From: [redacted]
To: dentalboardconsultation
Subject: Submission re draft Scope of Practice
Date: Monday, 17 June 2013 7:42:23 PM
Attachments: ADA response..pdf
ADA Nat dent Update.pdf

To who it may concern.

A as a practicing Dentist I am very concerned regarding these proposed changes to the scope of practice. I do not feel the proposed changes will advance the quality of patient care in any way and ultimately feel that the objective will harm the dental profession as a whole.

I have to say that I wholeheartedly agree with the view taken by the Australian Dental Associations combined response as sent to Ms Tanya Vogt on the 13th May 2013. (attached)

Yours
Christopher J Carter BChD
Principle Dentist
CJ Carter Dental
Maroochydore
Queensland

AUSTRALIAN DENTAL ASSOCIATION INC.

Incorporated in the ACT ARBN 131 755 989

14–16 Chandos Street St Leonards NSW 2065

All Correspondence to:
PO Box 520 St Leonards NSW 1590

13 May 2013

Ms Tanya Vogt
Executive Officer
Dental Board of Australia
GPO Box 9958
Melbourne VIC 3001

Dear Tanya,

Re: Scope of practice within workplace policies and new models of care

Thank you for seeking additional feedback from the Australian Dental Association Inc. (ADA) to assist with the Dental Board of Australia's (the Board) review of the Scope of practice Registration Standard (the standard).

We note that the Board is seeking specific advice in relation to only:

1. Any workplace policies that provide details as to how dental hygienists, dental therapists and oral health therapists work within their scope of practice within the workplace, and

2. Information regarding any new models of care or training being undertaken or considered for all dental practitioners.

Noting that the Board has separately called for detailed submissions on the Scope of Practice Standard, the ADA will opine that it is not possible to consider these two issues raised without making passing reference to the wider and more general "scope of practice" issues, as it is the very scope of practice which determines and defines the manner in which dental practitioners are employed and engaged in daily practice. The scope of practice defines the construct of any workforce policies and so must define models of care and training. The ADA is supportive of the existing DBA scope of practice standard remaining.

One of the major purposes of the move to national registration was to remove the variances in scope of practice and training of dental providers in each state. This has been complicated with the establishment of Oral Health Therapist courses by some universities with differing curricula.

1. **Workplace Policies**

Attached is a copy of the ADA's Policy Statement 3.3 – Allied Dental Personnel (Attachment A). This policy provides the ADA's position on the role of each allied dental practitioner within a dental team. ADA members, as employers, adhere to these principles. This policy reflects the limits on training received by allied dental practitioners and the resultant scope of practice. It further gives guidance as to effective workplace clinical governance modelling policies.

Given the massive workforce oversupply issues with dentists, now acknowledged by the HWA, expanding the scope of practice of lower level providers seems unnecessary. Some universities have acknowledged this and have gone as far as to withdraw courses.

It should also be noted that there is only limited demand for these personnel within the workforce. Approximately 90% of the dentist workforce operate within the private practice environment in one or two-person practices. In general, these practices do not have a need for or employ oral health therapists and in most cases where someone with either a dual qualification in hygiene and therapy or a bachelor of oral health qualification is employed, they are engaged to provide hygiene services. The dentist profession's preferred allied dental practitioner is a hygienist. This is reflected in the attached ADA policy document.

Therefore, in order to ensure clarity among ADA members as to the scope of practice of hygienists and therapists, the ADA has promoted and advocated that the treatment provided by a dental hygienist or a dental therapist must fall within the duties as outlined in the attached policy statement.

By defining the range of treatments that can be provided it will leave little doubt as to what duties are to be performed within the scope of practice and will allow the regulatory bodies such as the DBA and ADC to determine the scopes and competencies with clarity.

There seems to be an opportunistic push by some state based dental health services to utilise allied dental practitioners to provide a broad range of adult dental services on the assumption that cost savings will occur and that such actions will satisfy remote and very remote dental manpower issues. Both of these claims are unfounded and there is a distinct paucity of evidence anywhere in the world to support these claims. Where some evidence exists, it is generally based in countries that have very different dental service models to that which occurs in Australia. Many of these countries are aspiring to the "dental team" concept which currently is enjoyed and promoted in Australia. The profession has embraced and employed hygienists in both public and private practice. The utilisation of these allied dental practitioners under the prescription and

supervision of dentists has increased productivity. These ill founded calls to address remote workforce issues by scope of practice alteration will leave existing services to children under-resourced. Moving a practitioner from an area for which they have been trained in child dental care into the adult sector will only create a gap in child care – the very area for which this practitioner was trained.

Evidence put forward based upon hygienists being capable of carrying out comprehensive dental examinations with as little as 3 hours additional tuition is downright dangerous yet seems to be entertained by the DBA. One such study was based upon 4 allied dental practitioners examining a cohort of patients who had been identified as being in need of obvious dental care and requiring referral to a dentist. With these paramenters in place, it concluded that hygienists were therefore in all cases capable of performing competent oral examinations. This demonstrates a flawed methodology and thus gives rise to false conclusions.

Another study concluded that with minimal tuition therapists could perform simple restorative care in adults on the basis that the simple restorations placed in adult teeth by therapists were deemed satisfactory 6 months after their provision. It was thus concluded that therapists could perform simple restorative care as good as that of new graduate dentists on this basis. Again this reasoning is flawed.

The fact that the DBA can even entertain expanded scope of practice for auxiliaries based upon such flawed evidence is a significant concern.

Long term evidence exists in Australia that strongly questions whether there is any cost saving or solution to remote and very remote dental service supply. Prosthetists mounted a very strong campaign for independent practice and for expanded scope of practice on the basis they would be at least 20% cheaper than dentists for the same services and would solve remote and very remote access to dental care. Neither claim has proved to be correct and evidence exists of prosthetists in fact being more expensive than dentists. They have, for the last decade, campaigned to the Deptartment of Veteran Affairs and to Private Health Insurers for parity of fees and rebates with dentists as the original fees/rebates were struck at 20% less than dentist fees based on their original claims of being cheaper. The Public, Government and Regulatory Boards were misled. The same claims are once again being made for independent practice and expanded scope of practice.

As a service to members and in order to ensure that ADA members engage and employ hygienists within their scope of practice, the ADA has commissioned the development of professionally created job descriptions for dental hygienist positions within practices (Attachment B). This job description has been designed to capture all of the authorised activities of a dental hygienist. Members are advised to modify it based on the competencies of the individual being employed.

The ADA notes that there is also a range of documents publicly available which provide an insight into the actual role of allied dental practitioners that the Board may wish to consider in its

deliberations. For example, attached is an excerpt from a recent WA Health job advertisement for a dental therapist (Attachment C).

Also enclosed is a copy of the relevant section of the Western Australian Dental Act which existed prior to the introduction of national registration. This Act specified the scope of practice of a dental therapist and dental hygienist and as such provided a significant level of clarity for all interested parties (Attachment D).

In conclusion, the ADA believes there would be great value if the Board were to provide a similar level of detail in its documentation.

2. New Models of Care/Training

The ADA is not aware of any new models of care or training requiring any change in the scope of practice of allied dental practitioners. In fact, given the existing and projected oversupply of the dentist workforce and their current under-utilisation, it is unlikely that there will be any need for workforce reform in the near future. What is paramount is the preservation and enhancement of current safety and quality standards. If there are perceived deficiencies in workforce numbers, the priority should be to provide the most qualified and well trained professional, not use stop gap measures that compromise the public in both quality and safety.

The issue that has now surfaced is that the ADA is concerned as to there being any value in the continuation of Oral Health Therapists. The overwhelming opinion of the profession in Australia, and it appears overseas as well, is that the hygienist is the preferred auxiliary dental practitioner; with some argument that the dental therapist be the preferred "cutting" auxiliary restricted to school children only.

Dental science has evolved with research and development in line with the review of public health measures. The evidence of the benefits of 'prevention based oral health care' is clear and the current scope of practice supports an allied dental workforce that is prevention focused. There currently is a significant oversupply of skilled dentists to undertake the restorative and exodontia treatment required. This oversupply will remain for quite some time.

Allied dental practitioners are lower level providers (than a dentist) who best operate within a team environment and under the supervision of a dentist. Their training leading to qualification to be able to practise is based on the premise of this supervisory arrangement being in place and does not provide the graduand with the level of critical thinking and diagnostic skills required for independent practice.

The ADA would also strongly recommend to the Board that in determining its final position in relation to the content of the Scope of practice Registration Standard that it continues, as it is obligated to do, to place the protection of the public as the measure against which any proposed changes are made. The greater the degree of clarity in both the Standard and supplementary

Guidelines relating to scope of practice, the lesser the margin for confusion by the relevant practitioner, education providers and the public.

These issues will be addressed in greater detail in the ADA's response to the Scope of practice paper.

Yours sincerely,

Dr K Alexander
Federal President

Enc.

Telephone: (612) 9906 4412 Facsimile: Administration (612) 9906 4676 Executive (612) 9906 4736 Publications (612) 9906 4917
Email: adainc@ada.org.au Website: www.ada.org.au

Attachment B

Job Description for the Position of

Dental Hygienist

AUSTRALIAN DENTAL ASSOCIATION INC.

Last Review Date: 22 May 2012

Incumbent:	*[Insert name of employee]*	
Job analysts:	*[Insert name of job analyst]*	
Sign off:		**Sign off:**
Role Overview:	The duties of the dental hygienist include managing frequently encountered gingival conditions and chronic adult periodontitis, cleaning and polishing teeth, instructing patients in oral hygiene and post-operative care for dental treatments rendered, providing other preventative dental care, work chair side as needed in conjunction with the dentist. Working to the prescription of the dentist and only within the scope of their competence and training.	
Reporting Relationships:	*[Insert title of direct report]*	
Supervisory Responsibilities:	N/A	
Qualifications:	Graduates from a dental hygiene programme, with either an advanced diploma (TAFE), associate degree, or more commonly a bachelor's degree from a dental hygiene school that is accredited by the Australian Dental Council (ADC).	
Skills & Experience:	• Good hand-eye coordination • Manual dexterity • Good communication skills • To be able to work as part of a team. • Empathy skills	

Key Scorecard

This provides a high level snapshot of the expected outcomes from this role and the relative importance of each competency. This should be used by the employee on an ongoing basis as a quick reference to determine how he or she is performing in the role.

Key Competency	Relative Weighting
Technical Competencies	
1. Perform treatment	9 %
2. Patient relationship	9 %
3. Record accumulation	9 %
4. Communication with Dentist	9 %
5. Continuing education	8 %
6. Dental team	8 %
7. Clinical records	8 %
8. Equipment maintenance	8 %
9. Hand instrument maintenance	8 %
10. Infection protocol	8 %
11. Practice treatment philosophy	8 %
12. Patient instruction	8 %
Subtotal	**100%**
Personal Competencies	
1. Accepts direction	15 %
2. Accuracy / eye-for-detail	15 %
3. People management skills	14 %
4. Teamwork / Cooperation	14 %
5. Confidence	14 %
6. Empathetic	14 %
7. Listening skills	14 %
Subtotal	**100 %**
Grand Total	**200 %**

Technical Competencies

These describe the key outcomes that are to be achieved in the role and the precise performance standards against which the performance of the employee will be measured.

No.	Competency Description
1.	**Perform treatment** Perform treatment such as cleaning known as prophylaxis, scaling and root planning for patients with periodontal disease, and providing instructions for proper oral hygiene and care.
2.	**Patient relationship** Establish relationship with patient.
3.	**Record accumulation** Accumulates appropriate records fully and accurately.
4.	**Communication with Dentist** Ensure communication with Dentist in order to perform treatment.
5.	**Continuing education (CE)** Participation in CE and developing professional competence.
6.	**Dental team** Develops working relationship with the dental team.
7.	**Clinical records** Keeps the clinical records consistent with the requirements of the practice and the Dentists Act.
8.	**Equipment maintenance** Maintains the equipment and instruments.
9.	**Hand instrument maintenance** Maintain and manage hand instruments.
10.	**Infection protocol** Infection control protocols and practices are applied.
11.	**Practice treatment philosophy** Meets the practice treatment philosophy (PTP).
12.	**Patient instruction** Responsible for patient instruction in home care personal oral hygiene.

Personal Competencies

These are the personality traits and characteristics that are considered to be most important in the carrying out of the function and the achieving the objectives.

No.	Competency Description
1.	**Accepts direction** Accepts the Dentist's clinical direction and recommendations for patient care.
2.	**Accuracy / eye-for-detail** Demonstrates a concern for accuracy at every stage and in every aspect of a task. Being able to attend to all requirements of a task and implement processes of checking and follow-up.
3.	**People management skills** The ability to interact appropriately and successfully with people of all different types and at different levels.
4.	**Teamwork / Cooperation** The ability to work with other people towards a common goal. To establish effective collaborative relationships with other people in the practice.
5.	**Confidence** A quality of self-reliance. A confident person has a belief in their ideas and opinions and a willingness to express and act on them.
6.	**Empathetic** The ability to perceive and understand the feelings of others.
7.	**Listening skills** The ability to closely give attention to someone.

ATTACHMENT E

Government of **Western Australia**
Department of **Health**
Dental Health Services

Job Description Form

DENTAL HEALTH SERVICES

SECTION 4 - STATEMENT OF DUTIES

TITLE	CLASSIFICATION	POSITION NO.
DENTAL THERAPIST	LEVEL 3/4	Generic

BRIEF SUMMARY OF DUTIES TO BE PERFORMED LISTED IN DESCENDING ORDER OF IMPORTANCE

DUTY NO.	DETAILS	FREQ	%
1.	Provides dental care for enrolled children and where necessary refers patients according to the policies and procedures of the Branch.	D	100
2.	Maintains patient records and centre management records in accordance with Branch instructions.	D	
3.	Supervises and gives guide to Dental Clinic Assistants and student Dental Clinic Assistants.	D	
4.	Provides information on dental health to individuals, schools, community groups and health professionals and implements preventive programmes in community groups.	D	
5.	Provides statistical documentation in accordance with Branch instructions.	D	
6.	Maintains instruments and equipment in accordance with Branch instructions.	D	
7.	Carries out other duties as required.	O	

ORGANISATION CONTACTS

Will the occupant of this position be required to communicate with positions outside the normal reporting lines? YES/NO

IF YES, HOW FREQUENTLY?

1. Internal to the organisation ..... 2. External to the organisation .....

FREQUENCY: D - Daily; W - Weekly; F- Fortnightly; R - Regularly; O - Occasionally; A - Annually

50. Practice of dentistry by certain persons prohibited

(1) No person, other than a dentist, and no company shall —

(a) practise dentistry or perform any act of dentistry; or

(b) hold himself, or hold itself, out, either directly or by implication, as practising, or being prepared to practise, dentistry in any of its branches.

(2) This section does not apply to —

(a) a person who, without reward or the expectation of reward, extracts a tooth or teeth, for the immediate relief of pain, at a place not less than 50 miles by the shortest road journey from the nearest place of business of a dentist;

(b) a medical practitioner who performs an act of dentistry, not being —

(i) the preparation of a cavity in a tooth, with a view to the permanent restoration of the tooth; or

(ii) the fitting, insertion or fixing of artificial teeth, the artificial restoration of lost teeth or the mechanical construction of artificial dentures;

(c) a student of the Dental School of the University of Western Australia, under the direction of a dentist, within that University or in a place which is approved by that University for the teaching of dental students; or

(d) any person visiting the State, as an official dental clinician, for the purpose of giving professional instruction and who, although not being registered, or entitled to be registered, under this Act, performs acts of dentistry, in the course of giving the professional instruction, for a period not exceeding 12 months, pursuant to the permission in writing of the Board, which permission the Board is by, and subject to, this paragraph authorized to give; or

(e) a student who, while undertaking a prescribed course of training, performs an act of dentistry under the direction of a dentist;

(f) a dental therapist who performs under the direction and control of a dentist an act of dentistry authorized under section 50A;

(g) a dental hygienist who performs under the direction and control of a dentist an act of dentistry authorized under section 50B; or

(h) a school dental therapist who performs an act of dentistry authorized under section 50D.

(3) Every person who, or company that, contravenes the provisions of this section commits an offence.

Penalty: For a first offence, $400; and, for any subsequent offence, $2 000.

50A. Acts which may be performed by dental therapist

(1) This section applies to a dental therapist who is employed —

(a) by a dentist; or

(b) to perform acts of dentistry in —

(i) a hospital within the meaning of the Hospitals and Health Services Act 1927;

(ii) a university or tertiary educational authority established under any written law; or

(iii) the department of the Public Service principally assisting the Minister in the administration of this Act.

(2) Subject to subsection (3) and any condition, restriction or limitation imposed by the Board, a dental therapist to whom this section applies may, under the direction and control of a dentist and for the purpose of assisting that dentist in the prevention, control, or treatment, of dental disease —
(a) undertake the acts of dentistry specified in Parts 1, 2, 4, 5 and 6 of Schedule 2; and
(b) if the dental therapist —
(i) has the qualifications prescribed for the purposes of this paragraph;
(ii) has completed a course of study and training approved by the Board for the purposes of this paragraph; or
(iii) is, in the opinion of the Board, by reason of experience in undertaking those acts, competent to undertake the acts of dentistry specified in **Part 3 of Schedule 2,**
(3) A dental therapist shall not undertake the acts of dentistry referred to in subsection (2)(b) unless the dental therapist has the written approval of the Board to do so.

50B. Acts which may be performed by a dental hygienist

(1) This section applies to a dental hygienist who is employed —
(a) by a dentist; or
(b) to perform acts of dentistry in —
(i) a hospital within the meaning of the Hospitals and Health Services Act 1927;
(ii) a university or tertiary educational authority established under any written law; or
(iii) the department of the Public Service principally assisting the Minister in the administration of this Act.
(2) Subject to any condition, restriction or limitation imposed by the Board, a dental hygienist to whom this section applies may, under the direction and control of a dentist and for the purpose of assisting that dentist in the prevention, control, or treatment, of dental disease —
(a) **undertake the acts of dentistry specified in Parts 1 and 6 of Schedule 2;**
(b) if the dental hygienist —
(i) has the qualifications prescribed for the purposes of this paragraph; or
(ii) has completed a course of study and training approved by the Board for the purposes of this paragraph, undertake the acts of dentistry specified in **Part 2 of Schedule 2;** and

(c) if the dental hygienist —
(i) has the qualifications prescribed for the purposes of this paragraph; or
(ii) has completed a course of study and training approved by the Board for the purposes of this paragraph, undertake the acts of dentistry specified in **Part 3 of Schedule 2.**

50C. Supervision of dental therapist or dental hygienist

(1) Where an act of dentistry is to be undertaken by a dental therapist or dental hygienist, the dentist under whose direction and control the act is to be undertaken shall —
(a) examine the patient —
(i) before the treatment commences; and
(ii) after the treatment within such time as is prescribed;and

(b) if not in full-time attendance, remain reasonably available for consultation.
(2) A dentist complies with subsection (1)(b) if the dentist, or another dentist nominated by him, is available to render assistance to the dental therapist or dental hygienist if such assistance is required by the dental therapist or dental hygienist.
[Section 50C inserted by No. 64 of 1996 s.15.]
]

50D. Acts which may be performed by a school dental therapist
(1) This section applies to a school dental therapist who is employed to carry out acts of dentistry for a school dental service.
(2) Subject to any condition, restriction or limitation imposed by the Board and the regulations made under section 337A(4) of the Health Act 1911, a school dental therapist to whom this section applies may for the purposes of the school dental service —
(a) undertake the acts of dentistry specified **in Parts 1, 2, 4 and 7 of Schedule 2**; and
(b) if the school dental therapist —
(i) has the qualifications prescribed for the purposes of this paragraph; or
(ii) has completed a course of study and training approved by the Board for the purposes of this paragraph, undertake the acts of dentistry specified in **Part 3 of Schedule 2.**

Schedule 2

Part 1
Core Acts

1. Instruction in, and organization and supervision of, plaque controlroutine.
2. Recording of periodontal indices.
3. Dental prophylaxis.
4. Topical application of fluorides.
5. Application of desensitizing agents.
6. Application of plaque control agents.
7. Polishing and recontouring of restorations.
8. Application of fissure sealants to teeth.
9. Removal of calculus.
10. Application and removal of periodontal packs.
11. Dental radiography.
12. Taking of impressions for all purposes other than final impressions for all prosthetic procedures.
13. Application and removal of rubber dam.
14. Removal of sutures.

Part 2
Local Analgesia Acts

15. Administration of local dental analgesia.

Part 3
Orthodontic Acts

16. Placement of metallic or non-metallic separators.
17. Preparation of teeth for orthodontic banding.
18. Orthodontic band selection.
19. Attachment selection.
20. Placement of arch wire fixation.
21. Removal of ligatures.
22. Removal of arch wire fixation pins.
23. Removal of arch wires.
24. Routine checking for loose bands and broken appliances and re-cementing of loose bands.
25. Removal of bands.
26. Removal of attachments.
27. Removal of orthodontic cement.

Part 4
Dental Therapy Acts

28. Extraction by forceps of deciduous teeth under local analgesia.
29. Emergency treatment of pulp exposure.
30. Preparation and restoration of cavities in deciduous and permanent teeth of preschool and school children by direct placement materials.

Part 5

31. Restoration of prepared cavities in permanent teeth in adults by direct placement materials.

Part 6

32. Root planing

Part 7

33. Caries detection.

AUSTRALIAN DENTAL ASSOCIATION INC.

POLICY STATEMENT 3.3

ALLIED DENTAL PERSONNEL[1]

1. Introduction

1.1. Over the years dental workers other than dentists have been introduced into the dental workforce. This varies around the world depending on the particular country's existing dental workforce, resources, political climate but rarely on evidence based analysis.

1.2. The Australian Health Ministers' Conference 2004 has determined a National Health Workforce Strategic Framework. The first guiding principle of this framework asserts that 'Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market.'

1.3. There remains a substantive but lessening need for simple restorative treatments and patient removable dentures while there is an increasing demand for diagnostic, preventive and complex treatments that are only performed by dentists.

1.4. In the period of 2004 to 2012 there has been a sharp increase in the numbers of allied dental personnel students becoming eligible to practise in Australia. Several new allied dental personnel programmes have been established.

1.5. **Definitions**

1.5.1 ALLIED DENTAL PERSONNEL are those, other than dentists, working in the provision of dental services - namely dental assistants, dental therapists, dental hygienists, dental prosthetists, dental laboratory assistants, dental technicians and master dental technicians.

1.5.2 BOARD is the Dental Board of Australia.

1.5.3 INSTRUCTION is the oral elaboration of "prescription" and may include a teaching component.

[1] This Policy Statement is linked to other Policy Statements: *3.1 Dental Workforce, 3.2 Dentists, 3.8 Overseas Qualified Dentists, 3.9 Recency of Practice, 3.10 Clinical Practice Placements, 3.15 Post Graduate Year One Programmes, 4.1 Continuing Professional Development & 5.21 Regulatory Authorities*

1.5.4 INVASIVE PROCEDURES are those where entry to the tissue, body cavities or organs of a patient occurs, or where surgical repair of traumatic injury to a patient is undertaken.

1.5.5 NON-REGISTRABLE allied dental personnel are those whose autonomous duties and tasks do not include any invasive dental procedures.

1.5.6 PRESCRIPTION is detailed written instruction provided by a dentist to allied dental personnel, and usually specifies the treatment to be performed.

1.5.7 RANGE OF PRACTICE is the duties an individual dental practitioner can practice, within their category's scope of practice, for which they are formally educated and trained in programmes accredited by the Australian Dental Council, and are currently competent.

1.5.8 REGISTRABLE allied dental personnel are those whose autonomous duties and tasks include invasive dental procedures.

1.5.9 SCOPE OF PRACTICE is a clearly defined list of prescribed duties within dentistry for each category of dental practitioner which should be delineated by regulation.

1.5.10 SUPERVISION is the direction and/or oversight (including guidance and support) by dentists of the performance of duties by allied dental personnel. Supervision can be direct (i.e., the dentist is physically present in the treatment facility at all times the patient is being treated by allied dental personnel) or indirect (i.e., the dentist need not be physically present in the treatment facility, but must be able to be contacted at all times the patient is being treated by allied dental personnel).

2. Principles

2.1. All Australians should have access to modern, comprehensive oral health care.

2.2. Australia must be largely self sufficient with regard to the training of the dental workforce.

2.3. Clearly defined scopes of practice for allied dental personnel will assist:

- educational institutions to provide national uniform training outcomes;
- members of the dental workforce to better understand each others' roles;
- the public to understand each practitioner's role, and
- the accreditation of allied dental personnel training.

Allied dental personnel should only perform those duties within their range of practice,

2.4 Education and training institutions should use uniform nomenclature for qualifications for each category of the dental workforce.

2.5 Only allied dental personnel who perform invasive and irreversible procedures should be registered.

2.6 The dental workforce training numbers for each category of allied dental personnel should be based on the requirements and demand of the community.

Responsibilities of Dentists

2.7 The dentist must be responsible for the diagnosis, treatment planning, and delivery of dental procedures and the continuing evaluation of the oral health of the patient. The dentist is also responsible for the support, direction and supervision of allied dental personnel in the conduct of prescribed duties for which they are legally accountable.

2.8 With respect to allied dental personnel other than dental prosthetists, it is the responsibility of the dentist to:

- ensure that all members of the dental workforce at all times have appropriate competence and formal training for the tasks that are delegated to them i.e. work within their range of practice;
- have an understanding of the roles of all members of the dental workforce;
- inform patients that a specified part of their treatment is to be undertaken by allied dental personnel;
- monitor and supervise the performance of allied dental personnel;
- consult with patients regarding the treatment plan and to instigate referral to specialists;
- provide adequate prescription and instruction to ensure that the procedures and/or treatment to be performed are understood;
- be available for consultation and management of any complications that may occur; and
- ensure that all delegated procedures have been performed satisfactorily.

Responsibilities of Allied Dental Personnel:

2.9 It is the responsibility of allied dental personnel to:

- have a complete understanding of the role of all members of the dental workforce;
- carry out only those delegated tasks within their range of practice i.e. for which they are formally educated and trained and have appropriate competence;
- refer to a dentist any condition or task which is outside their range of practice, including changes in a patient's health status or medication; and
- if applicable hold appropriate professional indemnity cover.

3. Policy

3.1 The future dental workforce should provide services that:

- are population based;
- are patient focused;
- lead to the coordinated, non-fragmented provision of oral health services;
- are preventively oriented;
- should ensure an adequate dental workforce in rural and remote areas; and
- are delivered efficiently and effectively.

Categories

3.2 The following categories of allied dental personnel in Australia are recognised:

Non-registrable :

- dental assistant;
- dental laboratory assistant;
- dental technician; and
- master dental technician.

Registrable :

- dental hygienist;
- dental therapist; and
- dental prosthetist.

Regulation of Practice of Allied Dental Personnel

3.3 Dental hygienists, dental therapists and dental prosthetists must be registered and practise in accordance with all statutory requirements. Regulation of practice must be vested in the Board enacted by legislation under the relevant Federal, State or Territory Acts which must provide that:

- the scope of practice is clearly defined with a list of duties;
- the course of training is prescribed;
- registration is required and a register regularly maintained; and
- penalties apply for contravention of any provisions of the relevant Act.

3.4 Dental laboratories, especially those not owned and/or controlled by persons registered with a Board, should be accredited by a competent agency.

3.5 Provider numbers must only be issued to those members of the dental workforce who are registered to practise as independent practitioners by Boards.

Education and Scope of Practice of Allied Dental Personnel

3.6 Education and training for allied dental personnel must reflect their defined scope of practice, which should be nationally uniform.

3.7 The training of registrable allied dental personnel should be focused on prevention rather than restorative dentistry and exodontia.

Dental Assistant

3.8 Basic education and training of dental assistants must be at Certificate III level in the vocational sector and in accordance with the National Competency Standards. The title for such a qualification should be Certificate III in Dental Assisting.

3.9 With additional education and training in clearly defined areas to Certificate IV level in the vocational sector, and in accordance with the National Competency Standards, the duties of

dental assistants extend to:

- dental assisting - oral health promotion;
- dental assisting - dental radiography;
- dental assisting – technical procedures;
- dental assisting - general anaesthesia and conscious sedation; and
- dental assisting – dental practice administration.

3.10 Duties shall comprise established procedures associated with chair side assisting, infection control and practice administration.

3.11 A dental assistant must work under the supervision of a dentist or suitable allied dental personnel as detailed in Appendix 2 to this Policy Statement.

3.12 Education and training numbers of dental assistants should be in alignment with the numbers of dentists and registrable allied dental personnel.

Dental Hygienist

3.13 Education and training of dental hygienists must be to at least Diploma level and of at least two years' duration. The education and training should be conducted in either the higher education sector in a tertiary institution associated with the training of dentists or in the vocational sector in a course dedicated to only dental hygiene training and accredited by the Australian Dental Council (ADC). The title for such a qualification should be a Diploma / Bachelor of Dental Hygiene.

3.14 The duties of a dental hygienist should be directed towards oral health education and the prevention of dental diseases, including dental caries and periodontal disease.

3.15 Treatment services provided by a dental hygienist must be provided in accordance with a written treatment plan which has been signed and dated by a dentist who has personally examined the patient, and:

- such treatment plan shall be effective for not more than twelve months; and
- the need for examination of the patient by the dentist after completion of the treatment plan by the dental hygienist will depend on the needs of the patient, the treatment provided and the experience and competency of the dental hygienist.

3.16 The role of the dental hygienist in the provision of dental treatment shall be subject to the following :

3.16.1 The dental treatment must be supervised by a dentist who is on the premises at the time of treatment, except in the case of dental treatment within categories referred to in paragraph 3.16.2 a. to h. provided on the premises of long term residential care, either government or licensed under local government legislation, for the elderly or persons with physical or intellectual disability, provided that a medical practitioner or registered nurse is at close call.

3.16.2 The dental treatment must fall within the following scope of practice:

a. established procedures associated with chair side assisting and practice management;
b. oral health education;
c. instruction in monitoring and recording of plaque control routines and recording of periodontal disease;
d. prophylaxis;
e. polishing of restorations;
f. fluoride therapy, application of remineralising solutions and desensitising agents;
g. debridement to remove supragingival deposits from teeth;
h. debridement to remove subgingival deposits from teeth;
i. application and removal of rubber dam;
j. application of non-invasive fissure sealants;
k. taking of alginate impressions other than for the fabrication of prosthetic appliances;
l. removal of periodontal packs;
m. taking of dental radiographs;
n. orthodontic band sizing;
o. removal of orthodontic appliances including orthodontic cements and resins;
p. placement and removal of non-metallic separators and alastic modules; and
q. administration of local anaesthesia by infiltration and mandibular nerve block.

3.17 Education and training numbers of dental hygienists should be in alignment with the demand for preventive services.

Dental Therapist

3.18 Education and training of dental therapists must be to at least Diploma level and of at least two years' duration. The education and training should be conducted either in the higher education sector in a tertiary institution associated with the training of dentists or in the vocational sector in a course dedicated to only dental therapy training and accredited by the ADC. The title for such a qualification should be a Diploma / Bachelor of Dental Therapy.

3.19 A dental therapist must work under the supervision of a dentist.

3.20 The duties of dental therapists shall be restricted to prevention of dental diseases and control of dental caries in school children.

3.21 The provision of treatment by a dental therapist must fall within the following scope of practice:

a. established procedures associated with chair side assisting and practice management;
b. oral health education;
c. oral health examination;
d. taking of dental radiographs;
e. application and removal of rubber dam;
f. pre- and post-operative instruction;
g. irrigation of the mouth;

h. fluoride therapy, application of remineralising solutions and desensitising agents;
i. debridement to remove deposits from teeth;
j. taking of alginate impressions other than for the fabrication of prosthetic appliances;
k. application of fissure sealants;
l. direct coronal restoration of primary and permanent teeth;
m. pulpotomies in vital primary teeth;
n. administration of local anaesthesia only by infiltration and mandibular nerve block; and
o. forceps extraction of primary teeth under local anaesthesia.

3.22 Education and training numbers of dental therapists should be in alignment with the need for simple restorative treatments in children.

Dental Laboratory Assistant

3.23 Education and training of dental laboratory assistants must be to Certificate III level conducted in the vocational sector and in accordance with National Competency Standards. The title for such a qualification should be Certificate III in Dental Laboratory Assisting.

3.24 A dental laboratory assistant must work under the supervision of a dental technician or dentist.

3.25 The duties of a dental laboratory assistant shall consist of the following established laboratory procedures:

a. pouring impressions;
b. producing custom-made trays;
c. constructing occlusal registration rims;
d. constructing mouthguards;
e. articulating models; and
f. transferring records.

Dental Technician

3.26 Dental technician education and training must be to Diploma level and at least two years' full time study with a period of structured learning of at least one to two years. The training should be conducted in the vocational sector and in accordance with National Competency Standards. The title for such a qualification should be a Diploma in Dental Technology.

3.27 A dental technician may work independently of a dentist, but must adhere to the prescription of a dentist and is not permitted any direct dealings with members of the public except in the case of non-invasive shade taking at the direction of the dentist.

3.28 The duties of a dental technician shall consist of the following established laboratory procedures:

a. fabrication, maintenance and repair of complete and partial dentures;
b. fabrication of inlays, onlays, veneers, crowns and bridges;
c. fabrication of mouthguards, occlusal splints, medicament trays and stents; and
d. fabrication of appliances used in orthodontics, oral and maxillofacial surgery and other special areas of dentistry.

Master Dental Technician

3.29 A master dental technician must first be qualified as a dental technician and then gain an Advanced Diploma with a period of structured learning. The education and training must be conducted in the vocational sector and in accordance with National Competency Standards. The title for such a qualification should be an Advanced Diploma in Dental Technology.

3.30 The advanced training for a master dental technician shall include:

a. attachments to implants in complete and partial dentures;
b. precision attachments associated with inlays, onlays, crowns and bridges;
c. greater depth understanding of materials and processes; and
d. ceramic systems, CAD/CAM .

3.31 Education and training numbers of dental technicians should be in alignment with the need for custom-made dental prostheses and appliances.

Dental Prosthetist

3.32 A dental prosthetist must first be qualified as a dental technician and then gain an Advanced Diploma with a period of structured learning. The education and training must be conducted in the vocational sector and in accordance with National Competency Standards. The title for such a qualification should be an Advanced Diploma in Removable Dental Prosthetics.

3.33 The scope of practice for dental prosthetists is that they may independently provide treatment to the public limited to the provision, in healthy mouths, of flexible mouthguards and patient removable dentures not associated with implants.

3.34 All patients should be examined by a dentist prior to treatment by a dental prosthetist.

3.35 Education and training numbers of dental prosthetists should be in alignment with the demand for patient removable dental prostheses.

Career Path

3.36 Education and training institutions should facilitate entry of allied dental personnel into dental workforce training courses that are at a higher level than their current qualification (e.g. dental assistants training to become dental hygienists). This provides a career path for allied dental personnel within the dental workforce based on appropriate training.

. . . . . .

Policy Statement 3.3
Adopted by ADA Federal Council, April 10/11, 2003.
Amended by ADA Federal Council, November 11/12, 2004.
Amended by ADA Federal Council, November 10/11, 2005.
Amended by ADA Federal Council, November 2/3, 2006.
Amended by ADA Federal Council, April 12/13, 2007.
Amended by ADA Federal Council, November 15/16, 2007.
Amended by ADA Federal Council, November 13/14, 2008.
Amended by ADA Federal Council, November 12/13, 2009.
Amended by ADA Federal Council, November 18/19, 2010.
Amended by ADA Federal Council, April 12/13, 2012.

APPENDIX 1 TO POLICY STATEMENT 3.3

ALLIED DENTAL PERSONNEL

AUSTRALIAN QUALIFICATIONS FRAMEWORK

SECONDARY SCHOOLS SECTOR	VOCATIONAL EDUCATION AND TRAINING SECTOR	HIGHER EDUCATION SECTOR
		Doctoral Degree
		Masters Degree
		Graduate Diploma
		Graduate Certificate
		Bachelor Degree
	Advanced Diploma	Associate Degree Advanced Diploma
	Diploma	Diploma
Senior Secondary Certificate of Education	Certificate IV	
	Certificate III	
	Certificate II	
	Certificate I	

APPENDIX 2 TO POLICY STATEMENT 3.3

ALLIED DENTAL PERSONNEL

MODEL STANDARDS STATEMENT FOR DENTAL ASSISTANTS

EDUCATIONAL AND SUPERVISORY REQUIREMENTS FOR DENTAL ASSISTANTS

Introduction

Dentists, dental therapists and dental hygienists and their employers have a responsibility to know a dental assistant's clinical and educational experience, scope of duties in keeping with appropriate Federal, State or Territory legislation and regulations, and supervisory requirements during the provision of oral health care procedures. There is no necessity for dental assistants to be registered.

Purpose

This Standards Statement describes the supervisory responsibilities and the relationship between the scope of duties and educational experience associated with the employment of dental assistants

Scope of Duties

A dental assistant is primarily employed as a clinical assistant to the dentist. Their duties include clinical chair side assisting**,** maintaining infection control standards and to assist in practice administration.

The usual duties of a dental assistant are in accordance with their educational and clinical experience and require the direct supervision of a dentist, dental therapist and dental hygienist depending on the tasks undertaken by the dental assistant.

Educational and Clinical Experience

All dental assistants should be encouraged and supported to gain entry qualifications in dental assisting or recognition of equivalence, which has been issued by an Australian registered training organisation. Qualifications in dental assisting are particularly suited to the Australian Apprenticeship/Trainee pathway, which involves on-the-job and off-the-job training

There are several levels of dental assistant educational and clinical experience that are recognised.

1. A dental assistant undergoing on-the-job training for at least six months and has no prior work related experience. During the period of training a qualified dental assistant may support the training of an unqualified and inexperienced dental assistant.

2. A dental assistant undergoing on the job training and off the job training for a period of at least 12 months. During the period of training a qualified dental assistant may support the training of an unqualified and inexperienced dental assistant.

3. A dental assistant qualified in a nationally based Certificate III in Dental Assisting[2] or its equivalent working under the supervision of a dentist, dental therapist or dental hygienist. Minimum units include[3]:

    3.1 Communicate and work effectively in health
    3.2 Comply with infection control policies and procedures in health work
    3.3 Process reusable instruments and equipment in health work
    3.4 Participate in OHS processes
    3.5 Prepare for and assist with oral health care procedures
    3.6 Assist with dental radiography
    3.7 Assist with the administration in dental practice
    3.8 Apply first aid

4 A dental assistant qualified in a nationally based Certificate IV in Dental Assisting[1] or its equivalent working at an advanced level under the supervision of a dentist, including:

    4.1 Dental Assisting - dental radiography
    4.2 Dental Assisting - oral health promotion
    4.3 Dental Assisting - technical procedures (also known as 'extended duties'[2])
    4.4 Dental Assisting - general anaesthesia and conscious sedation
    4.5 Dental Assisting – dental practice administration

Supervision

The legal and ethical responsibilities associated with the actions and omissions of a dental assistant are attributed primarily to the supervising dentist. Any allied dental personnel or employer involved in the supervision of the dental assistant may also be liable

Compliance with Board and statutory regulatory bodies is essential. Consultation to clarify any matters related to a dental assistant's qualifications, experience and competence to perform advanced scopes of duties or undertake on the job training may be required to attain nationally based Certificate IV qualifications in Dental Radiography and Technical procedures such as taking an impression for study models.

The clinical responsibilities for the patient remain with the dentist, dental therapist and dental hygienist providing the treatment and/or providing supervision at all times.

All advanced duties undertaken by a dental assistant should be in accordance with a written treatment plan prepared by a dentist.

During the performance of an advanced duty by a dental assistant, a dentist should be on the premises to:

- Provide supervision
- Provide advice and consultation in relation to authorised dental assistant activities
- Be available for referral in relation to other matters falling outside the competence of an individual dental assistant

All the above supervisory responsibilities of dentists apply equally to dental prosthetists conducting independent practice.

Patient Consent

[2] Health Training Package HLT07 found at www.cshisc.com.au

[3] Terminology this section according to nationally based competency units, Health Training Package 07

Appropriate patient consent is to be obtained prior to the dental assistant undertaking any advanced duty involving direct patient contact

The patient may decline to have the dental assistant undertake the advanced duty and elect to have a dentist, dental therapist or dental hygienist to complete the task. The choice of dentist, dental therapist or dental hygienist is dependent on the task and the dentist's supervisory obligations.

Records

A dental assistant undertaking advanced duties must maintain a signed work record of each patient contact recording the date and procedure undertaken.

The name of the dental assistant performing an advanced duty should be entered into the patient record for that procedure according to the usual standards for record keeping.

Misrepresentation

When undertaking advanced duties involving direct contact with the patient, a dental assistant, supervisory dentist and employer should not hold out or represent a dental assistant as a dental care provider to the patient or through advertising.

APPENDIX 3 TO POLICY STATEMENT 3.3

ALLIED DENTAL PERSONNEL

GLOSSARY OF TERMS

PREFERRED TITLE	ALTERNATE TITLE	OCCUPATION APPROPRIATE FOR AUSTRALIA
Dental Assistant	Dental Nurse	Yes
Dental Hygienist		Yes
Dental Therapist		Yes – short term
Dental Laboratory Assistant		Yes
Dental Technician	Laboratory Dental Technician	Yes
Master Dental Technician		Yes
Denturist	Clinical Dental Technician, Advanced Dental Technician, Dental Prosthetist	Yes- short/medium term
Maxillofacial Prosthetist and Technologist		No
Orthodontic Chair Side Assistant		No
Orthodontic Technician		No
Orthodontic Therapist		No
Oral Health Therapist		No
Practice Manager		Yes (not Allied Dental Personnel)
Receptionist		Yes (not Allied Dental Personnel)

AUSTRALIAN DENTAL ASSOCIATION INC.

NATIONAL DENTAL UPDATE
October 2012
www.ada.org.au

MAJOR FLAWS IN HWA SCOPE OF PRACTICE REPORT

The standard of dental care provided in Australia is among the best in the world.

This level of quality is no accident. It has come about because the standards of education and training of dentists in Australia is world class. The regulatory structures surrounding dental practice contribute to ensuring safety and quality by placing the dentist at the forefront of diagnosis and treatment planning. But standards of care are potentially being put at considerable risk as a result of work being undertaken in reviewing the Dental Board of Australia's (DBA) Scope of Practice registration standard.

A recently released report from Health Workforce Australia (HWA) on a review of the Scope of Practice of oral health therapists, dental therapists and dental hygienists recommends the removal of the requirement for supervision of dental hygienists, dental therapists and oral health therapist by dentists.

These dental practitioners represent just 16% of the total registered dental practitioner workforce, yet the recommendations in the Report give the impression that as a result of the DBA Registration standard, their scope of practice is limited and this supposed limitation is having a significant impact on the delivery of oral health services to the Australian community.

The recommendations in the Report are neither balanced nor objective and are based on assumptions that are grossly incorrect.

The ADA believes it is critical that the premise upon which any reforms to the dental workforce occur are justified and underpinned by quality of care and safety of the public.

It is in this context that the ADA makes the following comments and dispels some of the misconceptions portrayed throughout this report.

HWA Project Approach

The study undertaken by HWA was, in the Association's view, cursory at best. The approach taken to the project is stated as including consultation with the community, dental professionals, peak bodies, government providers, regulatory bodies and dental educational institutions. It would seem from this statement that no stone was left unturned in seeking to understand fully the extent of the issues being considered.

> **The recommendations are neither balanced nor objective and are based on incorrect assumptions**

It is therefore a matter of concern that the Report does not even list the Australian Dental Council (ADC) among the groups it consulted. As the independent national standards body for dental education and training, the ADC is best placed to provide advice as to the content of curriculum leading to the award of a qualification that meets the requirement for registration as a dental hygienist, dental therapists, oral health therapist and dentist. Had the ADC been adequately consulted, the project team may well have discovered early on in the project that the requirement for supervision of such practitioners is founded in the knowledge that their education and training is limited.

The project adopted an unusual methodology. Firstly, the survey sought to gather information from two cohorts, dental health professionals and consumers, yet there was no difference in the questions asked of both groups. This is highly unscientific, given the depth in knowledge of the service by dental health professionals when compared to that of consumers,

Continued

Contacts: Dr. F Shane Fryer, President Robert Boyd-Boland, Chief Executive Officer
All correspondence to: Australian Dental Association Inc. PO Box 520 St Leonards NSW 1590
Tel: 02 9906 4412 Fax: 02 9906 4736 Email: adainc@ada.org.au

and thus the approach will limit the value of the information gleaned from the survey.

Secondly, for most consumers, the differentiation between the scope of practice of a dental hygienist and a therapist (dental or oral health) is unlikely to be well known. The ADA would proffer the view that in many cases consumers do not know which of these practitioners is treating them.

And to claim that the recommendations in the report are supported by the literature is plainly false. The articles reviewed and used as evidence were strongly biased to papers that supported the use of therapists rather than being inclusive of the extensive literature which demonstrated the negative impacts of expanding the scope of practice of therapists.

Claims about workforce supply

The argument about workforce shortages was raised as a justification for extending the scope of practice. This suggestion is based on the assumption that an oral health therapist can replace a dentist. To suggest that oral health practitioners can provide the same level of care to patients as that of a dentist ignores the difference in education and training between dentists and oral health practitioners.

If the two practitioners were interchangeable, then there would be no need to identify where the scope of practice of one ends and the other continues. The competencies of an oral health practitioner – regardless of whether they trained as a hygienist, therapist or oral health therapist, are a subset of the skills and competencies of a dentist and while these practitioners are highly valued members of the dental team, they do not have the necessary education and training to perform at the same level of a dentist.

Supervision is a long-standing practice

The use of the word supervision in registration standards is not new. Prior to the introduction of National Registration and Accreditation, dental practitioners were registered according to state based legislation. This legislation repeatedly stated that dental hygienists and dental therapists were required to practise under the supervision of a dentist. So to suggest, as is stated in the Report, that the move to national registration and the introduction of a national registration standard has in some way resulted in unintended and negative impacts is incorrect.

As it is currently worded, the Standard allows for all practitioners to work to their full scope of practice. It recognises that the education and training of these practitioners is not offered to the same academic level as that of a dentist and that training levels differ depending on whether the oral health practitioner was TAFE or University trained.

The Board's Standard accommodates that some oral health practitioners will need more support and supervision than others but ultimately, it ensures that the safety and wellbeing of the patients is foremost.

The training for oral health practitioners is unlikely to prepare them for independent practice

The HWA Report also claims that oral health practitioners are often more available in rural and remote areas. The data upon which this assertion was based is six years old. More recent reports were and are openly available. Current data on workforce distribution indicates that there is no statistical difference between the distribution of the dental therapy workforce to that of dentists.

Dental hygienists, dental therapists and oral health therapists with their education in oral health promotion and prevention are ideal to deliver preventive care.

In fact the reason that the role of a dental therapist was introduced in Australia was to address a gap in service provision to children. So for governments to encourage them to move out of this area of service delivery when the Commonwealth Government is introducing a Child Dental Benefits Scheme is completely nonsensical.

These oral health practitioners were trained to perform a specific role and function. Notwithstanding the fact that many hygienists and therapists have since undertaken further training and hold qualifications in both hygiene and therapy, their training is unlikely to have prepared them for independent and unsupervised practice akin to what is being suggested in the report.