Dental Council
Te Kaunihera Tiaki Niho

30 October 2020

Dear practitioner,

Consultation on proposed changes to the working relationship requirements for oral health practitioners with dentists, and the practising conditions for dental hygiene activities

The Dental Council (the Council) has prepared a consultation document following its review of:

- whether the current scope of practice requirement for a working/consultative professional relationship for dental therapy, dental hygiene, orthodontic auxiliary, and oral health therapy should remain, and the associated working/professional relationship practice standards
- the current practising conditions (clinical guidance and direct clinical supervision) for the dental hygiene scope of practice.

The consultation document outlines the preliminary conclusions reached by the Council and seeks your feedback on proposed changes and draft guidance.

Have your say

The consultation process provides practitioners and other interested organisations (including professional associations and societies, the Ministry of Health, district health boards and educational institutions) with an opportunity to have their say. We welcome and value all feedback, but multiple, identical submissions do not carry any more weight than a single submission. All feedback we receive will be considered and will inform our final decision.

Please ensure you include answers to the consultation questions outlined on pages 18 & 19 of the consultation document when you respond. The consultation document is also available on our website inviting feedback from any other interested party or member of the public.

Submissions

Your submissions must reach us by **5pm on 18 December 2020.**

You can submit your responses using our online survey, or you can email it to our email consultations@dcnz.org.nz.

Submissions received will be published on our website and will record the submitter's name and profession (for registered oral health practitioners). All other contact details will be removed. We will not publish any submissions containing derogatory or inflammatory content.

As this is a public consultation, "In confidence" information will only be accepted under special circumstances. Please contact us before submitting material in confidence.

If you have any questions about this consultation, you can contact us by email or phone 04 499 4820. I look forward to receiving your views on the proposals and draft guidance.

Yours sincerely

Marie Warner

Chief Executive

Consultation on proposed changes to:

1. **The working relationship requirements for oral health practitioners with dentists**
2. **The practising conditions for dental hygiene activities**

Issued: 30 October 2020

Submission closing date: 18 December 2020

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Contents

Introduction

The Council has reviewed:

- whether the current requirement for a working/consultative professional relationship should remain a scope of practice requirement for dental therapy, dental hygiene, orthodontic auxiliary, and oral health therapy practice in New Zealand; and the future role of the 'working relationship' practice standards for the following professions:
    - dental therapy
    - dental hygiene
    - orthodontic auxiliary
    - dental technology/clinical dental technology.
- the current practising conditions for the dental hygiene scope of practice – namely, whether dental hygiene scope activities should be performed under clinical guidance[1] and direct clinical supervision[2].

This consultation document outlines the Council's proposals and welcomes you feedback.

The key proposals are:

1. Review of the requirement for a professional relationship
    a. Retain the scope of practice requirement for a 'working relationship' between a dental therapist, dental hygienist, orthodontic auxiliary or oral health therapist, and dentist, and re-define it as a 'consultative professional relationship'; but remove the need for a signed agreement.
    b. To remove the working relationship practice standards, and replace them with the following guidance documents:
        - Guidance for the consultative professional relationship between an oral health therapist, dental therapist, dental hygienist, or orthodontic auxiliary and dentist/dental specialist. (Attachment A).
        - Guidance for the professional relationship between a dental technician or clinical dental technician and other health practitioners. (Attachment B).
2. To make the following changes to the dental hygiene scope of practice:
    a. Remove the requirement for direct clinical supervision for the administration of local anaesthetic (LA) and application of prescription preventive agents. Direct clinical supervision for currently specified orthodontic activities to remain.
    b. Remove 'clinical guidance' for the remainder of the scope activities.

[1] 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.

[2] 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.

c. The scope activities to be performed within a consultative professional relationship with a dentist or dental specialist.

d. Align the description of the following scope activity with current dental hygiene practice in the following way: *obtaining and ~~re~~assessing medical and ~~dental~~ oral health histories.*

The practising context today

The scopes of practice and the current working relationship practice standards were established with the introduction of the Health Practitioners Competence Assurance Act in 2004 (except for oral health therapy).

Since then, the Council has introduced the Standards Framework for Oral Health Practitioners (standards framework), in 2015. The standards framework defines the standards that oral health practitioners must meet, including the expectations for oral health practitioners' professional relationships with other health practitioners and colleagues.

The Council is of the view that with the introduction of the standards framework a number of these professional obligations are covered within the framework, specifically through the following professional standards:

You must:

- practise within your professional knowledge, skills, and competence, or refer to another health practitioner (8)
- keep your professional knowledge and skills up to date through ongoing learning and professional interaction (11)
- communicate openly in inter- and intra-professional healthcare teams for the enhancement of patient care (17)
- behave respectfully in communication to and about colleagues or other health professionals (18)
- collaborate with colleagues and other health practitioners and contribute to teamwork for enhanced patient outcomes (21).

Additionally, all practitioners must practise within their scope of practice and are responsible and accountable for the care they provide.

In this consultation document:

- *working relationship* represents the **existing** working relationship and professional relationship obligations, as currently defined in the respective scopes of practice and practice standards
- *dentists* include dentists and dental specialists
- *technicians* refer to both dental technicians and clinical dental technicians, unless specified.

The structure of the consultation document reflects the two proposal areas, as stated above.

The grey boxes reflect the Council's preliminary positions, and the light blue boxes detail the proposals on which the Council is seeking feedback.

Proposal area 1: Review of the requirement for a professional relationship

1. International positions on professional relationships

The Council considered whether the current scope requirement for a working relationship for dental therapy, dental hygiene, orthodontic auxiliary, and oral health therapy practice should remain.

Investigation into the registration and scope of practice requirements internationally for the various oral health professions showed that there is still a mixture of "structured" practising arrangements in place.

In the United Kingdom, this team approach to care is also emphasised in Standard 6.1 of the General Dental Council's Standards for the dental team, which states:

> You must work effectively with your colleagues and contribute to good teamwork

In Australia since the National Law came into effect in 2010, oral health therapists, dental therapists and dental hygienists have not had direct clinical supervision, guidance, or oversight requirements on their practice.

In addition, recent changes to the Dental Board of Australia's scope of practice registration standard has removed the need for a "structured professional relationship" with a dentist as a registration requirement.

The Australian registration standard (1 July 2020) emphasises a team approach to care, stating:

> All dental practitioners are members of the healthcare team. They are expected to work with other members of the healthcare team to provide the best possible care and outcome for their patients.

2. New Zealand context

The Council also envisages a team approach in providing oral health care where practitioners work collaboratively for the benefit of patient's overall health.

This is reflected in professional standard 21 of the standards framework which states:

> You must collaborate with colleagues and other health practitioners and contribute to teamwork for enhanced patient outcomes.

Arguably, given the requirements of the standards framework, having a working relationship as a *scope requirement* for dental therapy, dental hygiene, oral health therapy and orthodontic auxiliary practice is unnecessary.

However, the perceived benefits of retaining the requirement for a professional consultative relationship include:

- Having an identified 'go-to' person for professional advice who has agreed to fulfil that function and provide advice in a timely manner. It includes commitment by the dentist to arrange alternative access during times when they are not available for extended periods, such as holidays.
- Having an established pathway for referral.

- Having an established relationship to enable prescribing for patients that need prescription medication, and to secure access to medicines for use and administration during treatment.
- Easier facilitation of standing orders.
- Requiring practitioners to discuss the way their professional relationship will work.
- Offers an opportunity to provide guidance for practitioners in establishing and maintaining professional relationships within the oral health team.

On balance, the Council considers there continues to be value in having a 'working relationship' as a scope of practice requirement for dental therapy, dental hygiene, oral health therapy and orthodontic auxiliary practice in New Zealand.

Proposal:

1. Retain a 'working relationship' as a scope of practice requirement for the dental therapy, dental hygiene, oral health therapy and orthodontic auxiliary professions.

3. Existing 'working relationship' practice standards review

The Council reviewed the following existing working relationship practice standards to determine their future role:

- *The professional relationships associated with the practice of dental therapy – practice standard*
- *Working relationship between dental hygienists and dentists/dental specialists – practice standard*
- *Working relationship between orthodontic auxiliaries and dentists/dental specialists – practice standard*
- *The practice of dental technology and clinical dental technology and the working relationship within the practice of dentistry – practice standard.*

As part of the review process a mapping exercise was performed of the working relationship practice standards against the Council's professional and practice standards contained in the standards framework, scopes of practice content, and other legislative requirements, to identify any gaps and duplication.

3.1 Review outcomes for dental therapy, dental hygiene, and orthodontic auxiliary scopes of practice

In 2017, the oral health therapy scope of practice was established requiring a '*consultative professional relationship*' with no signed written agreement. This prompted questions as to why similar arrangements could not apply for dental therapy and dental hygiene practice.

The Council considers that the principles of the consultative professional relationship for oral health therapy are equally applicable to the working relationships and professional interactions in dental therapy, dental hygiene, and orthodontic auxiliary practice.

As can be seen from the existing practice standard titles the various 'working relationships' are termed differently across the various professions - but have similar meaning. The working relationship practice standards for dental therapy, dental hygiene and orthodontic auxiliary practice all describe a professional relationship between practitioners that exists to promote good, appropriate care.

This is consistent with the expectations of the consultative professional relationship for oral health therapy, which aims to provide a clear and reliable way for practitioners to seek/provide advice for treating and managing patients, and a potential pathway for referral.

Proposals:

2. The current working relationship for dental therapy, dental hygiene, and orthodontic auxiliary practice be redefined as a *consultative professional relationship*, in line with oral heath therapy.

3. The *consultative professional relationship* be defined as:

   The arrangement between an oral health practitioner and dentist to provide professional advice about treating and managing patients, within the oral health practitioner's scope of practice. It provides a clear and reliable way for the oral health practitioner to seek advice, and a potential pathway for referral.

4. A signed written agreement is no longer required for dental therapy, dental hygiene or orthodontic auxiliary practice, as it is anticipated that practitioners will reliably meet their responsibilities in the consultative professional relationship, consistent with the position held for oral health therapy.

   Practitioners may still choose to have a written agreement, or employers may require one.

3.2 Review outcomes for technicians

The Council does not consider that the consultative professional relationship, as described in the previous section, applies to the nature of the professional relationships that technicians typically have with oral health practitioners and other health practitioners.

Given the nature of technicians' work and the number of practitioners they interact with professionally, the Council considers a consultative professional relationship is unnecessary and impractical for technicians.

Generally, technicians will be able to seek clarification or advice from the prescribing practitioner about the work prescribed, or refer to a dentist or dental specialist, when necessary.

Currently there is no scope of practice requirement for dental technicians or clinical dental technicians to have a working relationship or a signed written agreement. The Council is not proposing any change to this area.

Proposal:

5. Describe the current 'working relationship' for dental technology and clinical dental technology practice as a 'professional relationship' between a technician and other health practitioners, to acknowledge the professionals involved and the oral health practitioners' professional obligations under the standards framework.

   No changes to the nature of this relationship are proposed, or to the current professional responsibilities of practitioners in this relationship.

4. Consultative professional relationship guidance documents

The following draft guidance documents have been developed to help practitioners understand and meet their professional responsibilities:

- Guidance for the consultative professional relationship between an oral health therapist, dental therapist, dental hygienist, or orthodontic auxiliary and dentist/dental specialist. (Attachment A).
- Guidance for the professional relationship between a dental technician or clinical dental technician and other health practitioners. (Attachment B).

The review found much of the detailed content of the working relationship practice standards was:

- redundant (with changes in legislation, for example, radiography requirements; or practice standard requirements, for example, sedation)
- contained in the relevant scope of practice
- covered by legislation
- covered by the Council's standards framework, including its professional and practice standards covered at a principle level in the draft guidance documents (consistent with the approach taken for oral health therapy).

As duplication of scope of practice information is unnecessary and considered a legal risk, the draft guidance documents represent the remaining content of the working relationship practice standard that is not covered by scope of practice information, legislation, or the Council's standards framework.

- For oral health therapy, dental therapy, dental hygiene, and orthodontic auxiliary professions a single guidance document based on the existing guidance for oral health therapy seemed most appropriate, given the level of overlap in describing a consultative professional relationship for these professions.
- For dental technicians and clinical dental technicians, it was found that the existing working relationship practice standard for dental technicians and clinical dental technicians mainly contains scope of practice information.

Proposal:

6. Remove the multiple 'working relationship' practice standards, and publish the following two guidance documents to help practitioners understand and meet their professional relationship responsibilities:
    - Guidance for the consultative professional relationship between an oral health therapist, dental therapist, dental hygienist, or orthodontic auxiliary and dentist/dental specialist.
    - Guidance for the professional relationship between a dental technician or clinical dental technician and other health practitioners.

Proposal area 2: Practising conditions for dental hygiene activities

Currently in the dental hygiene scope of practice the:

- administration of local anaesthetic (LA), application of prescription preventive agents, and specified orthodontic activities are performed under direct clinical supervision[3]
- remainder of the scope activities are performed under clinical guidance[4].

5. Clinical guidance

When reviewing the working relationship for dental hygiene it prompted the Council to examine the current requirement for clinical guidance.

The Council considers that the intent of *clinical guidance* and the *consultative professional relationship* is the same – that is, to ensure a dental hygienist can reliably receive professional advice (guidance/assistance) from a dentist about treating and managing patients.

There is considerable overlap in how both arrangements are described and operate. In both arrangements:

- the value of a team approach in providing oral health care where practitioners work collaboratively to provide comprehensive care for the benefit of patients' overall health is emphasised
- the dental hygienist is responsible and accountable for their own clinical practice within their scope of practice
- the dental hygienist and dentist can be in different practice locations while care is provided.

The key difference between *clinical guidance* and the *consultative professional relationship* (proposed definition), is that the dentist maintains "general oversight of the clinical care outcomes of the patient group" in a clinical guidance arrangement.

The Council considers that the general oversight of the clinical care outcomes of the patient group could be enacted equally well within a consultative professional relationship, with specific guidance to prompt discussion between the dental hygienist and dentist:

> *Consider and agree on a process for the dentist in the consultative professional relationship to provide general oversight of the clinical care outcomes of the hygiene patient group. This may involve review of the periodontal status of patients receiving hygiene care at intervals appropriate for the individual patient.*

If the Council's proposal that dental hygiene is practised within a consultative professional relationship is adopted, then based on the above, it considers *clinical guidance* within the dental hygiene scope of practice is no longer needed.

[3] 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.

[4] 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.

6. Direct clinical supervision

6.1 Administration of local anaesthesia

The question as to whether direct clinical supervision continues to be appropriate for dental hygienists to administer LA has arisen following the establishment of the oral health therapy scope of practice in 2017. Oral health therapists can administer LA without *direct clinical supervision*, needing only a *consultative professional relationship* with a dentist to practise (with the exception of specified orthodontic activities)[5].

Comparison of LA education between the earlier dental hygiene programmes with today's oral health therapy programmes

When developing the oral health therapy scope of practice, the Council worked closely with University of Otago and AUT who provide the oral health education programmes in New Zealand. Both supported the view that direct clinical supervision was not necessary to enable safe, competent and appropriate administration of LA by oral health therapists.

The justification for an oral health therapist to not need direct clinical supervision to administer LA was based on the following:

- The key competencies related to the LA technique in the scopes of general dental practice, dental hygiene, and dental therapy are the same:
    - correct solution and technique used
    - adequate anaesthesia achieved (dental hygiene had an additional competency defined – understanding and appropriate management of complications).

  The University of Otago Bachelor of Oral Health and AUT Bachelor of Health Science in oral health programmes were originally developed to meet the competency standards for dental hygiene and dental therapy.

- Oral health students are required to understand the potential interactions between patient medications and LA, and the complications of LA administration and the associated management; indicating that oral health graduates are equipped to know when not to proceed with the administration of LA.

- All registered oral health practitioners are required, at minimum, to complete a CORE Immediate or equivalent resuscitation course every two years. The Medical emergencies practice standard requires dental therapists and oral health therapists to have access through a standing order to Adrenaline (1:1000), to enable administration of adrenaline for anaphylaxis[6].

In considering what the appropriate practising conditions ought to be for dental hygienists when administering LA, the Council explored whether the oral health programmes contain any additional content that would enable an oral health therapist to administer LA more competently, safely and/or appropriately than a dental hygienist?

[5] Scope of practice for oral health therapy https://www.dcnz.org.nz/i-practise-in-new-zealand/oral-health-therapists/scope-of-practice-for-oral-health-therapists/

[6] November 2019 update to the Medical emergencies practice standard https://www.dcnz.org.nz/assets/Uploads/Practice-standards/Medical-Emergencies-practice-standard.pdf

To answer this question the Council approached the oral health programmes at University of Otago and AUT.

- The University of Otago confirmed that its oral health programme's LA module is more or less the same as the single scope hygiene and therapy degrees previously offered.
- Both universities confirmed that the LA content in their oral health programmes is comparable to that of the 'add-on' LA courses offered to practising hygienists to enable them to administer LA when their original programme of study did not include an LA component.

The comparability was verified by mapping of the 'add-on' LA courses historically offered by the two universities against the LA related content and assessment of the current accredited oral health programmes.

Based on these findings, the Council concluded that the earlier education and training in LA received by New Zealand dental hygienists is comparable to the LA components delivered in the oral health programmes today.

Risk assessment

Risks associated with administration of LA in the dental hygiene scope of practice were considered by the Council, and it reached the following conclusions:

a) When a patient has a significant or complex medical history, the dental hygienist can consult with the dentist to ascertain whether it is appropriate to administer LA. It is considered this can happen within a consultative professional relationship equally as well as in a clinical guidance arrangement.

The draft guidance highlights this area as a point for discussion between an oral health practitioner and dentist (page 6):

- Identify any specific circumstances where you expect the oral health practitioner will ask for professional advice or assistance, for example:
  - The interpretation of significant or complex medical histories and their potential influence when providing oral health care, including when planning to administer local anaesthetic.

b) In the event of a medical emergency, dental hygienists have the same level of resuscitation training as dentists not offering sedation (CORE Immediate or equivalent). Dental hygienists do not currently have access to adrenaline (1:1000) in case of anaphylaxis; dental therapists and oral health therapists do (through a standing order). This will need to be addressed if direct clinical supervision for LA is no longer required.

   If accepted, then dental hygienists will need to ensure that they have access to and obtain the necessary training to safely administer adrenaline to manage an anaphylactic event.

   A standing order by the dentist will provide access to LA and adrenaline – prescription medicines.

c) Dental hygienists who had received the necessary education and training in LA, either as part of their initial programme (For NZ trained hygienists, these were the prescribed qualifications gazetted in May 2005 for the LA additional scope of practice), or through subsequent courses, have been administering LA for an extensive period. To date the Council has not had any general concerns about hygienists' ability to safely administer LA.

d) Consideration will be given to overseas trained dental hygienists seeking registration in New Zealand in the future, to ensure their education and experience has equipped them to administer LA within the proposed consultative professional relationship.

e) The proposal does not change any of the existing exclusions on hygienists' scopes of practice. An exclusion is placed at the point of registration if the practitioner's education and training did not include the administration of LA, or if recency of practice was not maintained. A practitioner with a LA exclusion cannot administer LA.

Educators' views on practising conditions for administering of LA

Both oral health programmes were asked if they had a view from an educational perspective as to what the appropriate practising conditions ought to be for a dental hygienist to administer LA.

Both expressed the view that direct clinical supervision is not required for this activity, and should be carried out within the same practising conditions as a dental hygienist's overall scope of practice (currently clinical guidance).

Council's conclusion

Based on the educational comparison and risk assessment, there appears to be no reason why a dental hygienist cannot administer LA within a consultative professional relationship and without direct clinical supervision, the same as an oral health therapist.

To enable this, the dentist would need to issue a standing order which specified the circumstances under which the dental hygienist could administer LA.

6.2 Application of prescription preventive agents

In the dental hygiene scope of practice, 'application of prescription preventive agents' principally describes the application of high concentration fluoride (typically fluoride varnish) for the management of tooth surface sensitivity or dental caries; and is currently performed under *direct clinical supervision.*

The Council considers that the application of prescription preventive agents could be performed equally well within a consultative professional relationship and without the need for the dentist to be on-site, with no increased risk to patient safety.

To enable this, the dentist would need to issue a standing order which specify the circumstances under which the dental hygienist could apply fluoride varnish.

As diagnosis of dental caries is not in the dental hygiene scope of practice, it is presumed that the decision to apply a high concentration fluoride as part of a caries management strategy would be made by the dentist.

Similarly, when tooth surface sensitivity is not a direct result of the dental hygiene treatment performed, it is presumed that the dental hygienist would refer the patient to the dentist for assessment. Subsequent management may involve application of high concentration fluoride.

6.3 Orthodontic activities for dental hygienists

The Council considers that direct clinical supervision remains appropriate for the orthodontic activities currently specified in the dental hygiene scope of practice as being provided under *direct clinical supervision*. This is consistent with the provision of the same activities in the OHT scope of practice.

This view is based on the information received from University of Otago and AUT University, and the views they expressed during the development of the OHT scope of practice.

The Council is proposing that for clarity and consistency, the term *direct clinical supervision* and its associated definition are removed from the dental hygiene scope of practice, and that the orthodontic activities currently specified in the dental hygiene scope of practice as requiring direct clinical supervision are prefaced by the same wording as in the OHT scope of practice, namely:

> assisting the dentist or dental specialist in implementing orthodontic treatment plans, as directed by the dentist or dental specialist who is responsible for the patient's clinical care outcomes and is on-site at the time, through performing the following procedures:

This proposal is dependent on the removal of direct clinical supervision from the administration of LA and application of prescription preventive agents.

7. Assessment of medical history in dental hygiene practice

In the current working relationship practice standard for dental hygiene, it states that the dentist:

- "**should** be responsible for the initial assessment of the patient's medical history (as part of the patient's overall treatment plan) and be available for advice regarding the subsequent medical history reassessments performed prior to, but associated with, on-going hygiene treatment /maintenance."; and

- "**should** be the first team member to examine any new patient to a practice to diagnose the disease processes for that patient – the dentist/dental specialist formulates an overall dental care plan and makes a referral to the hygienist where appropriate".

Within these documents "should' statements are intended to guide behaviour – they are not obligations.

Dental hygienists practise as part of the dental team and work collaboratively with other oral health practitioners and health practitioners to provide comprehensive care to the benefit of patients' overall health. They are responsible and accountable for their own clinical practice, like all oral health practitioners.

While the majority of dental hygienists practise alongside a dentist in the same practice location, patients have, for some time, been able to access hygiene care directly from a dental hygienist in New Zealand, not only through dentist referral. Dental hygienists can also provide domiciliary care, remote from the dental practice.

Dental hygienists already use their professional judgement at both the initial hygiene assessment and subsequent hygiene visits, to identify medical histories that may have implications for care, and to seek professional advice from a dentist when needed.

The proposed consultative professional relationship will enable the dental hygienist to seek advice about a patient's medical history, in the same way as the clinical guidance arrangement does currently. The point already cited in the risk assessment section of the administration of LA (page 12) highlights this area as a point for discussion between the oral health practitioner and dentist.

The guidance in the current working relationship document that the dentist should do the initial assessment of the medical history and be the first team member to examine any new patient no longer reflects present-day dental hygiene practice in New Zealand.

The Council does not see any increased risk to patient safety with the loss of these guidance statements in the current working relationship (as stated above) which have not been replicated in the draft guidance for the consultative professional relationship.

8. Summary of proposed changes for dental hygiene scope of practice

Proposals:

7. All activities in the dental hygiene scope of practice be performed within a consultative professional relationship **without** the need for clinical guidance or direct clinical supervision for the administration of local anaesthetic and application of prescription preventive agents.

   Direct clinical supervision will remain for dental hygienists undertaking orthodontic activities currently specified as being performed under direct clinical supervision. The specific requirements for the dentist to: implement the orthodontic treatment plan; be responsible for the patient's clinical care outcomes; and be on-site at the time of the orthodontic activities being performed, to be included in the relevant scope activity description.

8. The clinical guidance and direct clinical supervision definitions to be removed from the dental hygiene scope of practice.

9. Update the Medical emergencies practice standard to require dental hygienists to have access to and obtain the necessary training to safely administer adrenaline (1:1000) to manage an anaphylactic event (with an implementation period of a year to allow for training to occur).

10. Update the dental hygiene scope of practice to reflect current practice, with the following activity being performed within the proposed consultative professional relationship:

    obtaining and ~~re~~assessing medical and ~~dental~~ oral health histories

11. To not replicate the guidance ('should statements') in the current dental hygiene working relationship relating to a patient's initial assessment into the new consultative professional relationship guidance document.

    The draft consultative professional relationship guidance document contains the following guidance:

    Identify any specific circumstances where you expect the oral health practitioner will ask for professional advice or assistance, for example:

    - *The interpretation of significant or complex medical histories and their potential influence when providing oral health care, including when planning to administer local anaesthetic.*

9. Orthodontic activities for orthodontic auxiliaries

No changes to the practising conditions for the orthodontic auxiliary scope of practice are proposed; direct supervision for all scope activities will remain.

Minor changes to the scope of practice wording are proposed for consistency with the oral health therapy and dental hygiene scopes of practice. These changes are not considered to change the nature of any of the orthodontic activities currently performed by orthodontic auxiliaries.

The proposed changes can be seen as tracked changes in the orthodontic auxiliary scope of practice (Appendix E).

Proposal:

12. Make minor wording changes to the orthodontic auxiliary scope of practice to align the description of the same activities across the relevant scopes of practice.

List of attachments to reflect proposed changes

The following documents are presented with proposed changes to give effect to the proposals contained in the consultation document.

A. Guidance for the consultative professional relationship between an oral health therapist, dental therapist, dental hygienist, or orthodontic auxiliary and dentist/dental specialist
B. Guidance for the professional relationship between a dental technician or clinical dental technician and other health practitioners
C. Dental hygiene scope of practice
D. Dental therapy scope of practice
E. Orthodontic auxiliary scope of practice
F. Dental technology scope of practice
G. Clinical dental technology scope of practice.

Consultation questions

Stakeholders are invited to comment by responding to the following questions:

Do you agree/disagree with the following proposals? Please detail why.

Working relationship

1. Retain a 'working relationship' as a scope of practice requirement for the dental therapy, dental hygiene, oral health therapy and orthodontic auxiliary professions.

2. The current working relationship for dental therapy, dental hygiene and orthodontic auxiliary practice be redefined as a *consultative professional relationship*, in line with oral heath therapy.

3. The consultative professional relationship be defined as:

   The arrangement between an oral health practitioner and dentist to provide professional advice about treating and managing patients, within the oral health practitioner's scope of practice. It provides a clear and reliable way for the oral health practitioner to seek advice, and a potential pathway for referral.

4. A signed written agreement is no longer be required for dental therapy, dental hygiene or orthodontic auxiliary practice, as it is anticipated that practitioners will reliably meet their responsibilities in the consultative professional relationship, consistent with the position held for oral health therapy. Practitioners may still choose to have a written agreement, or employers may require one.

5. Describe the current *working relationship* for dental technology and clinical dental technology practice as a *professional relationship* between a technician and other health practitioners, to acknowledge the professionals involved and the oral health practitioners' professional obligations under the standards framework.

   No changes to the nature of this relationship are proposed, or to the current professional responsibilities of practitioners in this relationship.

6. Remove the multiple 'working relationship' practice standards from the standards framework for oral health practitioners, and to publish the following two guidance documents to help practitioners understand and meet their professional relationship responsibilities:

   - Guidance for the consultative professional relationship between an oral health therapist, dental therapist, dental hygienist, or orthodontic auxiliary and dentist/dental specialist.
   - Guidance for the professional relationship between a dental technician or clinical dental

Consultation questions (continued)

Practising conditions for dental hygiene activities

7. All activities in the dental hygiene scope of practice be performed within a consultative professional relationship **without** the need for clinical guidance or direct clinical supervision for the administration of local anaesthetic and application of prescription preventive agents.

   Direct clinical supervision will remain for dental hygienists undertaking orthodontic activities currently specified as being performed under direct clinical supervision. The term 'direct clinical supervision' be replaced with a description of the requirements; to be included in the scope of practice wording that prefaces the relevant orthodontic activities (for consistency with the oral health therapy scope of practice).

8. The clinical guidance and direct clinical supervision definitions to be removed from the hygiene scope of practice.

9. Update the Medical emergencies practice standard to require dental hygienists to have access to and obtain the necessary training to safely administer adrenaline (1:1000) to manage an anaphylactic event (with an implementation period of a year to allow for training to occur).

10. Update the dental hygiene scope of practice with the following activity being performed within a consultative professional relationship:

    obtaining and ~~re~~assessing medical and ~~dental~~ oral health histories

11. To not replicate the guidance ('should statements') in the current dental hygiene working relationship relating to a patient's initial assessment into the new consultative professional relationship guidance document.

    The new consultative professional relationship guidance document contains the following guidance:

    Identify any specific circumstances where you expect the oral health practitioner will ask for professional advice or assistance, for example:

    - *The interpretation of significant or complex medical histories and their potential influence when providing oral health care, including when planning to administer local anaesthetic.*

Minor scope changes for orthodontic auxiliary practice for consistency across activities

12. Make minor wording changes to the orthodontic auxiliary scope of practice to align the description of the same activities across the relevant scopes of practice.

General

13. Any further comments not yet made?