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Consultations
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Sent via email only

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

Thank you for providing us with the opportunity to comment and to ask questions regarding the above matters.

The requirement for a professional relationship

1. Do you agree/disagree with the proposal to remove the mandated requirement for a professional relationship (dental therapy), working relationship (dental hygiene, orthodonticauxiliary practice), and a consultative professional relationship (oral health therapy) from the respective scopes of practice. Please detail why.

Disagree
Reasons:
The Dental Council's primary purpose is to protect the health and safety of the public.

It remains the Association's view that, when patients are involved in receiving oral health care from multiple practitioners (some of whom, in relation to the others, have relatively limited breadth to their scopes of practice), there is a need for a lead clinician. The lead clinician should be involved from the outset, to better ensure safe and appropriate diagnosis, treatment planning, informed consent and clinical care for those patients.

Clearly incorporated and described elements of 'consultation', structured 'clinical guidance', 'direct / indirect supervision' etc are beneficial to patients seeking appropriate, safe care, and improved oral health.

Q 1:
The Association appreciates the collaborative view expressed in the Council's standards, but requests the Council provide their reasons as to why they believe the public are better or equally well protected through the removal of these currently mandated requirements from the various scopes of practice.

2. Do you agree/disagree to remove references to working/professional/consultative professional relationships from the dental therapy, dental hygiene, orthodontic auxiliary practice, oral health therapy, dental technology and clinical dental technology scopes ofpractice? (as detailed in Appendices A – F) Please detail why.

Disagree, see response Q1
Further comment:
In the first consultation, the Council proposed removing the guidance ('should' statements) from the current dental hygiene working relationship relating to the initial patient assessment. In terms of patients continuing to receive full diagnosis, appropriate treatment planning, and informed consent relating to their entire oral health condition, it is important to us that this guidance not be removed.

There has been no disclosure as to why the Council considered that removing the existing guidance statements would maintain or improve the safety of the public; nor has this been specifically considered in the context of this consultation (no questions related to this).

It is a reasonable assumption that the Council has decided the 'guidance statements' will be removed, and if that is the case, then the Association strongly objects to that course of action.

The Association reiterates in this submission; our position is that we fully support the current guidance statements, we believe they guide practitioners to provide safer care and better outcomes for patients.
The existing guidance statements are:

> *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.*

It remains our view that whatever the Council decides, these guidance statements should remain and that they are proactively circulated to all practitioners involved. The alternative of removing this guidance, indicates that Council no longer believes the guidance is appropriate or important.

We hold the view regarding their importance 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 general care.

Further, as we previously submitted
Whilst reviewing the current working relationship guidance document we noted 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:

Q 2:
Will the dentist / dental specialist still be the practitioner responsible for the overall management or is it the Council's current view that this is no longer the case?

Q 3:
In the context of ensuring public safety, what are the reasons for the Council holding their view?

Q 4:
Will the Council's view be clearly outlined in the new documentation?

Practising conditions for dental hygiene activities

Within the context of the revised proposal to remove the scope of practice requirement for a working relationship for dental hygiene:

3. Do you agree/disagree with the removal of the requirement for direct clinical supervision for administration of local anaesthetic and prescription preventive agents? Please detail why.

Disagree – with respect to LA.
Reason – this change means the dentist /dental specialist will now no longer be required to be onsite during the administration of LA by the hygienist.

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.

Q 5:
Will such IV access be the responsibility of the hygienist or the dentist/ dental specialist who is no longer required to be on premises?

The fact that the dentist and dental specialist will no longer be on site, also leads us again to seek answers to the following questions.

Q 6:
When / if a patient suffers a cardiac arrest, and the dentist or dental specialist is not present, who is the Council stating will be responsible for the delivery of the actions described in the Practice Standard (IV, IO use of adrenaline)?

Q 7:
To meet the Practice Standard, when either the use of glycerol trinitrate or salbutamol are required to alleviate medical emergencies, who is responsible for administering that in the absence of the dentist/ dental specialist?

Q 8:
How is what is being proposed, maintaining or improving patient safety?

Q 9:
Is the Council proposing to amend the Practice Standard such that there will be different Standards relating to the care of patients suffering anaphylaxis, dependent on the registration category of the practitioner?

Q 10:
Does Council have direct evidence that dental hygienists have the training to meet the Council's practice standard (Medical Emergencies IV administration etc) and that they can ably do so in the absence of a dentist being on the premises

4. Do you agree/disagree with the removal of clinical guidance for the remainder of the dental hygiene scope activities? (excluding the orthodontic activities currently defined as being performed under direct supervision). Please detail why.

Disagree – the Association supports the retention of clinical guidance as an important part of patients receiving oral health care via dentists / dental hygienists. We have covered this in our previous submission.

5. Do you agree/disagree to align the description of the following scope activity with currentdental hygiene practice in the following way: *obtaining and ~~re~~assessing medical and ~~dental~~ oral health histories?* Please detail why.

Agreed but with qualifications it is our view that neither practitioner within a working relationship should rely on the other's assessment of the medical history or oral health history.
Should the Council decide to retain the Guidance statements, then perhaps this could also be included.

General

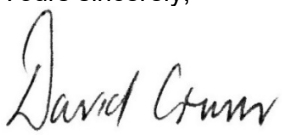
6. Any further comments?

The Association's previous submission was largely supportive of much of the proposed changes but expressed the following concerns which we reiterate here:
We are very much opposed to removing the mandatory and sensible safeguard of written professional relationship working agreements. There is clear benefit for all practitioners involved in retaining these agreements in writing. They result in improving clarity of responsibility of shared care. It seems apparent that the Council does not share our view.

Q 11:.
In the context of patient safety, could the Council please outline to us why they believe these agreements should no longer be mandated?

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

Yours sincerely,



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