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

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, OHT and orthodontic auxiliary professions.**

Response: Qualified agreement
When patients are involved in receiving oral health care from multiple practitioners there is a need for effective working relationships to better ensure safe and appropriate care for those patients.
Team based care is the most desirable and effective.
Consultation is essential, but teams work better with a designated lead clinician rather than a consultative arrangement. This is where aspects of structured clinical guidance, supervision etc are beneficial to patients seeking appropriate, safe care (see answers to Q9) and improved oral health (Q11).

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 health therapy.**

Response: Qualified agreement
For better patient outcomes, there needs to be a clear demonstration in writing that a suitable agreed consultative relationship and process thereof, is in place. (see answer Q4)
Our support of this proposal would be stronger if Council maintained the requirement for a written working relationship agreement.

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.

Response: Qualified agreement
There are benefits and also risks when more than one practitioner is involved in sequenced combined components of patient care. As time passes the ongoing commitment to the working relationship has the potential to move to habitual default settings.

In our view it is entirely preferable (patient and practitioner interests) to have a recorded agreement to refer back to lessen the chance of relationship drift.
We strongly believe '*clear and reliable*' will certainly be enhanced and, in many situations, only achieved, if a written agreement is in place. (Also see concerns/answers to Q9, 11).

4. A signed written agreement 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.

Response: Strongly disagree
In our view the Council needs to take a stronger position than, *'it is anticipated that practitioners will reliably meet their responsibilities in the consultative professional relationship'* and at least stipulate there must be a written agreement in place, demonstrating the discussed and agreed basis of such relationship within the practice.

Reasons:

- Written agreements give structure, minimise misunderstandings, increase understanding and provide better clarity to descriptions of, and responsibilities within, working relationships.
- In the context of the various practitioners involved (dentists/ dental specialists on one hand and hygienists/ therapists on the other) and services thereby delivered to patients, such a consultative working relationship (with no longer clinical guidance / direct supervision) is new.

and

- The Council has already identified two type written pages of '*Responsibilities of Practitioners*' involved and, three type written pages of '*Suggested items of substance that should be included in the consultative professional relationship'.* Our view is that it is best to have them outlined and agreed on paper. i.e written agreement.

and

- Amongst the full cohort of practitioners across NZ attempting this new consultative working relationship, there is likely a large range of abilities and understandings of what is required (inclusive of change) and of approaches to meet the requirements.

and

- It is our belief that through the active process of the practitioners within a working relationship (in this case - consultative) having to not only consult, but agree to a written set of responsibilities / suggested items of substance, will increase the chance that more adequate discussion and foundation exists within the new working relationship.

Further:

- The ability to meet and review an agreement is likely to lessen 'drift' into patterns of less than optimum coordination of care. Professional working relationships evolve over time and as such periodic review being recorded in written agreements is advisable.
- It is not usual for Council to rely on a notion of expectation that '*practitioners will reliably meet responsibilities'*. Council requires practitioners to record in writing (and for reference) many aspects of treatment and treatment delivery. There are many written practice protocols required, and in our view, this working relationship should be one of them.
- Patient redress - Less likelihood of poor care exists when practitioners are clear about their own responsibilities and their part in joint responsibilities. With respect to redress, it is our experience that when a patient complains that care was not adequately provided, then both the patient and those who contributed to that care (having joint responsibility for the outcome), are better served if the practitioners at least have a written understanding as to who is, has been or should have been responsible for:
- aspects of the care in general
- the coordinated process of care delivery
- the connection between the elements of care provided – what is individual and what is shared responsibility.

Summary

- There is new ground here and it is our position, from the outset and particularly over time, that written agreements are necessary to provide clarity of what responsibilities both parties have within and to, the consultative professional relationship. We believe patients and practitioners are likely better protected when written working relationship agreements are in place.

We urge the Council to retain the requirement for written working relationship agreements.

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.

Response: Agreed.

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**

Response: Concerns. but with addition of written consultative relationship agreements and please see our questions / concerns relating to medical emergencies Q9

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).**

Response: Our concerns are expressed in the previous and in the following answers to questions Council has set.

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

Agreed if done in conjunction with resolving issues / concerns expressed in previous (Q4) and following answers (particularly Q9).

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).**

Agreement dependent on adequate answers to the following questions.

The proposal is to mandate adrenaline being available for the dental hygienist to administer presumably in line with the DCNZ Medical Emergency Standard. The proposed changes also lead to dentists and dental specialists not providing direct supervision i.e also not being on site.

Access to adrenaline

Cardiac Arrest

The Council's Practice Standard states, in event cardiac arrest the Advanced Life Support algorithm (ANZCOR version) is to be used (see flowchart page 15 DCNZ Medical Emergencies Practice Standard 2019 version). This involves IV or IO use of adrenaline.

- Given the dentist will no longer necessarily be on site, is Council proposing that dental hygienists will be trained and able to administer adrenaline IV so as to be able to meet the Practice Standard?
- Given the potential outcome of cardiac arrest and adequate adrenaline being or not being delivered and / or the consequence of not having adrenaline available, is Council stating a written agreement between parties is not required to specifically allocate responsibility regarding access to adrenaline and its administration?
- When / if there is a significant medical event, is the Council willing to accept, that at some point in the past (perhaps years earlier) the parties 'consulted' on adrenaline availability and assurances of training, without any record of such consultation let alone the agreed decision that resulted from the consultation i.e nothing in writing – no written agreement?

Anaphylaxis

- The Council's Practice Standard requires adrenaline to be administered IM and, in the event of the patient entering shock, IV access be obtained for the administration of rapid saline infusion. The same questions listed above apply to this proposal.

Anaphylaxis / Shock

- The Council's Practice Standard requires adrenaline to be administered IM and, in the event of the patient entering shock, IV cannulation for the IV administration of rapid saline infusion. Will such IV access be the responsibility of the hygienist or the dentist/ dental specialist who is no longer required to be on premises?

Access in general

Council is proposing hygienists having access to adrenaline be a requirement.

- What about Glyceryl trinitrate and
- Salbutamol?

Amending the Scope of Practice.

Sedation

It is not uncommon for hygiene patients to have their care provided under sedation although it is not previously outlined in the Dental Hygiene scope of practice.

- Should there be clear information presented in the scope (statements replicated from the Conscious Sedation Practice Standard) concerning the need for a dentist to be present and administering any sedation?

General adverse medical events

- Given that the suggested changes will likely result in more absence of the dentist from the practice whilst hygienists are working (utilising LA etc) is the Council satisfied that the training these practitioners receive adequately prepares them to recognise and act 'alone' in situations of angina, myocardial infarction, asthma, choking, hypoglycaemia, epileptic seizure etc

10. Update the dental hygiene scope of practice with the following activity being performed within a consultative professional relationship:
obtaining and r[illegible]ssessing medical and dental oral health histories.

Response: Agreed but with qualifications (see Q11) **and** additionally it is our view that neither practitioner within the consultative working relationship should rely on the other's assessment of the medical history or oral health history.

Perhaps this should be stated in any written working relationship agreement.

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.***

The Association disagrees with the removal of 'should statements'.
The detail of these 'should statements' was not included with the material in the consultation documents. It is likely respondents may well have overlooked this material.

The existing guidance document from the Council website states:

In relation to examination and timely advice on procedures and in keeping with the clinical guidance and/or clinical supervision relationship between the dental hygienist and dentist/dental specialist, the dentist/dental specialist should:

a) 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;
b) 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;
c) collaborate with the dental hygienist regarding the ongoing periodontal health status of the patient receiving hygiene treatment – the dentist/dental specialist should provide an ongoing yearly review of the periodontal status of the patients within his/her practice;
d) be available for timely advice regarding any hygiene treatment needs. If the dentist/dental specialist, whose role it is to provide the clinical guidance for the hygienist, is off the premises and not contactable, another dentist/dental specialist should be contactable for such guidance; and
e) be prudent regarding such availability when a new graduate hygienist is employed or contracted to provide hygiene services – recognition should be given to the need for added support for this group of hygienists.

These are very relevant and, in our view, sensible indications as to what should happen.
It is the Association's view that these 'should statements' be retained in any new documentation.
We hold this view because:

- A significant benefit and driver for team care is the delivery of better sequenced 'comprehensive' care i.e care that better outlines the full set of problems and options to address all of those with appropriate priority sequencing.

- Patients are better served (safer care, better diagnosis and initial patient practitioner discussions) if seen by the general dental practitioner whose knowledge extends across the delivery care spectrum rather than by a clinician providing a subset of the general care.

Further
Whilst reviewing the current the current working relationship guidance document we note it also states:

The dentist/dental specialist is responsible for the overall management of the patient's dental health within a team service delivery system.

This existing statement confirms for us a significant dynamic within the team delivery and leads us to the question with respect to the Council's proposed amendments:

- Will the dentist / dental specialist still be the practitioner responsible for the overall management and will this be clearly outlined in the new documentation?

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.

In the reworded scope of practice for orthodontic auxiliary practice, Council is proposing, orthodontic auxiliaries and dentists are to have a *consultative professional relationship*.

Council is also proposing in the same consultation document that, by definition, a *consultative professional relationship* only mandates the 'seeking of advice' when required.
Council is also proposing the auxiliary is to practise under the 'direction' and direct supervision of the dentist/ orthodontist and who is onsite at the time care is being provided.

How does this form of *consultative professional relationship* (i.e being that of also taking direction under direct, onsite supervision) fit the Council's described definition of just *seeking advice when required*?

If there is some way of reconciling – *consultative* with taking *direction under direct onsite supervision*, what is it that makes administering LA, and conducting dental / surgical interventions (i.e what a hygienist does) suitable for '*consultative professional relationship'* without clinical guidance or direct supervision whilst orthodontic auxiliary care needs to be *consultative professional relationship requiring direction and direct onsite supervision* by a dentist or orthodontist?

The NZDA does not understand why Council believes it is not an advantage for patient safety, protection and treatment outcomes to have clinical guidance / direct supervision for the treatment planning and the invasive / often irreversible aspects of dental hygiene yet does require such of a dentist led team approach for orthodontics.

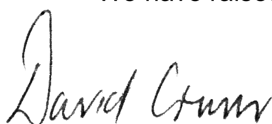
General

13. Any further comments not yet made?

NZDA is largely supportive of much of the proposed changes but expresses the following concerns:

- We are very much opposed to removing the mandatory and sensible safeguard of written professional relationship working agreements.
- We wish to have the 'should statements' retained as they are appropriate indicators of what should happen.
- We believe there are incongruities in what is described as the proposed working relationship between dentists / orthodontists and orthodontic auxiliaries.

We have raised a range of questions within this feedback and would appreciate a response to those.



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