13 May 2018

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Dear Dr Lockwood

Consultation on proposed revised scope of practice registration standard and guidelines

Thank you for the opportunity to provide feedback for the Consultation on a proposed revised scope of practice registration standard and Guidelines for scope of practice.

The Dental Hygienists Association of Australia Ltd. (DHAA) is the peak professional body representing some 1600 dental hygienists, oral health therapists and oral health students throughout Australia. In line with our Strategic Plan, we regularly survey members about issues affecting the profession, including the Scope of Practice Registration Standard and Guidelines. This feedback encompasses data collected from our membership regarding the existing and proposed registration standard and guidelines.

The DHAA have undertaken two member surveys in the past eight months, to determine our members understanding and gather their feedback on the existing scope of practice registration standard and guidelines, and the recently proposed revisions. Further, we have worked together with our colleagues at ADOHTA to reach a shared understanding on this consultation.

As requested, this submission will address the eight questions raised in the consultation paper.

1. From your perspective, how is the current registration standard and guidelines working?

In October 2017, the DHAA invited members to provide their opinions on the current scope of practice registration standard, via an online survey. 205 members completed the survey; based on a sample size calculation, we required a minimum sample of 91 respondents to be representative of our membership base. Respondents included dental hygienists (68%), oral health therapists (18%) and dual qualified hygienist-therapists (10%), from all States and Territories in Australia.

The overwhelming majority of respondents (91%) indicated that they were satisfied with the requirement that “All dental practitioners are members of the dental team who exercise autonomous decision making within their particular areas of education, training and competence, to provide the best possible care for their patients”. They also agreed (87%) that “Dental practitioners must only perform dental treatment: for

which they have been educated and trained in programs of study approved by the National Board, and in which they are competent". Comments provided related specifically to the lack of clarity and confusion within the profession regarding this standard.

Respondents indicated that independent practice would recognize the dental hygienist and oral health therapist as a highly trained and educated health professional, with some 50% unsatisfied with the lack of independent practitioner status. Respondent's comments recognised that independent practitioner status still required a team approach to care and referral for areas outside their scope of practice. There were some concerns that undergraduate training has not prepared the profession for independent practice (37%), and suggestions for implementation were centred on the provision of provider numbers and include established guidelines, an application process and post-graduate training, as well as looking to other countries that have implemented independent practice.

There are concerns from our members regarding the structured professional relationship (SPR). We have received feedback that this has been poorly implemented in practice, and that the required one-on-one relationship with a dentist is restricting practice for hygienists, therapists and oral health therapists. Further, our members have reported numerous incidents where their clinical expertise and tertiary qualifications have been questioned, despite the current standard and guidelines outlining we are able to make autonomous decisions within our scope of practice.

2. Are there any issues that have arisen from applying the existing registration standard and guidelines?

The current registration standard and guidelines are not clear, with many of our members describing them as unclear and difficult to interpret. Further, when seeking clarification from AHPRA, they have been advised that the Dental Board does not assist practitioners in interpreting the standards and guidelines, and that they should seek independent legal advice. In our opinion it is essential that the registration standard and guidelines be written in plain English.

For dental hygienists and oral health therapists, the current standard does not enable flexibility for dental practice and referral pathways. We understand this viewpoint is shared with our colleagues at ADOHTA. Feedback from our member survey indicates that the structured professional relationship is not always 'professional', with hygienists and OHTs experiencing a lack of respect and trust for clinical decision making within their scope, despite being tertiary qualified practitioners. Our members would welcome an opportunity to work within a collegial team-based approach to care, with multiple dentists, specialists, hygienists, therapists, oral health therapists and prosthetists.

3. Is the content and structure of the proposed revised registration standard and guidelines helpful, clear, relevant and more workable than the current registration standard and guidelines?

In April 2018, the DHAA invited members to provide their opinions on the proposed revised scope of practice registration standard, via an online survey. 144 members

completed the survey; based on a sample size calculation, we required a minimum sample of 91 respondents to be representative of our membership base. It should be noted that our survey directed members to read the DBA consultation paper and reflective tool; many members responded that the consultation paper was wordy and difficult to understand, and could not find the reflective tool.

Removing reference to programs to extend scope, completing CPD to broaden skills, knowledge and competence

The majority of members surveyed (80%) agreed that they understand the new guideline, while the remaining (20%) did not understand or are unsure.

There is concern that CPD programs, mini courses and short education sessions do not necessarily provide sufficient information, opportunity for skill repetition/development and consolidation of new skills to enable a practitioner to safely provide a new treatment or procedure for a patient. Members indicated that when learning a new skill or technique, one does not necessarily have the confidence or ability to determine whether the learning that has taken place is comprehensive and safe. The suggestion was made that DBA should provide more guidance to allow practitioners to make an informed decision on what is suitable CPD; this includes dentists, specialists, hygienists, therapists, oral health therapists and prosthetists. The DBA should also consider a process for monitoring the content of CPD courses, for the safety of the public.

Removal of all reference to independent practitioners

It is clear that our members find this proposed change ambiguous and unclear. Only 55% of survey respondents understand this guideline, with the remaining 45% do not understand.

Removing the requirement that dental hygienists and oral health therapists must not practise as independent practitioners is welcomed by the DHAA. We understand this viewpoint is shared with our colleagues at ADOHTA. Removing this restriction for dental hygienists and oral health therapists will allow greater opportunities to practise in a variety of settings, including residential aged care facilities (RACF's), group homes, wards and units in hospital settings, and homes for the disabled. Hygienists and oral health therapists have capably and safely worked within their scope for many years, demonstrated by very low notification rates (approximately 10%, compared to 90% received for dentists and specialists).

Many countries around the world recognize the value of preventive dental care and place a high community value on preventive dental services. Many encourage independent practice and direct access, meaning citizens may see a dental hygienist without first having to see a dentist. In Ontario, Canada, Bill 171 was introduced in 2007 which allows the public to access the dental services of registered dental hygienists. Other countries with similar legislation include the United Kingdom, the Netherlands, New Zealand, Scandinavian countries including Sweden and Norway, and many states in America. A review undertaken prior to the legislative change in the UK highlighted that direct access to dental hygienists resulted in increased access to care, improved patient satisfaction and no significant risks to patient safety.[1] In California, USA, dental hygienists may register for alternative practice; these

[1] Turner S, Tripathee S, MacGillivray S. Benefits and risks of direct access to treatment by dental care professionals: A rapid evidence review. Final Report to the General Dental Council 2012

practitioners have specialized training and an additional license that allows them to have their own independent business and work in settings other than a dental office and without the supervision of a dentist. These services can be provided in designated underserved areas, as well as schools, institutions, residences, skilled nursing facilities, and private homes of homebound persons. This model reaches some of the most underserved populations.[2]

However, as currently worded, this proposed revision causes confusion due to the poorly phrased double negative. Further, completely removing the premise of an independent practitioner at this point may create further confusion among the dental professions. We note the Board agreed that it should move incrementally towards removing the bar on independent practice from the registration standard for hygienists and OHTs; we believe by removing the restriction AND the term independent practitioner in one revision, there will be a significant gap in understanding and interpreting the standard and guidelines by the profession. We suggest removing the restriction in this review, and then phasing out the standard (including reference to independent practitioners) in five years. Note that the AHPRA Code of Conduct includes plain language statements regarding scope of practice that are applicable to all health practitioners.

Our members understand that there is a huge responsibility that comes with working independently. The DBA, through its accreditation of dental and oral health programs, needs to ensure adequate training is provided for this change in the scope of practice to protect the integrity of the profession. Further, the DBA needs to work with the professional associations to ensure adequate training is provided for the current workforce.

Team based approach to care
The vast majority of members (87%) are supportive of, and understand the team-based approach to care. Members indicated that this approach is logical, and important for dentistry. The DHAA welcome a model where dentists, specialists, hygienists, therapists, oral health therapists and prosthetists can work together respectful of each other's scope of practice, in a team-based approach to care. We understand this viewpoint is shared with our colleagues at ADOHTA.

Determining individual scope of practice
The overwhelming majority of members (85%) indicated that they understand how to determine their individual scope of practice. The minority continue to have some concerns that the scope of practice is too open to interpretation, and it is easy for a practitioner to make an error of judgement because of the vagueness of the standard and guidelines.

4. Is there any content that could be changed or deleted in the proposed revised registration standard and guidelines?

Due to the obvious confusion regarding the reference to independent practitioners, this requires revision. We urge the Board to reconsider removing all reference to

[2] http://www.rdhmag.com/articles/print/volume-32/issue-1/features/start-up-company.html

Independent Practitioners, and rather look at a new definition. For your consideration, we propose:

> An independent practitioner is a practitioner who may practise autonomously within their scope of practice, within a team-based approach to care.

5. Do you think that a review period of at least every five years (rather than three) is appropriate? Why or why not?

The DHAA holds the view that dental practitioners, like all other health practitioners, should not require a registration standard to define their scope of practice. We propose that, with the assumption that the current proposed changes are approved, that the Scope of Practice Registration Standard and Guidelines are phased out after 5 years.

It should be noted that "registrations standards … may be used in disciplinary proceedings against health practitioners as evidence of what constitutes appropriate practice".[3] While ever the standard and guidelines are perceived by practitioners as unclear and confusing, then it is not guiding appropriate practice and is therefore potentially detrimental to public safety.

It should be noted that the Dental Board is the only Board under the National Registration and Accreditation with a Scope of Practice Registration Standard for the health practitioners it regulates. Like the Dental Board, other Boards have numerous divisions of practitioners, that are also required to deliver care using a team-based approach, and yet they do not require a registration standard that spells out to health professionals the need to work within their areas of education, training and competence. In fact, all other health practitioners work within their scope of practice in line with the AHPRA Code of Conduct, which includes plain language statements applicable to all health practitioners; there is no reason dental practitioners should be treated differently. We understand this viewpoint is shared with our colleagues at ADOHTA.

A professional can be defined as "a member of a profession…governed by a code of ethics, and profess commitment to competence, integrity and morality, altruism, and the promotion of the public good within their expert domain. Professionals are accountable to those served and to society".[4] All health professionals, regardless of their profession, division or endorsements, through the process of registering for practice are committing to providing services within their scope of practice. Therefore the purpose of a registration standard is questionable.

6. Do you have any other comments on the proposed revised registration standard and guidelines?

The DHAA are broadly supportive of the proposed changes to the standard and guidelines, which recognise the need for professionalism, reflection and justification

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[3] www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines/Guidelines-Scope-of-practice.aspx

[4] Cruess SR, Johnston S, Cruess RL. (2004) Profession: a working definition for medical educators. Teaching and learning in medicine: 16(1); 74-6.

in clinical decision making, and encourage a more team based approach to care provision. We understand this viewpoint is shared with our colleagues at ADOHTA.

7. Is the content and structure of the new reflective tool helpful, clear and relevant?

The DHAA has received positive feedback from its members on the reflective tool. The tool appears to be thorough yet easy to understand, and provides a reference point for clinician's to self assess their current clinical competence. Further, it supports the strong focus of self-reflection and assessment that dental hygienists and OHTs receive during their education and training.

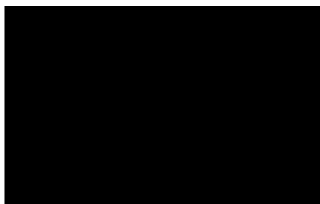
8. Is there anything missing that needs to be added to the new reflective tool?

There is concern from our members that the consultation period did not allow them sufficient time to consider the new reflective tool. The DHAA would be supportive of developed education and training for the profession on how the tool should be used. Further, a strategy for how the Board intends to engage the profession on using the tool, and how its use will be monitored require consideration. After a period of testing, the tool should be evaluated and reviewed. We understand this viewpoint is shared with our colleagues at ADOHTA.

There is concern that self-regulation will be abused by a small minority, and that the Board should have a strategy for identifying such individuals. While a small minority, any abuse of the privilege of self-regulation may tarnish the credibility and public trust for all those in the profession.

We again thank you for opportunity to provide this feedback, and are pleased to be contacted for any clarifications or ongoing discussions.

Yours sincerely,



Kathryn Novak
DHAA Ltd. National President

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