Submission on a proposed oral health therapy scope of practice

From:
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[redacted]

1. Do you agree with the proposed changes to the oral health therapy scope of practice? If not, please explain.
   - I do not believe that dental therapists have the competencies to plan care for children and adolescents who have complex restorative needs related to dental and oral facial anomalies. Care for permanent teeth with anomalies should be undertaken by dentists. Initial care even as the teeth erupt will determine the lifetime outcomes for these teeth.
   - I believe therefore the scope should read: **Restorative activities for dental caries for patients up to age 18.**

   I also believe that the detailed description of the scope should include specific procedures that are restricted. For example:
   - It should note that permanent teeth with anomalies should not be restored without informed consent for a treatment plan from a dentist.
   - It should note that children with orofacial anomalies should have opportunity for early diagnosis and treatment planning before routine care is undertaken.

2. Do you agree with the proposed consultative professional relationship between an oral health therapist and one or more dentist/dental specialist, without the need for a signed agreement? If not, please explain.
   - I believe that for both parties a written agreement should be in place defining the relationship and responsibilities. It is inappropriate for a dentist to not have clearly defined parameters they are expected to support for another practitioner. For management of permanent teeth and orofacial anomalies, there should be a plan from a dentist as the dental therapy scope of practice does not allow informed consent to be obtained for many procedures that may be needed.

3. Do you agree with the proposed competency standards for oral health therapists? If not, please explain.
   - I believe that it is artificial to restrict restorative care to under 18 years-of-age. The definition of what restorative care can be performed (for dental caries) needs to be more clearly defined so that restorative care under the direction of a dentist in adults could be carried out.
   - I would ask what is different to restoring a molar at 17 years or 18 years? It could suggest that it is possibly less important in the 17 year-old.

10 May 2016

From: Bernadette Drummond
Sent: Friday, 13 May 2016 10:27 p.m.
To: Consultations
Subject: Re: Dental Council response - Oral Health Therapy Scope of Practice consultation

Dear Suzanne

Thank you for your reply to my latest submission. With regard to the Scope of Practice in relation to developmental problems - I accept the document is aligned to what is in teaching programme. However, the document does not define what is not included and this is what I see as the biggest issue as it leaves everything open to interpretation by a therapist who within the scope of their knowledge and practice will only have a very basic understanding of developmental problems. This issue is not solvable by putting more in the teaching programme. The scope is the scope.

I believe that the scope must indicate what is not in the scope. This will be critical if therapists are to have autonomy to care for children up to age 18 as it will mean that New Zealand children will only have the most basic of oral health care and in the main only care related to dental caries.

A way forward after this current process is complete may be to consider actually defining for the first time ever in the history of care for children in New Zealand which care can be delivered for children and adolescents by oral health therapists, general dentists, and a range of specialists. This process has just been completed in the UK and the document is about to be released. While I do not believe we can be aligned to the work here (I am in the UK on sabbatical) I do think that New Zealand has not provided good care for children because it has been overshadowed by the historical belief that therapists provide comprehensive care. The only reason the system survived as it has is because of all the back up provided in private and hospital practice. Even now, children only have access to publicly funded specialist services in 5 DHBs and most are very part time.

I am happy to talk/discuss this more as I feel it is time over the next few years to really think about what kind of care children and adolescents should receive.

With kind regards

Bernadette Drummond

> On 13 May 2016, at 4:13 am, Consultations <Consultations@DCNZ.org.nz> wrote:
>
> <OHT individual response - Dr Drummond.pdf>

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