) covers the management of information about an individual's health and disabilities and sets out rules which health practitioners must follow when collecting, storing, using, and disclosing information.

The [Privacy Commissioner's – Te Mana Mātāpono Matatapu website](#) contains useful information and tools that practitioners can use.

The standards and guidance in the Council's [Patient records and privacy of health information practice standard](#) are principally based on the legal and professional obligations described in the Privacy Act and the Privacy Code, and other New Zealand standards in this area.

Consumer protection law

There are several laws that protect consumers from unfair trading practises. The [Fair Trading Act 1986](#) exists to promote fair competition; make sure consumers get accurate information before buying products and services; and promote product safety. It applies to anyone in trade, including all professions and businesses.

The Act prohibits misleading and deceptive conduct, unsubstantiated claims, false representations, and certain unfair practices. The Act is enforced by the [Commerce Commission](#) – New Zealand's competition, consumer, and regulatory agency.

The standards and guidance in the Council's [Advertising practice standard](#) and [Informed consent practice standard](#) relate to the legal obligations in the Fair Trading Act.

7



SECTION 7:

Concerns about your competence and fitness to practise

- Concerns about your practice
- Competence
- Conduct
- Health

What happens when there are concerns about your practice?

You must be able to practise your profession without putting patients or the public at undue risk. Concerns and complaints about oral health practitioners fall into one of three categories:

- Competence – is the practitioner competent to practise?
- Conduct – is the practitioner’s conduct appropriate and safe?
- Health – is the practitioner with a physical or mental health issue fit to practise?

For each of these, the Council has a range of ways to respond, depending on the nature and seriousness of the concern or complaint.

We examine each notification made under the HPCA Act and decides whether it should be handled as a competence, conduct or health issue.

The Council does not have any powers to award compensation or costs, or to impose discipline. We decide whether a risk of serious harm exists, and if it does, the Council has interim powers to restrict your scope of practice or suspend your registration during an investigation.

Patient safety is the Council’s absolute priority in all cases.

The Council’s approach to competence concerns

Under the HPCA Act the competence of an oral health practitioner can be reviewed at any time, or in response to concerns about their practice.

Competence reviews are not carried out routinely. The Council will only carry out a competence review when a practitioner has been identified as having deficiencies in their competence, or allegedly has deficiencies in their competence, creating a risk to public health and safety.

The Council does not set out to establish guilt or fault. We do not aim to punish those who fall short.

Instead, we look to assess competence. If we find that the practitioner’s practice falls short in some way, we aim to help them meet the required standards. We use a supportive and educative process, putting in place the training, education and safeguards needed to make sure the practitioner comes up to Council’s minimum standards, while remaining safe to practice.

What is a competent practitioner?

A competent practitioner is one who uses their knowledge, skills, attitudes, communication, and judgement to deliver appropriate oral health care in the scope of practice within which they are registered. Performance is the output, and its measurement assesses how well a practitioner is actually working.

Where do concerns about a practitioner's competence come from?

From time to time, people express concerns about a practitioner's competence. The Council may be notified of concerns about competence from a variety of sources, including:

- other health practitioners – if they know or suspect that patients may be at risk because of a colleague's competence, they have a professional obligation to inform the Council
- employers – if a practitioner resigns or is dismissed from their employment for reasons relating to competence, the employer is required under the HPCA Act to notify the Council
- patients – by way of the HDC
- ACC – if a treatment injury claim indicates the practitioner may pose a risk of harm to other patients
- a professional conduct committee can recommend that the Council reviews a practitioner's competence.

What happens when someone expresses a concern about competence?

The practitioner will be told about the concern and asked to comment. Initial inquiries may then be carried out by one of the Council's professional advisors. The matter will not be taken any further if the notification is considered to be frivolous or vexatious.

After initial inquiries, the Council considers the concern, the practitioner's comments, the professional advisor's report, and any other information it may have about the practitioner's performance against the requirements of the standards framework and decides whether a competence review is required.

The following factors are likely, in combination or on their own, to lead to a competence review:

- a pattern of poor standards of care or competence – several instances, or one instance over a sustained period
- the magnitude of the mistakes, including the size of the suspected deficit, and the possible degree of serious departure from normal safe and accepted standards of practice
- the practitioner belongs to an 'at risk' group which includes practitioners working in a professionally isolated environment (for example, working alone in private practice and/or not affiliated with any professional body) and those working at the outer boundaries of, or beyond, their scope of practice.

What does a competence review involve?

A competence review aims to ensure that an oral health practitioner is practising at the required standard of competence.

A competence review is not a punitive or disciplinary process. Nor is it normally a re-examination of knowledge or skill. Rather, it is an assessment of performance in actual practice.

The review is an educative opportunity where the practitioner is assessed and where necessary, assisted through an educational programme which is fair, meaningful, and manageable, to ensure they are practising to the required standard of competence.

Specific complaints are not investigated as part of the competence review process – although they may give an indication where the review should be focussed.

What happens if the Council decides a competence review is needed?

If the Council considers that a competence review is needed it will appoint a competence review committee (CRC), comprised of two professional peers and one lay person (non-oral health practitioner representing the interest of the patient).

Understandably, a practitioner will feel anxious about a competence review. The competence reviewers are aware of this and aim to be as supportive as possible.

The peers usually include a practitioner familiar with education, examinations, or peer review and a true professional peer. In rare instances, a one-person review may take place. The reviewer in this instance will be a practitioner who practises in the same scope(s) of practice as the practitioner under review.

CRC members must sign a confidentiality agreement in which they undertake not to reveal or release any personal or health information obtained about the practitioner or their practice and patients, except as legally required during the review.

What information does the practitioner under review receive?

The Council will inform the practitioner that a competence review will be carried out, giving detail on:

- the substance of the concerns, and the grounds on which the Council has decided to carry out a review
- information relevant to their competence that the Council has in its possession
- the terms of reference and proposed membership of the CRC who will carry out the competence review, including their qualifications.

The practitioner is given the opportunity to make written submissions and be heard, either personally or through a representative on:

- the nature of the planned review
- the committee membership.

When a practitioner is heard personally, they are entitled to have a support person present.

The practitioner may request a change in the membership of the CRC if they perceive a conflict of interest or lack of expertise to review their specific practice.

After considering any submissions by the practitioner and making any agreed changes to the format of the review or committee membership, the Council sends the CRC a copy of the terms of reference for the competence review so members can plan the review and tailor it accordingly.

The CRC chair will contact the practitioner concerned, to fix a date for the review and to discuss how the review will be carried out.

Terms of reference for competence review

If a competence review is required, the Council will develop terms of reference for the review.

This provides a summary of:

- why the competence review is being carried out
- the scope of the review
- the recommended assessment methods to be used.

Most reviews will be focussed on particular areas of concern, but on occasion the terms of reference may be wider if there are indications of a more general competence problem.

The competence review process

The CRC will visit the practitioner in their practice. The practitioner can expect the on-site part of the review to last one day and may have a support person present.

The review will be limited to specific areas of concern unless there are indicators of a general competence problem.

The competence review may review clinical management, practice systems, record keeping, prescribing, communication skills, and may involve direct observation.

Wherever possible, the CRC will use carefully developed and standardised tools to assess the practitioner's performance.

The practitioner is legally obliged under the HPCA Act to allow the Council (or its representatives, for example, the CRC) to inspect all or any of their clinical records as part of the competence review, or a competence programme.

As soon as possible after conducting the review, the CRC writes a report to the Council with a recommendation that the practitioner either does or does not meet the required standard of competence.

We send the report to the practitioner for comment. The Council will then consider all the information before it and decide what, if anything, happens next.

Outcomes of competence review

If the Council decides the practitioner's **practise of the profession does not meet the required standard of competence** it will require one or more of the following, that:

- the practitioner undertakes an educational programme
- one or more conditions be included on the practitioner's scope of practice
- the practitioner sits an examination or undergoes an assessment
- the practitioner is counselled or assisted by one or more nominated people.

An educational programme may consist of one or more of the following:

- a period of practical experience and/or training
- the practitioner passing a further examination or assessment
- undertaking a course of instruction
- the practitioner working under supervision
- a review of the practitioner's clinical records.

The Council will specify how soon the practitioner must comply with the requirements of an educational programme and will appoint educational and clinical supervisors, if appropriate. The practitioner is responsible to meet the costs associated with their competence programme, including any supervision requirement.

The aim of an educational programme is to produce the best possible outcome for the practitioner.

The practitioner is legally obliged under the HPCA Act to comply with any orders the Council may make following a competence review, or with any educational programme.

Confidentiality of information

The HPCA Act protects the confidentiality of certain information.

Section 44(4) provides that no information, statement or admission that is disclosed or made by a practitioner in the course of, or for the purposes of satisfying the requirements of, any competence review or competence programme and that relates to any conduct of that practitioner (whether that conduct occurred before or during that review or programme):

- may be used or disclosed for any purpose other than the purposes of that review or programme; or
- is admissible against that person, or any other person, in any proceedings in any court or before any person acting judicially.

Costs

The Council meets the costs of a competence review, but the practitioner pays the educational programme costs.

Appeal rights

The competence review process observes the statutory requirements of the HPCA Act and the principles of natural justice. The practitioner has the right of appeal to the District Court when the Council imposes conditions on their scope of practice or suspends registration or their practising certificate.

More information about the [competence review process](#) can be found on our website.

Concerns about practitioner conduct

Oral health practitioners must respect patient rights and follow the principles of ethical conduct for oral health practitioners. Failing to provide good care or behaving in a way that shows a lack of professional integrity are matters of conduct. These could result in the practitioner facing a disciplinary process before a professional conduct committee (PCC) appointed by the Council.

The role of the PCC is to investigate the practitioner's conduct and decide whether the matter should be referred to the HPDT for a hearing.

More information about conduct concerns and the disciplinary process can be found on the [Council website](#) and the [HPDT website](#).

What is a professional conduct committee?

A PCC is an independent statutory committee that the Council appoints to investigate the basis of specified convictions or the appropriateness of the conduct of a practitioner. It comprises two registered practitioners and a lay person.

A PCC operates independently of the Council and may:

- receive evidence about the complaint or conviction
- appoint its own legal advisors and/or investigators as necessary
- make recommendations and determinations on the completion of its investigation.

A PCC can:

- decide to take no further action
- make certain specific recommendations to the Council
- lay a charge against the practitioner before the Health Practitioners Disciplinary Tribunal
- refer the matter to the police.

Health Practitioners Disciplinary Tribunal (HPDT)

The HPDT considers cases where a practitioner has been charged with professional misconduct under the HPCA Act. The charges may be brought by a PCC or the Director of Proceedings of the Health and Disability Commissioner's office.

The HPDT operates independently of the Council. It consists of a chairperson who is a barrister or solicitor and four persons selected from a panel maintained by the Ministry – three must be from the same profession as the practitioner under investigation and one must be a layperson.

An order can be made against a practitioner if the HPDT is satisfied that the practitioner has:

- been guilty of professional misconduct
- been convicted of an offence against various health related statutes
- been convicted of an offence punishable by imprisonment for a term of three months or longer and that offence reflects adversely on their fitness to practise
- failed to practise exclusively within and in accordance with their scope of practice
- practised while not holding a current APC
- breached any order of the HPDT.

The HPDT can regulate its own procedures and has powers to summon witnesses and records. It has the power to suspend the practitioner and/or impose conditions on their practice pending the hearing. The Tribunal hearings are held in public unless it orders otherwise.

All decisions and summaries are published on the [Tribunal website](#), and those involving oral health practitioners can also be found on the [Council website](#).

Penalties

Penalties ordered by the HPDT include cancellation of registration, conditions to be complied with before re-registration, practise subject to conditions, suspension, a fine or censure.

Concerns about your health

Health conditions may impair fitness to practise. The Council's primary objective is to ensure the health and safety of patients is protected. However, it does endeavour to support practitioners to continue in practice, while making sure that patients and colleagues remain safe. It puts supports and safeguards in place to help practitioners with mental or physical health issues affecting their ability to practise their profession.

Oral health practitioners, like anyone else, get ill and suffer injury. If you develop a physical or mental health problem, it may impair your ability to practise your profession safely, endangering patients. Depending on the nature of your illness or injury, you may:

- be unable to exercise judgement safely
- be unable to demonstrate the level of skill and knowledge required for safe practice
- behave inappropriately
- risk infecting patients with whom you come into contact
- act, or omit to act, in ways that impact adversely on patient safety.

Health conditions that may make you unfit to practise include alcohol or drug dependence, psychiatric disorders, a temporary stress condition, an infection with a transmissible disease, and certain illnesses, injuries or physical disabilities.

Delaying intervention, treatment and assistance may not only result in patient care being affected but may also impact you, both professionally and personally. In the Council's experience, early intervention usually enables a practitioner with a treatable illness or condition to continue practising while receiving treatment.

Notify the Council if you have concerns

You must notify the Council if you have doubts about your fitness to practise, or if you have reason to believe another oral health practitioner is unwell and may be unable to perform the functions required of their profession. You have a legal obligation to do so.

Similarly, if you are an employer of an oral health practitioner, or you are in charge of an organisation that provides health services, you must notify the Council if you have reason to believe an oral health practitioner in your employ is unable to perform the functions required for the practise of their profession.

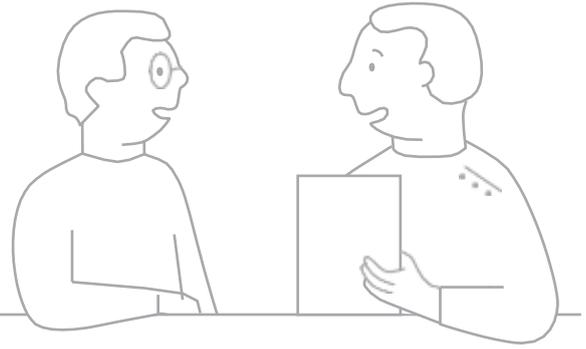
The Council's approach

If you notify the Council that you have a health concern, or if we receive a notification about you, we will endeavour to work with you and your medical team. Although our primary objective is to always ensure your patients are kept safe, this does not necessarily preclude you from continuing to work.

Whilst we do have the right to require you to undergo medical examination, and the ability to place conditions on, or restrict your scope of practice, or to suspend your practising certificate, in most cases, we have been able to work cooperatively with the affected practitioner to manage the situation.

The way we manage a health issue may involve regular reporting from your medical team, urine screening in the event of substance abuse, working under supervision, or if you have suffered an injury, a return to work plan developed in consultation with your medical advisors.

8



SECTION 8:

Your professional support network

- Professional associations
- Specialist bodies
- Other interest groups
- Self-care

Support networks

Interacting and collaborating with other oral health professionals provides opportunities for enhancing your ongoing professional development and learning, outcomes of patient care, and professional support.

There are several professional organisations for oral health practitioners which aim to provide this support for their members, alongside other services. Membership is voluntary.

Links to their websites are provided below:

Professional associations

[New Zealand Dental Association \(NZDA\)](#)

[Te Ao Mārama – The NZ Māori Dental Association](#) – the professional association for Māori oral health professionals – dental therapists, dental hygienists, dentists, dental specialists, oral health promoters, dental assistants and administrators, researchers, teachers, and students.

[New Zealand Dental and Oral Health Therapists' Association \(NZDOHTA\)](#)

[New Zealand Dental Hygienists' Association \(NZDHA\)](#)

[New Zealand Institute of Dental Technologists \(NZIDT\)](#)

Specialist bodies

New Zealand

[New Zealand Association of Orthodontists \(NZAO\)](#)

[New Zealand Association of Prosthodontists and Restorative Dentists \(NZAPRD\)](#)

Australasian

[Australian and New Zealand Association for Oral and Maxillofacial Surgeons \(ANZAOMS\)](#)

[Royal Australasian College of Dental Surgeons \(RACDS\)](#)

[Royal College of Pathologists of Australasia \(RCPA\)](#)

Australian and New Zealand Academy of Endodontists (ANZAE) – no website available

Contact the [Australian Society of Endodontology](#)

[Australian and New Zealand Academy of Periodontists \(ANZPA\)](#)

[Australasian Academy of Paediatric Dentistry \(AAPD\)](#)

[Australian and New Zealand Society for Paediatric Dentistry \(ANZSPD\)](#) – for paediatric dentists

[Australian and New Zealand Academy of Special Needs Dentistry \(ANZASND\)](#)

[Academy of Australian and New Zealand Prosthodontists \(AANZP\)](#)

Other interest groups

[New Zealand Dentists Orthodontic Society \(NZDOS\)](#)

[New Zealand Society of Endodontics \(NZSE\)](#)

[New Zealand Society of Periodontology](#)

[New Zealand School and Community Oral Health Services Society \(NZDCOHSS\)](#)

[New Zealand Society for Anaesthesia and Sedation in Dentistry \(NZSSD\)](#)

[New Zealand Academy of Cosmetic Dentistry \(NZACD\)](#)

[New Zealand Society of Forensic Odontology \(NZSFO\)](#)

[New Zealand Society of Hospital and Community Dentistry \(NZSHCD\)](#)

Taking responsibility for your self-care

A booklet, [Self-care for dentists \(2013\)](#) was published by the NZDA to encourage dentists to take positive actions towards self-care.

The focus of this booklet is on positive practice – and it provides activities, assessments and resources that address self-care issues specifically relevant to work in dentistry. It covers aspects of what it means to be a dentist, how to control problem areas (for example, your work environment, patient care and complaints, job satisfaction, stress, and health issues), and where to go for more information and help.

This booklet can be helpful to all oral health professions and can be found on the [Council website](#).



We are available to help.

You can find more information on our website:
www.dcnz.org.nz.

If you have further questions, please contact us:

Email: **inquiries@dcnz.org.nz**

Telephone: **+64 4 499 4820**

SECTION 9:

Appendices

- Scope of practice definitions
- List of abbreviations

Appendix A: Scope of practice definitions

<p>General dental practice</p>	<p>General dental practice encompasses the practice of dentistry in the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures in accordance with this scope of practice and a dentist's approved education, training, experience and competence.</p>
<p>Dental specialist scopes⁷</p>	<p>Endodontic specialist</p> <p>Endodontic specialists practise in the branch of dentistry that is concerned with the morphology and pathology of the pulpo-dentine complex and periradicular tissues. Its study and practice encompasses the basic clinical sciences including the biology of the normal pulp, and the aetiology, diagnosis, prevention, and treatment of diseases and injuries to the pulp and associated periradicular tissues.</p> <p>Oral and maxillofacial surgery specialist</p> <p>Oral and maxillofacial surgery specialists practise in the branch of dentistry in that part of surgery which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the human jaws and associated structures.</p> <p>Oral medicine specialist</p> <p>Oral medicine specialists practise in the branch of dentistry that is concerned with the oral health care of patients with chronic and medically related disorders of the oral and maxillofacial region, and with their diagnosis and non-surgical management.</p> <p>Oral pathology specialist</p> <p>Oral pathology specialists practise in the branch of dentistry which deals with that nature of diseases affecting the oral, maxillofacial, and adjacent regions.</p> <p>Oral surgery specialist</p> <p>Oral surgery specialists practise in the branch of dentistry concerned with the diagnosis and surgical management of conditions affecting the oral and dento- alveolar tissues.</p> <p>Orthodontic specialist</p> <p>Orthodontic specialists practise in the branch of dentistry that is concerned with the supervision, guidance, and correction of the growing and mature dentofacial structures and includes the diagnoses, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures.</p> <p>Paediatric dental specialist</p> <p>Paediatric dentistry specialists practise in the branch of dentistry that is concerned with oral health care for children from birth through to adolescence. It includes management of orofacial problems related to medical, behavioural, physical, or developmental disabilities. It may include management of adults with special needs.</p>

⁷ **Dental specialist scopes** are undertaken by a practitioner who possesses additional postgraduate qualifications, training and experience recognised by the Council as appropriate for registration.

Dental specialist scopes – (Cont.)	<p>Periodontic specialist</p> <p>Periodontic specialists practise in the branch of dentistry that is concerned with the prevention, diagnosis and treatment of diseases or abnormalities of the supporting tissues of the teeth or their substitutes.</p>
	<p>Prosthodontic specialist</p> <p>Prosthodontic specialists practise in the branch of dentistry that is concerned with diagnosis, treatment planning, rehabilitation, and maintenance of patients with a range of clinical conditions involving missing or deficient teeth and/or craniofacial tissues, using biocompatible substitutes.</p>
	<p>Public health dentistry (or community dentistry) specialist</p> <p>Dental public health (community) specialists practise in the branch of dentistry that is concerned with the science and art of preventing oral disease, promoting oral health, and improving the quality of life through the organised efforts of society.</p>
	<p>Restorative dentistry specialist</p> <p>Restorative dentistry specialists practise in the branch of dentistry that is concerned with dental procedures in the dentulous or partially edentulous mouth. This may include operative, endodontic, periodontic, orthodontic and prosthetic procedures.</p>
	<p>Special needs dentistry specialist</p> <p>Special needs dentistry specialists practise in the branch of dentistry that is concerned with the oral health care of people adversely affected by intellectual disability, medical, physical, or psychiatric issues.</p> <p>(NB Special needs specialists who wish to identify their particular expertise in hospital dentistry can apply to the Dental Council to use the specialist title ‘Special needs dentistry (hospital)’.)</p>
Oral health therapy	<p>The practice of oral health therapy is the provision of oral health assessment, diagnosis, management, treatment and preventive care for patients in accordance with this scope of practice and an oral health therapist’s approved education, training, experience and competence.</p> <p>Oral health education, disease prevention and oral health promotion for individuals and communities are core activities, aimed at achieving and maintaining oral health as an integral part of general health.</p> <p>Oral health therapists practise as part of the dental team and work collaboratively with other oral health practitioners and health practitioners to provide appropriate and comprehensive care to the benefit of patients’ overall health.</p> <p>Oral health therapists and dentists have a consultative professional relationship. The relationship may be between an oral health therapist and one dentist or dental specialist or an oral health therapist and a number of dentists or dental specialists. The establishment and maintenance of the consultative professional relationship is required for the practice of oral health therapy.</p>

Dental therapy	<p>The practice of dental therapy is the provision of oral health assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures in accordance with this scope of practice, and a dental therapist's approved education, training, experience and competence. Dental therapy services are provided to children and adolescents up to age 18.</p> <p>Disease prevention, oral health promotion and maintenance are core activities.</p> <p>Dental therapists have a consultative professional relationship with dentists or dental specialists.</p>
Adult care in dental therapy	<p>The practice of dental therapy on adults is the provision of oral health assessment, treatment, management and prevention services within the general dental therapy scope of practice for adult patients aged 18 years and older. Depending on the dental therapist's qualifications this is provided in a team situation under direct clinical supervision⁸ or the clinical guidance⁹ of a practising dentist or dental specialist. Disease prevention, oral health promotion and maintenance are core activities.</p>
Dental hygiene	<p>The practice of dental hygiene is the prevention and non-surgical treatment of periodontal diseases through the provision of oral health assessment, diagnosis, management and treatment of any disease, disorder or condition of the orofacial complex and associated structures in accordance with this scope of practice and a dental hygienist's approved education, training, experience and competence.</p> <p>A dental hygienist guides patients' personal care to maintain sound oral tissues as an integral part of a patient's general health.</p> <p>Dental hygienists practise in a team situation with clinical guidance provided by a practising dentist or dental specialist¹⁰. Some aspects of the scope of practice are provided under direct clinical supervision¹¹.</p>

8 **Direct clinical supervision** means the clinical supervision provided to a dental therapist by a practising dentist or dental specialist when the dentist is present on the premises at the time the dental therapy work is carried out.

9 **Clinical guidance** means the professional support and assistance provided to a dental therapist by a practising dentist or dental specialist as part of the provision of overall integrated care to the adult patient group. Dental therapists and dentists/specialists normally work from the same premises providing a team approach. Clinical guidance may be provided at a distance but appropriate access must be available to ensure that the dentist or specialist is able to provide guidance and advice, when required and maintain general oversight of the clinical care outcomes of the adult patient group.

10 **Clinical guidance** means the professional support and assistance provided to a dental hygienist by a practising dentist or dental specialist as part of the provision of overall integrated care to the patient group. Dental hygienists and dentists or dental specialists normally work from the same premises providing a team approach. Clinical guidance may be provided at a distance but appropriate access must be available to ensure that the dentist or dental specialist is able to provide guidance and advice, when required, and maintain general oversight of the clinical care outcomes of the patient group. Dental hygienists are responsible and accountable for their own clinical practice within their scope of practice but the dentist or dental specialist is responsible and accountable for the clinical guidance provided. Further detail on the working relationship between dental hygienists and dentists is set out in the relevant Dental Council Practice Standard.

11 **Direct clinical supervision** means the clinical supervision provided to a dental hygienist by a practising dentist or dental specialist when the dentist is present on the premises at the time the dental hygiene work is carried out.

Orthodontic auxiliary	<p>Orthodontic auxiliary practice is a subset of dental hygiene practice that involves implementing orthodontic treatment plans prepared by a dentist or orthodontists, by performing orthodontic procedures and providing oral health education and advice on the care and maintenance of orthodontic appliances in accordance with this scope of practice and an orthodontic auxiliary's approved education, training, experience and competence.</p> <p>Orthodontic auxiliaries practise under the direct supervision of a dentist or orthodontist who is present on the premises at which the work is carried out and who is responsible for the patient's</p>
Dental technology	<p>The practice of dental technology involves the processes and procedures associated with the design, manufacture and repair of fixed and removable oral and extra-oral appliances and prostheses prescribed by a practising health practitioner¹², and carried out in accordance with this scope of practice and a dental technician's approved education, training, experience and competence¹³.</p>
Clinical dental technology	<p>The practice of clinical dental technology involves the processes and procedures associated with taking impressions, undertaking other non-invasive clinical procedures related to the design, manufacture, repair and fitting of complete or partial removable oral and extra-oral appliances and prostheses, in accordance with this scope of practice and the clinical dental technician's approved education, training, experience and competence¹⁴.</p>
Clinical dental technology for implant overdentures	<p>The practice of implant overdentures by clinical dental technicians is the processes and procedures associated with taking impressions, undertaking other non-invasive clinical procedures related to the design, manufacture, repair and trial fitting of removable complete and partial implant overdentures, in accordance with this scope of practice and the clinical dental technician's additional approved education, training, experience and competence.</p>

Practice in a scope of practice is wider than just clinical activity. It includes reporting or giving advice in an oral health capacity and those involved in teaching, research, and management positions, given that such roles influence clinical practice and public safety.

12 Appliances and prostheses are prescribed by a practising dentist, dental specialist, clinical dental technician, medical practitioner or other practising health practitioner.

13 The working relationship between dental technicians and prescribing health practitioners is set out in the relevant Dental Council Practice Standard.

14 The working relationship between clinical dental technicians and prescribing health practitioners is set out in the relevant Dental Council Practice Standard.

Appendix B: List of abbreviations

ACC	Accident Compensation Corporation
APC	Annual practising certificate
AUT	Auckland University of Technology
CARM	Centre for adverse reactions monitoring
COHS	Community oral health service
CCRS	Conflict complaints and resolution committee
CPD	Continuing professional development
CRC	Competence review committee
CSC	Community services card
DHBs	District health boards
HDC	Health and Disability Commissioner
HPCA Act	The Health Practitioners Competence Assurance Act
HPDT	Health Practitioners Disciplinary Tribunal
NCLO	National Consumer Liaison Officer
NZDA	New Zealand Dental Association
NZIDT	New Zealand Institute of Dental Technologists
PCC	Professional conduct committee
PDA s	Professional development activities
PDP	Professional development plan
TMVI	Transmissible major viral infections
WHO	World Health Organization

