Recruitment and Practice of Dental Therapists

June 2004
This document reflects advice and recommendations to the Ministry of Health and other agencies from the Dental Therapy Technical Advisory Group (TAG). In finalising the recommendations, the TAG was aware of the diversity of opinions across the sector on some issues. Some recommendations do not necessarily reflect the views of the organisations from which individual members are nominated. The Chairperson wishes to express her thanks to the members of the TAG for their frankness and openness in the debate.


Published in June 2004 by the Ministry of Health, Manatū Hauora PO Box 5013, Wellington, New Zealand

ISBN 0-478-28286-9 (Web)
HP 3857

This document is available on the Ministry of Health’s website http://www.moh.govt.nz
Contents

Executive Summary v
Recommendations vi

1 Review of Future Organisation of Dental Therapy Practice 1
   1.1 Scope of practice 1
   1.2 Removal of current employment restrictions 2
   1.3 Sole operators 3

2 Dental Therapy Education Programmes 4
   2.1 Current situation 4
   2.2 Future educational requirements for dental therapy 5

3 Dental Therapy Workforce Analysis 9
   3.1 Current dental therapy workforce 9
   3.2 Planning the future workforce 11

4 Recruitment and Retention 14
   4.1 Working environment 14
   4.2 Education 15
   4.3 Legislation 16
   4.4 Remuneration 16
   4.5 Career promotion 17
   4.6 Career options 18

5 Assessment of Overseas Dental Personnel 19
   5.1 The current system 19
   5.2 Principles of the proposed assessment process 19
   5.3 Process for dental therapists re-entering the workforce 22

Appendices
   Appendix 1: The Dental Therapy Technical Advisory Group 23
   Appendix 2: Proposed Scopes of Dental Therapy Practice 25
   Appendix 3: Ministry of Health Stocktake, 2003 42

References 43
List of Figures
Figure 1: Education pathway 6
Figure 2: Age of dental therapy workforce, 2003 9
Figure 3: Ethnic make-up of workforce, 2003 10
Figure 4: Geographic spread of the dental therapy workforce, 2003 10

List of Tables
Table 1: New Zealand dental therapy students entering the workforce 11
Table 2: Projected number of patients, by ethnicity 12
Executive Summary

This document provides guidelines to assist District Health Boards (DHBs), the Dental Therapists Board and private employers on the recruitment, staffing expectations and competencies of dental therapists in providing dental services.

The Dental Therapy Technical Advisory Group (TAG) on the Recruitment and Practice of Dental Therapists was formed in October 2003 to provide recommendations on strategies for dental therapy workforce issues such as recruitment and retention, staffing expectations, educational opportunities, career structures, and the assessment of overseas dental personnel (see Appendix 1 for terms of reference and membership).

New Zealand has a long history of providing school dental services to children and adolescents. Since the early 1990s, however, there have been significant changes to the education and training of dental therapists, and to their recruitment and retention in the public dental service.

In March 2001 a former Dental Therapy TAG reported on the future organisation of dental therapy in relation to legislative arrangements to introduce the Health Practitioners Competence Assurance (HPCA) Act 2003. That report identified a number of issues that required immediate and long-term action. Some of the recommendations from the report have been actioned and others are still under consideration (see section 1 of this document).

At the time of the review the University of Otago was the only provider of dental therapy education and training. Since then the Auckland University of Technology (AUT) has also introduced a dental therapy programme. Both institutions now offer a three-year dental therapy education and training programme at the bachelor level, and the University of Otago also offers a two-year diploma qualification. In the past these courses have fallen short of their target student intakes. This has been attributed to the uncertainties surrounding long-term career opportunities in dental therapy. In addition, a postgraduate course offered by the University of Otago has failed to attract any applicants.

Data available from surveys and audits conducted in the 1990s indicate an acute shortfall in the supply of dental therapy services. The dental therapy workforce is ageing, and there will soon be very few dental therapists available to deliver the current levels of care, unless there are career development opportunities to provide incentives to enter the occupation. The recruitment of overseas-trained dental therapists and dentists has been suggested as a short-to mid-term solution to recruitment. However, the variability of overseas courses and programmes and the requirement to compare them to New Zealand courses has made it difficult to recruit appropriately and quickly.

Workforce development is a critical factor in being able to deliver on government priorities and in contributing to improving oral health outcomes. Key government health policy drivers are the New Zealand Health Strategy (Minister of Health 2000), the Primary Health Care Strategy (Minister of Health 2001), He Korowai Oranga (Minister of Health and Associate Minister of Health 2002) and Reducing Inequalities in Health (Ministry of Health 2002). A well-educated and sustainable workforce is required to ensure a safe, high-performing and efficient health system. Such a system is necessary to reduce the inequalities in health for Māori, Pacific and low-income people, to contribute to equitable and affordable access to services, and to maintain a public health and primary care focus.
In particular, the report to the Minister of Health, *Improving Child Oral Health and Reducing Child Oral Health Inequalities* (National Advisory Committee on Health and Disability 2003), identified that increasing the recruitment of dental therapists is essential. The report also highlighted the disparity in the ethnic composition of the present dental workforce, the requirement for a larger Māori and Pacific workforce, and the need for a culturally competent workforce.

In 2001 the Health Workforce Advisory Committee undertook a stocktake of the health workforce. The resulting report (Health Workforce Advisory Committee 2002a) highlighted the fact that the expected development of publicly funded oral health will have workforce implications for the number of dental therapists needed, and will require a reversal of the trends that show the capacity of the dental therapy workforce declining.

Under the HPCA Act 2003 the present Dental Council of New Zealand (DCNZ) will be replaced in September 2004 by a combined council comprising representatives from the various dental professions. Individual professional workforce boards will operate under this ‘umbrella’ DCNZ to manage the regulatory matters of each profession. Changes to the legislation will allow dental therapists to provide services to patients through both private and public dental clinics. There is, therefore, the potential for dental therapists to shift from public sector employment into the private sector and for the role of dental therapists to expand into a more primary care role for a wider range of patients.

The impact of this change has not been fully explored, but it brings with it the need for a broader range of employing agencies to understand and appreciate the role of dental therapy and its relationship to other aspects of dental practice. Also, because of workforce shortages the consequences of the possible movement of dental therapists out of the School Dental Service into the private sector would seriously impact on the ability of the School Dental Service to retain the present level of service delivery.

Clear, professional career outcomes for current dental therapists and young New Zealanders considering careers in this area of dentistry are required. The novelty of changes within the profession requires broad stakeholder and consumer agreement to the educational and philosophical aspects of dental therapy. These need to be in keeping with the dental service needs and demands envisaged by the New Zealand community.

**Recommendations**

The Dental Therapy Technical Advisory Group recommends that the Dental Therapists Board:

- produce a New Zealand Dental Therapy Conditions of Practice document which recognises New Zealand’s unique cultural and ethnic mix, and to this end should include a description of cultural competencies and be developed in consultation with Te Ao Marama and other relevant groups (see section 5.2)
- commission the setting of a national exam to assess the competence of dental personnel wishing to practise dental therapy in New Zealand (see section 5.2)
- include a communications skill test in the Dental Therapy Registration Examination to ensure communication skill levels are appropriate for managing a wide range of patients, in particular children and adolescents, and are appropriate for implementing informed consent requirements (see section 5.2)
- develop effective data collection systems, which include identifying annually the number of practising dental therapists by gender, age, ethnicity, type of practice, region of practice and hours of practice (see section 3.2).
The Dental Therapy Technical Advisory Group recommends that the Dental Council:

- adopt the draft scope and code of practice as proposed by the New Zealand Dental Therapists’ Association, with additional changes made by due process within the DCNZ, with the following provisions:
  - that the term ‘clinical guide’ is omitted with reference to the relationship between dentists and dental therapists and, further, that any reference to a named person being responsible for oversight of a dental therapist be deleted
  - that the wording ‘in the interest of patient safety a dental therapist should seek advice and guidance from the appropriate health professional’ be included in the scope of practice
  - that dental therapist patient groups should not be restricted by source of funding (see section 1.1).

The Dental Therapy Technical Advisory Group recommends that the Ministry of Health:

- together with DHBs, direct a review of dental therapy salaries and working conditions within the public sector (see section 4.4)
- together with the New Zealand Dental Therapists Association and Te Ao Mārama, develop a strategy to build the capacity of the Māori and Pacific dental therapy workforce (see section 3.2)
- determine a mechanism to identify the optimum number of dental therapists required annually, so that educational institutions can be advised of the industry needs (see section 3.2).

The Dental Therapy Technical Advisory Group recommends that tertiary educational institutions and the joint Australian Dental Council and DCNZ Accreditation Committee:

- recognise the changing education and clinical requirements of dental therapists with respect to scope of practice, and give immediate consideration to removing the diploma programme so that minimum dental therapy education and training be a degree programme at bachelor level (see section 2.2)
- explore the suitability of combining dental therapy and dental hygiene education and training (see section 2.2).

The Dental Therapy Technical Advisory Group recommends to DHBs and other employers that:

- dental therapists should not treat patients when working as sole operators (see sections 1.3 and 4.1)
- when developing workforce strategies for the recruitment and retention of dental therapists they take into account the barriers and incentives that contribute to the attractiveness of dental therapy as a career (see section 4)
- they support dental therapists to further their education by implementing strategies such as study leave, scholarships and recognition of educational advancement (see section 4.2).
1 Review of Future Organisation of Dental Therapy Practice

The report of the Dental Therapy Technical Advisory Group 2001, Future Organisation of Dental Therapy Practice, was developed at the early stages of detailed policy development for the HPCA Act 2003 and in response to the Government’s initiatives to upgrade the training of, and introduce registration for, dental therapists.

Recommendations from the report related to providing advice on registration, training, discipline, employment arrangements and competencies of dental therapists. Since then many of the recommendations have been implemented, largely by the establishment of new academic programmes for dental therapy at the University of Otago and AUT, and the introduction of the HPCA Act and inclusion of the dental therapy profession under that legislation.

The principal purpose of the HPCA legislation is to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions.

1.1 Scope of practice

Recommendations and issues from the 2001 TAG document that are still unresolved mainly relate to the setting of a dental therapy scope of practice.

Recommendation 9 (TAG 2001) states:

... the TAG supports the option to remove current employment restrictions. Therapists would still, however, work as part of a team with ongoing clinical guidance from a practising dentist.

Further, recommendation 12 (TAG 2001) states ‘the TAG considers that a named dentist should be designated to provide clinical guidance for each dental therapist’.

Under the HPCA Act health practitioners are responsible for their own professional practice within their scope of practice. Dental therapists will therefore be able to operate as autonomous health professionals within the dental therapy scope of practice. Ongoing competency of dental therapists will be regulated and monitored by the Dental Therapists Board.

When a dental therapist is faced with situations or clinical matters that fall outside their scope of practice, the patient will be referred for continuing care. Under existing scopes of practice dental therapists already work in this way. The reasons for referral are, and will be, wide ranging and the therapist refers to the health professional best suited to provide the required treatment. Referral to a single named person responsible for providing clinical guidance, as was previously the case, is not appropriate or in the patients’ best interests.

It is anticipated that a wide range of clinical arrangements between dental therapists and dentists will evolve under the provisions of the new legislation. These inter-professional relationships will be based on collaboration and collegiality, on ensuring best possible outcomes for patients, and on the recognition of the diversity in expertise, skills, knowledge and practice of different health professionals.

The standard of graduate emerging from dental therapy programmes at AUT and the University of Otago is considerably different from that of graduates from Ministry of Health institutions more
than five years ago. Current training provides graduates with the skills and resources to practise independently within their scope of practice. However, it is recommended that such a person, whether employed within the School Dental Service or in private practice, be provided with support from a suitable mentor so that knowledge and skills are consolidated and strengthened, and confidence gained through the application of what has been learnt as an undergraduate.

Therapists may extend their scope of practice in two ways:
- the completion of additional modules at an accredited institution
- the formal addition of modules from an accredited educational institution completed in the workplace while working under clinical oversight provided by a person who has a recognised qualification in that particular area.

The HPCA Act interprets oversight as ‘professional support and assistance to a health practitioner by a professional peer for the purposes of professional development’.

The draft dental therapy scope of practice, as proposed by the Dental Therapists Board of the new DCNZ, and the New Zealand Dental Therapists Association’s code of practice and competency cluster 2003 (see Appendix 2) have been drafted and circulated within the sector for consultation. The scope of practice will be subject to final approval by the DCNZ on 2 June 2004. The following distinctions should be borne in mind:
- the scope of practice defines the services provided
- the code of practice defines the working relationship between dental therapists and dentists and other health professionals
- the competency clusters describe the skills and knowledge required to perform given tasks effectively and to work safely.

Note that discussions on the proposed scope of practice indicated a diversity of opinion among the group on some aspects of the scope. This was acknowledged, and the group arrived at its final view that the DCNZ adopt these documents and that any additional changes be modified subsequently through due process involving the new DCNZ.

### 1.2 Removal of current employment restrictions

As per Recommendation 9, the 2001 TAG supported the option to remove current employment restrictions that limit therapists to work for DHBs and the School Dental Service. Due to concerns about retaining the workforce capacity of the School Dental Service until therapist numbers are increased, consideration has been given to including a clause in the Scope of Practice that would restrict dental therapists to work only on publicly funded patients. The Ministry of Health has sought advice regarding this from a variety of sources, including a health legal opinion and comment from the Commerce Commission. Both these sources advise that such an inclusion would risk breaching the Commerce Act 1986, in particular section 27. Section 27 provides a broad rule that prohibits any person from entering into, or giving effect to, a provision of a contract, arrangement or understanding that has the purpose, or effect or likely effect, of substantially lessening competition in a market. In line with regulatory boards’ responsibilities, the decisions on scopes of practice are for the DCNZ to make. However, it is the recommendation of the TAG that dental therapists should be able to practise on a wide range of patients, not restricted by the source of funding for care.
Recommendation
That the DCNZ adopt the draft scope and code of practice as proposed by the New Zealand Dental Therapists Association, with additional changes made by due process within the DCNZ, with the following provisions:

- that the term 'clinical guide' is omitted with reference to the relationship between dentists and dental therapists and, further, that any reference to a named person being responsible for oversight of a dental therapist be deleted
- in this regard it is recommended that the wording 'in the interest of patient safety a dental therapist should seek advice and guidance from the appropriate health professional' be included in the scope of practice
- that dental therapist patient groups should not be restricted by source of funding.

1.3 Sole operators

Recommendation 17 (TAG 2001) states that 'dental therapists should not treat patients as sole operators'.

This is still one area that has not been fully addressed in most School Dental Services. It was also identified as a problem by dental therapists in the recent New Zealand Dental Therapists’ Association / Public Service Association ‘Challenge of Change’ symposium. Factors such as professional isolation, safety issues and problems managing cross-infection were identified as issues for sole practice.

The current TAG endorses the TAG 2001 recommendation and emphasises that to promote safe and effective practice dental therapists should not work as sole operators. It is acknowledged that there are funding issues for DHBs in implementing this recommendation. There is also a facilities issue, as space is limited in many present school dental clinics, which precludes the use of dental assistants. The development of new service delivery models within the School Dental Service will provide opportunities for addressing the sole operator problem.

Recommendation
That dental therapists should not treat patients when working as sole operators.
2 Dental Therapy Education Programmes

2.1 Current situation

There are currently two educational institutions offering dental therapy education: the Auckland University of Technology (AUT) and the University of Otago.

The University of Otago introduced the two-year Diploma in Dental Therapy in 1999 and the three-year Bachelor of Health Sciences (endorsed in Dental Therapy) in 2001. In 2000, the Postgraduate Diploma in Dental Therapy was also introduced. The dental therapy undergraduate programmes are integrated into teaching and learning at the School of Dentistry, along with dentistry, dental technology and dental hygiene. Dental therapy students undertake four weeks’ ‘off-site’ learning in school dental clinics throughout New Zealand in their final year of study.

AUT introduced a three-year degree for dental therapy in 2002. In the new degree there is an emphasis on core health science papers, research and health promotion. The clinical education takes place in existing community clinics within the Auckland Regional Dental Service. AUT hopes to develop its own clinic on the Akoranga campus in 2005.

Course structures and alignments

AUT and the University of Otago provide extremely different facilities for educating dental therapists. Dental therapists at Otago are educated alongside all other disciplines in dentistry, and sections of the education are integrated with these disciplines, with the intention of developing more integration.

AUT has a community focus, and students are educated alongside a wide range of other Bachelor of Health Science students. In a short time AUT has built a strong relationship with the Auckland Regional Dental Service, ensuring that students have good facilities in field clinics.

Despite these differences, the teaching philosophy at both institutions has a focus on students developing and attaining proficiency and competence, so that they meet the required standards of the dental therapy health profession.

Relationship between AUT and the University of Otago

The relationship between the two universities is new. Despite the competitive climate imposed on today’s universities due to the objective of achieving financial success, staff in the dental therapy programmes at AUT and the University of Otago are conscientiously developing strategies to become more collaborative. Also, staff are aware of the new emphasis given by the Tertiary Education Commission of working collaboratively, and it is the intention to try to develop this relationship further.
Accreditation

Dental therapy courses at both AUT and the University of Otago will be undergoing an accreditation process by a team that includes members of the joint DCNZ and Australian Dental Council accreditation committee. The accreditation panel was to have visited both institutions in May 2004 and final assessment reports are due to the Dental Therapists Board in August 2004.

2.2 Future educational requirements for dental therapy

The Health Workforce Advisory Committee has identified the need to build a robust and responsive health workforce that is equipped to address the future health needs of New Zealanders. They have identified that developments in the health sector – such as the increasing emphasis on prevention, the changes of scopes of practice of health practitioners and developments in science and technology – will provide the framework for health workforce education. District Health Boards New Zealand, through the joint DHB/DHBNZ Workforce Action Plan, is also developing strategies to enhance workforce development within DHBs and to develop collaborative mechanisms with the education sector.

It will be crucial for educators of dental therapists to maintain strong linkages with the health sector. The education of dental therapists will be a process of ongoing change. Evolutionary changes within oral health service delivery and population needs will influence future education requirements of the dental therapy profession and the workforce.

Career options in dental therapy

Significant career options will be apparent with the lifting of restrictions for employment. The role of dental therapists will be extended to include dental treatment (within the dental therapy scope of practice) on a wider range of patients. Therapists will work in a variety of situations, including the School Dental Service, in private clinics, in primary health organisations and with Māori health providers.

Appropriate qualifications will be needed to equip therapists for these positions and for the future leadership roles that will develop within the profession.

Module development and upgrades

There will be opportunities for graduate dental therapists to upskill. Therapists will be able to extend their scope of practice beyond their basic scope through training modules in specific subjects, such as care of adult patients, pulpotomy training, stainless steel crowns and dental radiography. National consistency in competency is important and methods for the development of modules need to be investigated. Further, pathways for existing therapists with certificate or diploma qualifications to upgrade to the degree qualification need to remain available in the short to medium term.

Postgraduate education

The research base of dental therapy education will further develop the profession. The focus should emphasise intellectual independence, excellence in communication skills, and demonstrable commitment to lifelong learning and professional development.
Postgraduate programmes will further these skills by building on the undergraduate qualification and will equip postgraduates wishing to take up leadership roles within the profession. There has been little interest from the sector so far in the existing postgraduate course, but with the development of a clear clinical pathway for dental therapists postgraduate courses should attract more interest. There is a clear need for dental therapy to develop a research culture.

Tertiary education allows a dental therapy education pathway through to advanced level, and it is possible – yet unique – for therapists who hold certificate or diploma qualifications to undertake postgraduate courses.

Figure 1: Education pathway

Certificate in Dental Therapy

Diploma in Dental Therapy

Bachelor of Health Sciences (endorsed in dental therapy)

Minimum of two years’ clinical practice in dental therapy

Postgraduate Diploma in Dental Therapy

Master’s Degree

PhD

Cultural competency

New Zealand has a unique cultural mix and it is important to ensure that the dental therapy workforce is culturally competent. Māori culture and health care are included in the training courses, but it is important that all therapists have the necessary cultural understanding to provide culturally safe and appropriate care across a broad range of community groups. The description of cultural competency requirements for dental therapists should be included in a New Zealand conditions of practice document.

This should be undertaken in addition to working towards achieving an ethnic mix of dental therapists that better reflects New Zealand’s ethnic mix (see section 3).
Distance learning
Dental therapists have indicated that a barrier to participating in postgraduate courses is the geographical distance of most from the educational institutions. In the past, distance learning has been limited, and a more flexible education platform needs to be developed to meet consumer demand. Distance learning courses, summer schools and outreach programmes need to be available for therapists wishing to further their education.

Significant resource issues for providers have been identified, and these need to be considered before such programmes can become viable.

Programmes need to educate people to address inequalities in health and oral health needs
At present AUT and the University of Otago courses include education about the inequalities in health and the specific oral health needs of sectors of the New Zealand population. Specialists in all fields of dentistry and public health teach in these subjects at Otago. Commensurate with the role of a primary oral health care worker, the education and training provided to dental therapists in the future should have a strong public health focus, with the aim of developing skills to enable the workforce to reduce oral health inequalities.

Portability
There could be the opportunity for students to move from AUT to the University of Otago following a closer alignment of the structures of the two degrees. Some international portability exists for graduates, and employment has been secured by Otago graduates in Victoria and New South Wales. The Australian Dental Therapists Association is developing portability within all Australian states. The joint Australian Dental Council and DCNZ accreditation committee will also accredit the dental therapy courses in New Zealand and Australia. Once this occurs, the dental therapy qualification should automatically be portable, within the teaching scopes of practice, between the different Australian states and New Zealand. Canada is currently compiling dental therapy curricula from all Commonwealth countries, New Zealand included, to work towards international portability within the Commonwealth. In the future this will provide opportunities for therapists from these countries to use their qualification overseas.

Deletion of Diploma in Dental Therapy
To date the University of Otago has graduated 48 dental therapists with the Diploma in Dental Therapy. The diploma course has equipped these students with competence in all scopes of dental therapy practice to either secure employment in the School Dental Service, or prepare them to advance into further study. Less than 20 percent of diploma students have been school leavers. Of the remaining 80 percent, a significant proportion have been dental assistants prior to enrolling for the diploma. While the School Dental Service is understaffed, and until the degree courses attract full class numbers, consideration has been given to maintaining the diploma. However, it is recognised that the preference is for the minimum period of dental therapy education and training to be a three-year degree programme.
Recommendation
That tertiary educational institutions and the joint Australian Dental Council and DCNZ Accreditation Committee recognise the changing educational and clinical requirements of dental therapists with respect to the scope of dental therapy practice, and give immediate consideration to removing the diploma programme so that the minimum dental therapy education and training be a degree programme at bachelor level.

Combining dental therapy and dental hygiene skills
At present the University of Otago offers both a diploma course and a degree course in dental hygiene. Students of therapy and hygiene undertake generic health science papers in the first year and share some aspects of education in the following years. However, the clinical skills of a therapist focus on dental disease and those of a hygienist on gum disease.

The current dental therapy scope of practice taught at the University of Otago is not restricted to children and adolescents. Students are taught basic dentistry skills that can be applied to all age groups, although at present periodontal care for all age groups is restricted to scaling above the gingival margin. It is anticipated that the existing curricula at AUT and Otago could be adjusted in the future to include the clinical dentistry skill of scaling below the gingival margin, with appropriate knowledge to ensure routine dental skills are proficient and competent for all age groups. An essential requisite will be additional knowledge and understanding of the pathogenesis of mucosal conditions, including gingivitis and periodontitis.

Population and disease trends will strengthen the demand for a primary care oral health workforce that has the required skills and competencies to respond to future oral health needs in the population. As the population ages, this will bring an increase in demand for dental care from an older, more dependent population. Disease trends show that these people will be more likely to retain their teeth into old age, but will have high restorative needs. Increasing technological advancements and specialisation in private dental practices could mean an increasing section of the community on low incomes will be unable to access higher-cost private dental treatment. In the future, therefore, inequities in access to dental care, particularly in the area of publicly funded dentistry, may be reduced by the use of a dual-skilled dental auxiliary that would be able to provide routine and basic dental care to a wide age range.

It is in this regard that consideration could be given to developing an undergraduate programme that incorporates aspects of dental hygiene with dental therapy.

Recommendation
That the tertiary educational institutions and the joint Australian Dental Council and DCNZ accreditation committee explore the suitability of combining dental therapy and dental hygiene education and training.
3 Dental Therapy Workforce Analysis

3.1 Current dental therapy workforce

Profile
At present dental therapists are employed within the School Dental Service by DHBs, with the focus of service on preschool and school-aged children and, to a lesser extent, adolescents. Some therapists provide care to adults in situations such as hospital dental units.

In November 2003 the Ministry of Health collected dental therapy workforce data from DHBs. At this time there were 24 job vacancies. These were noted as budgeted vacancies, so the actual number of vacancies in some DHBs would be more.

The dental therapy workforce has a disproportionate number of older therapists to younger therapists (Figure 2). In November 2003, 80 percent of dental therapists were over 40 years of age and 40 percent were over 50. Of the 508 full-time equivalent dental therapists employed, only 28 were between the ages of 20 and 29 years. Over the next 10–15 years, therefore, the profession stands to lose a large number of the workforce as therapists reach retirement age.

![Figure 2: Age of dental therapy workforce, 2003](image)

New Zealand European therapists made up 91 percent of the workforce, with 8 percent Māori and 1 percent of Pacific ethnicity (see Figure 3). These proportions of the workforce are inconsistent with the population’s ethnic mix. Two percent of therapists are male and 98 percent female.
The spread of the dental therapy workforce varies throughout the country (Figure 4). Vacancies were confined to the Auckland, Waikato, Northland and Wellington areas.

At present workforce shortages and high patient-to-therapist ratios in some areas means that service delivery is aimed primarily at treatment services with little or no time for therapists to do preventive work.
3.2 Planning the future workforce

A planning framework similar to that described in Oral Health of Australians: National planning for oral health improvement (Australian Health Ministers' Advisory Council 2001) for estimating the supply of dental services and requirements for dental services is needed to more accurately predict workforce requirements. This framework takes into account the many factors involved in the supply of and demand for dental services, such as population factors, disease levels, consumer expectations, and the level of services available. The following factors are some that could be considered as part of an initial crude analysis.

- therapist-to-patient ratios
- student admissions
- need versus demand
- service delivery models.

Therapist-to-patient ratios

Therapist-to-patient ratios can be used at a macro level to ascertain optimum workforce numbers. The Ministry of Health, through the oral health toolkit, provides guidelines to assist DHBs with ascertaining dental therapy staffing levels in their own districts, given each area has its own requirements.

Student admissions

Currently, both the University of Otago and AUT dental therapy programmes can each accept 25 new dental therapy students a year. However, the reality is that fewer than 50 students per annum will enter the workforce, taking into account natural attrition and students who choose to work overseas after graduating. Table 1 shows the numbers of New Zealand students at present enrolled in dental therapy programmes that will enter the workforce at the end of 2004 and 2005.

Table 1: New Zealand dental therapy students entering the workforce

<table>
<thead>
<tr>
<th></th>
<th>University of Otago</th>
<th>Auckland University of Technology</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>2005</td>
<td>16</td>
<td>15</td>
<td>31</td>
</tr>
</tbody>
</table>

Need versus demand

Needs and demands for oral health services relate to the inequalities that exist within the New Zealand population.

There are documented disparities in oral health status between New Zealand’s population groups. On average, Māori and Pacific peoples, those from low socioeconomic homes and those in rural areas experience higher levels of dental disease than others in the community. Better health outcomes can be achieved if people have access to health practitioners who are able to affiliate and relate to an individual’s cultural or ethnic group. There is a need to address dental therapy workforce development in a way that better meets the needs of those groups with relatively poor health. In this regard, consideration needs to be given to having a Māori and Pacific dental therapy workforce that better reflects New Zealand’s population mix. Table 2 shows the projected ethnic mix within the child population.
Using data for 0–13-year-olds from the Statistics New Zealand ‘Projected resident population aged 0–20 years by sex at 30 June 2002–2026’ (Table 2), we can see the projected patient population and ethnic mix of the population. From this it is clear that there will be an increase of both Māori and Pacific children over the next 20 years.

<table>
<thead>
<tr>
<th></th>
<th>Projected number of patients, by ethnicity</th>
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<tbody>
<tr>
<td></td>
<td>2004</td>
</tr>
<tr>
<td>Total 0–13 years olds</td>
<td>756,460</td>
</tr>
<tr>
<td>Māori (% of total)</td>
<td>188,700 (24.9)</td>
</tr>
<tr>
<td>Pacific (% of total)</td>
<td>68,450 (9.1)</td>
</tr>
<tr>
<td>Other (% of total)</td>
<td>499,320 (66)</td>
</tr>
</tbody>
</table>

**Recommendation**

That a strategy be developed to build the capacity of the dental therapy Māori and Pacific dental therapy workforce.

There are also sections of the population – in particular older people, low-income adults, adolescents and those who live in rural areas – that experience difficulty in accessing dental services. Many low-income adults, who in the future will include an increasing percentage of older people, will not be able to afford the high cost of private dental treatment. Also, fewer private practitioners are taking up publicly funded oral health contracts and therefore many adolescents have difficulty accessing the free dental treatment available to them. Some isolated populations do not have easy access to dental care.

Following the HPCA Act, when employment restrictions are lifted, dental therapists may move out of the School Dental Service and provide basic oral health care to these sections of the population. It is difficult at this stage to predict the extent of this movement but by using projected population numbers and present workforce data it is possible to identify the level and composition of the workforce necessary to maintain the current services provided by the DHB School Dental Service.

**Service delivery models**

Data shows that in the past the School Dental Service has been very effective at improving the oral health of children (see *Improving Child Oral Health and Reducing Child Oral Health Inequalities*). However, since the 1990s the decline in decay rates has ceased and there is a need to reorient services to a more preventive role. Early enrolment of preschoolers, as well as oral health education for parents, would assist in the prevention of early childhood caries. Dental therapists are educated in this role, but an intersectoral approach is also required. Training dedicated oral health educators, community health workers such as Plunket nurses and public health nurses in oral health promotion could greatly influence future dental disease trends.

Ongoing analysis of the workforce and workforce requirements is required so that service provision can be aligned as closely as possible to service needs.
Recommendation
That the Dental Therapists Board develop effective annual data collection systems, which include identifying the number of practising dental therapists by gender, age, ethnicity, type of practice, region of practice and hours of practice.

Recommendation
That a mechanism be developed to identify the optimum number of dental therapists required annually, so that educational institution can be advised of the industry needs.
4 Recruitment and Retention

Between 1990 and 1998 the total number of dental therapists fell from 859 to 569. Present numbers stand at 508 full-time equivalents. This decline in numbers is due to a number of factors.

The move from six-monthly recall of patients to annual recalls has meant a decrease in therapist-to-patient ratios. Also, the successive health reforms of the 1990s saw the national service fragmented when competitive models of health provision were introduced. For the dental therapy profession this period resulted in:

- loss of jobs as areas ensured optimal outcomes
- varying remuneration rates and conditions throughout the country
- no national long-term workforce planning.

During this time there was also a marked reduction in student intakes, as shown by the fact that 80 percent of the dental therapy workforce is over 40 years of age (see Figure 2). This indicates a serious workforce problem in the future as these people reach retirement age.

Insufficient numbers entering the dental therapy workforce has contributed to the difficulties some school dental services have in maintaining current services. Some areas in the country that are experiencing continuing problems filling position vacancies are using overseas-trained dentists and dental therapists, when available, to alleviate their workforce shortages.

Under the HPCA legislation dental therapists will be able to move outside the School Dental Service and work in other employment situations. This will further exacerbate present staffing shortages in the School Dental Service.

Young people need to view dental therapy as a desirable career choice. There is no single way to improve the profile of dental therapy, but factors such as remuneration, career opportunities, status, attractiveness of work environments and work satisfaction all contribute to the recruitment and retention of a workforce. An understanding of the barriers and incentives relating to these factors is essential to the planning of workforce development strategies.

**Recommendation**

That Ministry of Health, DHBs and other employers, when developing workforce strategies for the recruitment and retention of dental therapists, take into account the barriers and incentives that contribute to the attractiveness of dental therapy as a career.

4.1 Working environment

**Sole operators**

Despite the recommendation from the 2001 TAG that dental therapists should not practise as sole operators, there are many therapists that still work for all or part of the time as sole practitioners. Therapists identify this situation as problematic, and those that work alone feel professionally isolated and unsupported – and in some instances unsafe.
Many areas have followed this recommendation and have introduced assistants. Therapists who work this way acknowledge that working in a team contributes to reducing stress levels and helps to provide a more professional image.

As this form of professional support is provided for therapists, job satisfaction should improve.

Recommendation:
That dental therapists should not treat patients when working as sole operators.

Facilities
The physical working environment for many dental therapists is far from ideal. Most of the school dental clinics in use today were erected in the 1950s and 1960s and have not been maintained or updated. Unresolved conflict between the education and health sectors over responsibility for the clinics has been the cause of this. Many of the facilities are cramped, not suitable for more than one practitioner, poorly designed for work flow and do not comply with present health and safety standards. These traditional clinics are no longer adequate for the provision of modern dentistry. Operating from these buildings presents a profile to the public of an outdated service.

The School Dental Services Review, presently being carried out, has charged DHBs with undertaking a survey of school dental service facilities and with developing plans for alternative service delivery models. Changes that will occur as a result of this review should bring a more modern and appropriate delivery approach that will also improve the profile of dental therapy services.

4.2 Education
The movement of dental therapy training into the university system has been effective in raising the academic status of the profession. The development of dental therapy education and training to the degree qualification has brought the training into line with other health professional training.

Dental therapy will, in future, profit from the educational pathway opportunities of tertiary education. Many present dental therapists were trained in the Department of Health training schools, where training was skill based and prescriptive. In contrast, the new university-based dental therapy education programmes are knowledge based, emphasise intellectual independence and have a focus on disease prevention and health promotion. With the development of postgraduate studies a culture will develop within the profession that values ongoing research and education, and a more professional status will result. Postgraduate studies will equip dental therapists to take up leadership roles within the profession, and this will cultivate new career opportunities for therapists.

Therapists who hold two-year certificate or diploma qualifications are at present automatically eligible to apply for postgraduate programmes in dental therapy. This is not common within academic frameworks and provides a definite incentive to those that wish to further their professional education.
Some barriers to the uptake of advanced education exist at present, such as the absence of visible career pathways, the lack of compensatory remuneration for advanced training, the geographical location of the universities (which requires many therapists to be away from home), and the unavailability of distance learning.

Dental therapists should be encouraged into further education, and employers can support this by providing study leave and through recognition of educational advancement. Scholarships can provide financial support for postgraduate education.

**Recommendation**

That DHBs and other employers support dental therapists to further their education by implementing strategies such as study leave, scholarships, and recognition of educational advancement.

### 4.3 Legislation

The registration of dental therapists under the HPCA legislation will give the profession self-regulation. Dental therapists make up the majority of the Dental Therapists Board, which has the delegated responsibility to consider and advise the DCNZ on issues affecting the dental therapy workforce, such as therapist competencies and fitness to practise. The Board also advises educational institutions on dental therapy education matters and facilitates accreditation of these institutions.

Registration facilitates the move of dental therapists from 'health workers' to 'health professionals'. As health professionals, dental therapists will be responsible and accountable for their own practice, professional development and research.

While this enhances the image and profile of the profession, it should be recognised that for some therapists a degree of 'change resistance' is possible. Access to information and support may be necessary as these changes are implemented.

It is anticipated that there will not be, nor will there ever be, legislative barriers to dental therapists providing services to a wider range of patients in a wider range of situations. Increased choices will be attractive to those looking at dental therapy as a career.

### 4.4 Remuneration

Up to the 1980s pay scales for dental therapists were related to those of schoolteachers, and salary and conditions were consistent nationally. With the health reforms of the 1990s these linkages were broken and pay scales and conditions varied across regions. Dental therapy pay rates did not progress or maintain parity with teachers between 1990 and 2000.

Dental therapy salaries on average range between $25,000 and $47,000, with significant regional differences and variations of working hours and leave entitlements. Whether alignment with teachers is still appropriate or not, it should be noted that dental therapy salaries now fall approximately $10,000 per annum behind previously equivalent teacher salaries. Figures taken from the Kiwicareers website [www.kiwicareers.co.nz](http://www.kiwicareers.co.nz) show that dental therapists’ pay scales have also fallen behind those of other allied health professionals.
Health professionals’ salaries in industry and private practices are considerably higher than those in the public sector. This could be significant to the dental therapy workforce, who in the future may have opportunities outside the public sector. The ability of the School Dental Service to retain its workforce capacity could be affected if salaries and terms and conditions in the public sector are not competitive with private sector conditions.

Dental therapy is a profession dominated by women, and as such experiences the inequity in pay and conditions commonly associated with female employment. For this reason, and because dental therapy has a small workforce, dental therapists have had little wage bargaining power.

University-based training has incurred higher fees and students often have loans to repay when they enter the workforce. Therefore, starting rates and possible salary advancement throughout their career is a consideration for young people making career choices. A shortage of health workers globally has caused competition for health workers. The attractiveness of working overseas may also affect the retention of dental therapists in the School Dental Service. The range of pay scales must reward extra responsibility and advanced education.

Dental therapist salaries should recognise the particular factors that differentiate dental therapy from other health professions. Dental therapists are community based, work autonomously and make independent decisions in their daily practice. They are accountable and responsible for their own practice. Remuneration levels should also recognise the invasive nature of dental procedures, the occupational skill level required and the stress levels involved with dental care, especially those associated with the care of children.

**Recommendation**

That the Ministry of Health together with District Health Boards direct a review of dental therapy salaries and working conditions within the public sector.

### 4.5 Career promotion

Research carried out at the University of Otago has shown that students choosing to study dental therapy have not accessed information from within the dental therapy profession. At the age when young people are starting to make decisions about a career, most have little to no contact with dental therapists. Dental therapists should be encouraged to provide effective and positive communication about their profession to school leavers.

The availability of jobs on graduation, the variety of employment opportunities becoming available, the mobility of the qualification and the emerging professional status of the dental therapist are all messages that should be conveyed to young people.

Employers could create opportunities for secondary school students to view this career on work experience days and provide holiday work as assistants to dental therapy students.
4.6 Career options

The expansion of employment opportunities for dental therapists following the HPCA Act will create career development opportunities for the profession. Dental therapists will work in the School Dental Service, primary health organisations, private clinics and Māori health services as the dental therapist assumes a greater role in the provision of primary oral health care within the community.

Therapists may specialise in particular areas of care such as with preschool children, older people, adult patients or in health promotion roles. They may be involved with mentoring, teaching and clinical oversight, and in leadership and management positions.

Practising at specialised or advanced levels will require appropriate preparation in terms of formal education.
5 Assessment of Overseas Dental Personnel

Under the HPCA Act the responsibility for assessing overseas dental personnel wanting to work as dental therapists in New Zealand will lie with the DCNZ. The purpose of this section is to provide the Dental Therapists Board with guidelines for the process of assessing overseas-qualified dentists and dental therapists seeking registration as dental therapists in New Zealand.

5.1 The current system

Currently dental therapists are able to practise in New Zealand through an exemption (section 7) of the Dental Act 1988. Under section 7, the Director-General of Health approves the conditions of the practice of dentistry by any person employed by the School Dental Service through a DHB.

Applicants who are not holders of a New Zealand dental therapy qualification are required to produce evidence of having completed a course of training that is accepted by the Director-General of Health as being equivalent to New Zealand dental therapy training.

Once application for assessment has been made to the Director-General of Health, the available documentation supporting previous training and practice is assessed with regard to its equivalence to New Zealand dental therapy training. Approval may then be given, with the recommendation that a retraining/orientation course be undertaken to upskill the applicant in New Zealand dental therapy practice.

Evaluation of the current system

An evaluation of the current system for assessing overseas dentists and dental therapists has highlighted areas of inconsistency. While the course content of each applicant is examined closely, there is no opportunity to test an applicant’s knowledge and understanding and practical application of the dental knowledge prior to acceptance or employment. There is also no way to determine the applicant’s level of English.

Once the Director-General of Health approves the application, the relevant DHB is responsible for overseeing any recommended training or orientation. Standards may vary between DHBs, and orientation lacks a process to determine levels of communication and understanding, or an assessment of competency against national standards.

5.2 Principles of the proposed assessment process

- With the introduction of the HPCA Act in September 2004, the process of assessing the competency of overseas-trained dental personnel wishing to become registered and work in New Zealand as dental therapists will be the responsibility of the DCNZ.
- The DCNZ will commission and control the Dental Therapy Registration Examination/assessment process. Assessment needs to address the following requirements of the HPCA Act:
  - prescribed qualifications (ie, a qualification approved and gazetted by the DCNZ)
  - fitness to practise
  - competency to practise.
• The Trans-Tasman Mutual Recognition Act 1993 (TTMRA) is to be recognised. Under the TTMRA a person who is registered as a dental therapist in a participating jurisdiction in Australia will be entitled to work as a dental therapist in New Zealand.

• Overseas-trained dental therapists and dentists applying to work as dental therapists, and not included in the TTMRA, should be subject to the agreed assessment of overseas-trained personnel procedure set by the DCNZ.

• All qualifications need to be examined individually by the DCNZ’s Dental Therapists’ Assessment Panel.

• All applicants (other than those covered by the TTMRA) will be required to sit a New Zealand Dental Therapy Registration Examination to assess their competency to practise.

Assessment process for all overseas trained applicants

• Applicants must provide to the DCNZ either:
  - confirmation of their dental qualification and a certificate of good standing from their previous regulatory board, or
  - if from a country or state that does not register dental therapists, references and copies of all qualifications, including details of course content.

• Where English is not the applicant’s first language, evidence of passing a recognised English assessment examination must be provided.

• Documentation must be verified by the DCNZ.

• The DCNZ must then make the decision on whether the applicant must undergo further assessment to establish their competency to practise as a dental therapist in New Zealand. (Eventually other dental therapy education programmes around the world may be accredited as equal to the New Zealand training programmes and the DCNZ should have the flexibility to make that decision, with expert advice.)

• All applicants will be provided with a copy of the New Zealand Conditions of Practice. This document should recognise New Zealand’s unique cultural and ethnic mix, and in this regard must include a description of the required cultural competencies.

• All applicants (other than those covered by the TTMRA) will be required to pass a national examination to test their competency to practise. There will be a charge to the applicant, determined by the DCNZ.

• All applicants must display an awareness of, and be appropriately assessed on, the cultural and health component in the New Zealand Conditions of Practice.

Recommendation
That the Dental Therapy Workforce Board produce a ‘New Zealand Dental Therapy Conditions of Practice’ document for the DCNZ. This document should recognise New Zealand’s unique cultural and ethnic mix, and to this end should include a description of cultural competencies and be developed in consultation with Te Ao Marama and other relevant groups.

Recommendation
That the Dental Therapy Workforce Board commission the setting of a national exam for the DCNZ to assess the competence of dental personnel wishing to practise dental therapy in New Zealand.
Assessment of written and spoken English

- Overseas-trained dental personnel who can demonstrate that their first language is English and that they have studied and gained their qualification in English may be exempt from the English-language requirement.

- Where English is not the first language, applicants will be required to demonstrate their competence in English by passing an approved English-language test. These are the same as those listed in the registration requirements of the DCNZ and are set out below.

International English Language Testing System (IELTS academic band)
The examination has four parts: reading, writing, listening and speaking.

Applicants will be required to:
- sit the academic level of IELTS
- pass all four parts of IELTS (reading, writing, listening and speaking)
- get an average score of 7 or more for IELTS (all parts), with a minimum score of 6 for listening and 6 for speaking.

Test of English as a Foreign Language (TOEFL)
There are two formats for the TOEFL: a paper test and a computer-based test.

A. Paper test – applicants will be required to:
   - score at least 570 in TOEFL
   - score at least 4 in TWE (written)
   - score at least 50 in TSE (spoken).

B. Computer-based test – this has four sections:
   - listening
   - structure
   - reading
   - written expression.

Applicants must score at least 230 in TOEFL, and at least 50 in TSE.

Occupational English Test (OET)
The OET examination is available in Australia and in Australian embassies throughout the world. The examination has four parts: reading, writing, listening and speaking. Applicants are required to pass all four parts of the OET with either a grade A or B pass mark.

Recommendation
That a communication skills test be included in the dental therapy registration examination to ensure communication skill levels are appropriate for managing a wide range of patients, in particular children and adolescents, and are appropriate for implementing informed consent requirements.
Orientation courses for overseas applicants

An overseas-trained dentist or dental therapist may, in preparation for sitting the New Zealand Dental Therapy Registration Examination, choose to attend:

- a New Zealand orientation course / refresher course for dental therapists, such as that offered by the University of Otago
- a recognised update course of longer duration, such as the retraining course offered by the Auckland Regional Dental Service
- either of the dental therapy programmes at Otago or Auckland, and complete the whole course or part of those respective programmes.

A New Zealand orientation course should include factors that are particular to New Zealand dental therapy practice. This would include:

- behaviour management
- the development of occlusion and orthodontics
- infection control
- legislative requirements – informed consent, privacy requirements, Code of Health and Disability Services Consumer Rights 1996
- New Zealand health system
- cultural awareness and the Treaty of Waitangi
- scope of practice of dental therapy
- health promotion concepts and principles, including the dental therapist’s role in improving oral health outcome.

5.3 Process for dental therapists re-entering the workforce

Therapists who have had a break of three years or more from professional practice and who wish to re-enter the workforce will be required to sit and pass the Dental Therapy Registration Examination. This examination will be the benchmark to ascertain a practitioner’s competence to practise and will test skills to a level that is commensurate with what is required of a graduating student.

The type of refresher/update course that an applicant might undertake in preparation for sitting the Dental Therapy Registration Examination will depend on the applicant’s length of time away from practice and may range, as for overseas personnel, from a short refresher course to a course of longer duration. Likewise, the results obtained in the registration examination may determine the length and type of orientation or upskilling course an applicant may require to acquire competency to practise.
Appendix 1:
The Dental Therapy Technical Advisory Group

Purpose

The purpose of the Dental Therapy Technical Advisory Group (TAG) is to assist the DHBs, the New Zealand Dental Therapists Board and private employers in the recruitment, staffing expectations and competencies of dental therapists in providing services.

The TAG has worked closely with DHBs, the New Zealand Dental Therapists’ Association, educational institutions, the New Zealand Dental Association and the Oral Health Advisory Group and has built on work already completed by the DCNZ, the Health Workforce Advisory Committee, Te Ao Marama and the 2001 Dental Therapy Technical Advisory Group.

The Ministry of Health is particularly aware of its obligations under the Treaty of Waitangi to improve child oral health and to reduce oral health inequalities for Māori. To this end it sees it as a priority to encourage Māori and Pacific young adults to pursue a career in dental therapy.

Managers and principal dental officers have discussed, through the School and Community Dental Services Society, the current shortage of trained dental therapists and the difficulty in filling vacancies. The society called for national guidelines to assist in the recruitment and retention of staff. The New Zealand Dental Therapists’ Association, DHB managers, Te Ao Marama, the Ministry of Health and educational institutions are jointly committed to the recruitment and retention of personnel in dental therapy.

Terms of reference

- To review the Dental Therapy Technical Advisory Group’s *Future Organisation of Dental Therapy Practice* report and identify gaps between their recommendations and implementation plans impacting on the recruitment and retention of dental therapists in New Zealand.

- To identify opportunities in the training and education programmes, career structures and associated conditions for employment of dental therapists in New Zealand, including training requirements for dental therapists re-entering the workforce.

- To elaborate the range of ongoing educational requirements and opportunities for dental therapists in postgraduate education.

- To provide guidelines for the recruitment, examination and training for overseas-trained dental therapists and dentists wishing to practise as dental therapists in New Zealand.

- To provide a cohesive educational framework for the enhancement of dental therapy as an ongoing professional career for young New Zealanders.

- To provide a draft strategy for the recruitment and retention of dental therapists in New Zealand, including the identification of incentives and constraints that will impact on these outcomes.
Members of the Technical Advisory Group

The following people have participated in the TAG and have contributed to the development of this document. The Ministry of Health would like to thank them for their time and contribution.

Brent Stanley/Mary Livingston  DCNZ
Linda Buttle  University Dental Therapy Education Programmes
Helen Tane  Te Ao Marama
Vicki Kershaw  New Zealand Dental Therapists Association
Trish Simpson  New Zealand Dental Therapists Association
Pip Zammit  New Zealand Dental Therapists Association
Tom Kardos  University Dental Therapy Education Programmes
Tony Waghorn  New Zealand Dental Association
Sarah McGill  School and Community Services Society
Andrea Jarrold  District Health Boards representative
Bronwyn Signal  New Zealand Dental Hygienists’ Association

The Dental Therapy Technical Advisory Group was sponsored by Clive Wright, Chief Advisor (Oral Health) within the Ministry of Health. Coral Ross-Taylor, Ministry of Health, provided the secretariat support for the group.
Appendix 2: Proposed Scopes of Dental Therapy Practice

At the time of this report the attached draft scope of practice was the most current version under consideration.

The Dental Therapy Board of the new DCNZ is proposing that the following scopes of practice should be prescribed for dental therapy practice under the Health Practitioners Competence Assurance Act 2003 (HPCA).

(a) Draft scope of general dental therapy practice

Description

The DCNZ defines the practice of dentistry as the maintenance of oral health through the assessment, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures.

Dental therapy practice is a subset of the practice of dentistry, and is commensurate with the dental therapist's approved education, training and competence.

In collaboration with dentists and other health care professionals, and in partnership with individuals, whānau and communities, dental therapists provide oral health assessment, treatment, management and prevention services for children and adolescents. Disease prevention and oral health promotion and maintenance are core activities. Dental therapy practice includes:

- assessment of medical history, examination of oral tissues, diagnosis of dental caries and recognition of abnormalities
- preparation of an oral care plan
- informed consent procedures
- administration of local anaesthetic, including infiltration and inferior dental nerve block and topical local anaesthetic
- preparation of cavities and restoration of primary and permanent teeth using direct placement of appropriate dental materials
- extraction of primary teeth
- pulp capping in primary and permanent teeth
- preventive dentistry, including cleaning, polishing and scaling (supragingival and subgingival up to 5 mm), fissure sealants, and fluoride applications
- oral health education and promotion
- referral as necessary to the appropriate practitioner/agency.

Dental therapy practice goes wider than clinical dentistry to include teaching, research and management, given that such roles influence clinical practice and public safety.
Qualifications

- Diploma in Dental Therapy (issued by a New Zealand educational institution)
- Bachelor of Health Sciences (Dental Therapy), University of Otago
- Bachelor of Health Sciences (Dental Therapy), Auckland University of Technology
- undergraduate dental therapy degree or diploma from an accredited Australian Dental Council-accredited educational institution
- a pass in the DCNZ Dental Therapy Registration Examination.

(b) Draft scope of dental diagnostic radiography in dental therapy practice

Description
Taking and interpreting periapical and bitewing radiographs for children and adolescents under the supervision or instructions of a dental licensee.

Qualifications

- An approved undergraduate qualification which included training in radiography; or
- An approved undergraduate qualification and approved postgraduate training in radiography.

(c) Draft scope of stainless steel crowns in Dental Therapy Practice

Description
Preparing and placing stainless steel crowns for children and adolescents.

Qualifications

- An approved undergraduate qualification which included training in stainless steel crowns; or
- An approved undergraduate qualification and approved postgraduate training in stainless steel crowns.

(d) Draft scope of pulpotomies in dental therapy practice

Description
Performing pulpotomies on primary teeth.

Qualifications

- An approved undergraduate qualification which included training in pulpotomies on primary teeth; or
- An approved undergraduate qualification and approved postgraduate training in pulpotomies on primary teeth.
(e) Draft scope of adult care in dental therapy practice

Description
Providing care to adult patients within the general dental therapy scope of practice (and/or an additional registered scope) in a team situation with a named dentist.

Qualifications
A minimum number of years of approved experience in the provision of oral health to adults within the scope(s) of dental therapy practice, under the direction and supervision of a dentist who can attest to competency.

Draft Code of Practice on Working Relationships and Quality Assurance as proposed by the NZDTA.

Working relationships

Clinical relationship

In collaboration with dentists and other health care professionals, and in partnership with individuals, whanau and communities, dental therapists provide oral health assessment, treatment, management and prevention services for children and adolescents. (Dental Therapy Scope of Practice)

It is anticipated that a wide range of clinical working arrangements between dental therapists and dentists will evolve under the provisions of the new legislation. The clinical environment may range from a large, publicly operated school dental service to a small private practice. The practice of dental therapy will be based on collaboration and collegiality, which has been defined as ‘interprofessional relationships’ between the dental therapist and other health care professionals based on:

• concern to ensure the best possible outcomes for patients
• recognition of the diversity in expertise, skills, knowledge and practice.

Dental therapists will refer patients to the appropriate practitioner/agency when required. Some examples of when referral will be necessary to an oral health professional are:

• when the dental therapist has assessed that the patient may require clinical treatment beyond the dental therapist’s scope of practice
• for orthodontic treatment
• when abnormal oral pathology has been recognised.

Other instances will include when a patient requires either general anaesthetic or sedation to enable treatment, and for some special needs and medically compromised patients.

Within the Dental Therapy Scope of Practice, extensions to ‘practise the profession’ are listed. When a dental therapist learns one of the extensions listed, she/he is required to practise the skill under ‘oversight’ until competence is proved.
Employment relationship

There are two principal arrangements recognised for the provision of work between two parties. A ‘contract of service’ is the common arrangement of an employer and an employee. It is subject to employment legislation. The Employment Relations Act 2000 clearly outlines the requirements for an employer–employee relationship.

Alternatively, parties may agree to a ‘contract for services’, which is when an independent contractor arrangement is entered into. In this arrangement the parties are not automatically subject to employment law. However, the Employment Relations Act 2000 does provide a procedure for the status to be determined between the two parties, and it is recommended that the real nature of the relationship is examined carefully.

Dental therapists have traditionally been employees of large government-operated institutions and have commonly had collective employment agreements with those employers. Conversely, most dentists operate small owner-operated businesses and have individual employment agreements or a contract for services with workers in the practice.

It is important that dentists and dental therapists establishing a new working relationship under the altered employment options that will be enabled by the Health Practitioners Competence Assurance Act 2003 take the time to document and understand the working relationship. It is recommended that independent professional advice be sought by both parties in establishing the relationship.

Dental therapist as employer/business owner

It is possible, and legal, for a dental therapist to be the owner of a business that is providing dental care. Under the Health Practitioners Competence Assurance Bill those services may include dental care provided by the owner-operator dental therapist. In these circumstances the dentist may be engaged as an employee or as an independent contractor.

It is recommended that in these circumstances both parties document and agree to an understanding of the responsibilities of the respective roles of:

- business owner
- employer
- employee/independent contractor.

Quality assurance

Quality assurance encompasses systems and processes designed to maintain and continually improve the quality of care received. These are evidence-based, patient-centred and supportive of dental therapists. They can include continuing professional development, risk identification, clinical audit and clearly written clinical and practice protocols. To ensure public safety, dental therapists will be required to participate in quality assurance procedures. The Dental Therapy Competency Clusters document is an important tool to aid assessment of a dental therapist’s competence.
Definition of terms

- Dental therapist
- Scope of practice
- Oversight
- Professional peer
- Dental therapy competency clusters.

Dental therapist

This is a dental therapist who has been registered with the DCNZ and has a current Annual Practising Certificate (APC).

Scope of practice

This defines the activities a New Zealand-registered dental therapist with a current Annual Practising Certificate (APC) can perform, as approved by the DCNZ and the Dental Therapy Workforce Board.

Oversight

Oversight means professional support and assistance provided to a health practitioner by a professional peer for the purposes of professional development (see HPCA, section 5: ‘Interpretation’).

Professional peer

In relation to a health practitioner, is a person who is registered with the same authority with which the health practitioner is registered (see HPCA, section 5: ‘Interpretation’).

Dental therapy competency clusters

These describe the:

- professional, legal and ethical responsibilities of the dental therapist
- the interpersonal skills required by the dental therapist
- the skills required for the provision of dental therapy services to the patient
- the organisation and management skills required by the dental therapist.
<table>
<thead>
<tr>
<th>Dental therapy competency clusters</th>
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<tbody>
<tr>
<td><strong>Personal orientation</strong></td>
<td>• Professional manner, responsibility/accountability</td>
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<td></td>
<td>• Professional development</td>
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<tr>
<td></td>
<td>• Time management/productivity/efficiency</td>
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<tr>
<td><strong>People orientation</strong></td>
<td>• Communication</td>
</tr>
<tr>
<td></td>
<td>• Interpersonal understanding/ cultural safety</td>
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<td></td>
<td>• Teamwork and co-operation</td>
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<td></td>
<td>• Relationship building/patient management</td>
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<tr>
<td><strong>Service provision</strong></td>
<td>• Documentation (information gathering/recording)</td>
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<td></td>
<td>• Diagnosis/care plan</td>
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<td></td>
<td>• Preventive dentistry</td>
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<td>• Restorative dentistry</td>
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<td>• Radiography</td>
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<td></td>
<td>• Oral health promotion</td>
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<tr>
<td><strong>Organisation and management of dental therapy environment</strong></td>
<td>• Equipment/stores management</td>
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<tr>
<td></td>
<td>• Control of cross infection</td>
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<tr>
<td></td>
<td>• Clinic environment/group organisation</td>
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<tr>
<td></td>
<td>• Occupational Health and Safety</td>
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<td>• Quality improvement</td>
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</table>
Competency Cluster 1: Personal orientation
This competency cluster describes the professional, legal and ethical responsibilities of the dental therapist. These responsibilities relate to all aspects of dental therapy practice.

Range statement
Legislation referred to in this competency cluster includes the following:

- Health Information Privacy Code
- Health and Disability Commissioner Act 1994
- Health Practitioners Competence Assurance Act 2003
- New Zealand Dental Therapists Association Code of Ethics and Codes of Practice.

Professional manner, responsibility/accountability
Element: Work professionally in dental therapy practice

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaves in a professional manner</td>
<td>• Maintains professional conduct and participates in a collegial and co-operative way with peers and other health professionals</td>
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<tr>
<td></td>
<td>• Interacts with patients and the public in a professional manner</td>
</tr>
<tr>
<td>Works within Dental Therapy Scope of Practice</td>
<td>• Demonstrates understanding of extent/limitations of Scope of Practice</td>
</tr>
<tr>
<td></td>
<td>• Refers aspects of care outside of Scope of Practice</td>
</tr>
<tr>
<td>Maintains a consistent standard of work</td>
<td>• Demonstrates a consistent standard of work</td>
</tr>
<tr>
<td>Accepts responsibility for own work tasks and performance</td>
<td>• Owns the results of her/his work</td>
</tr>
<tr>
<td>Shares professional strengths with others</td>
<td>• Shares experiences and case studies of dental therapy practice with colleagues</td>
</tr>
</tbody>
</table>

Element: Comply with legal requirements and Code of Ethics

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<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands and is able to explain the application of the legislation and Codes relating to her/his dental therapy practice</td>
<td>• Discusses the application of the current legislation relating to dental therapy practice</td>
</tr>
<tr>
<td></td>
<td>• Complies with legislation</td>
</tr>
<tr>
<td>Complies with Codes of Practice</td>
<td>• Discusses the application of the Codes</td>
</tr>
</tbody>
</table>
### Professional development

**Element: Commitment to lifelong professional development**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
</table>
| Reviews own professional practice | • Monitors performance against set standards  
|                                 | • Identifies skills, knowledge and attitudes to be developed  
|                                 | • Identifies learning needs for personal professional development  
|                                 | • Implements an active professional development programme                         |

| Undertakes professional development | • Discusses professional issues with colleagues  
|                                    | • Reads scientific publications in oral health  
|                                    | • Remains current in research-informed practice  
|                                    | • Contributes scholarly articles to professional journals |

### Time management/productivity/efficiency

**Element: Contribute to management of the dental therapy service**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
</table>
| Organises own work                            | • Meets deadlines/targets  
|                                               | • Prioritises work  
|                                               | • Decides what to do, plans to get it done and does it |
| Complies with employment conditions           | • Works required hours                                                            |
| Contributes to maintenance and development of  | • Contributes ideas for improving, developing and updating  
| procedures and services                        |   dental therapy service                                                           |

**Element: Prioritises workload**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
</table>
| Identifies workload, prioritises and carries  | • Fulfils completions/arrears management requirements  
| out accordingly                                |                                                                                  |
Competency Cluster 2: People orientation
This competency cluster describes the interpersonal skills required by the dental therapist to undertake the work effectively. This includes encouraging and assisting patients to take responsibility for their own oral health.

Range statement
Legislation and documentation applicable to this competency cluster includes the following:
- Treaty of Waitangi
- Health Practitioners Competence Assurance Act 2003
- Dental Therapy Scope of Practice
- New Zealand Dental Therapists Association Code of Ethics and Codes of Practice
- District Health Board employment conditions
- New Zealand Dental Association and New Zealand Dental Therapists Association Code of Practice on the working relationship between dentists and dental therapists

Definition of terms used in this cluster:

‘Oversight’ means professional support and assistance provided to a health practitioner by a ‘professional peer’ for the purposes of professional development (HPCA, section 5: ‘Interpretation’)

‘Professional peer’, in relation to a health practitioner, is a person who is registered with the same authority with which the health practitioner is registered (HPCA, section 5: ‘Interpretation’).
### Communication

**Element: Communicate effectively**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaks in a clear and concise manner</td>
<td>• Able to speak to patients and the public so that they understand what is being said to ensure informed consent</td>
</tr>
<tr>
<td>Speaks English equivalent to at least overall level 7.5 on the General Skills Category of the International English Language Testing System (IELTS) with at least Level 8 in speaking and 7 in listening</td>
<td></td>
</tr>
<tr>
<td>Writes clearly so that recipient clearly understands the purpose and content of the communication</td>
<td>• Writes English of a standard expected of a professional (eg, correct grammar and spelling)</td>
</tr>
<tr>
<td></td>
<td>• Structures and presents written information in appropriate way for situation and meets needs of the receiver, e.g. Care Plan, referrals, memos, letters, newsletters</td>
</tr>
<tr>
<td>Communicates effectively with others</td>
<td>• Communicates effectively with others (dental therapy staff, other health professional patients, school staff, parents/caregivers)</td>
</tr>
<tr>
<td></td>
<td>• Summarises what speaker has said to ensure understanding</td>
</tr>
<tr>
<td></td>
<td>• Listens actively</td>
</tr>
<tr>
<td></td>
<td>• Asks questions that fit the situation</td>
</tr>
<tr>
<td></td>
<td>• Provides advice, information and recommendation</td>
</tr>
<tr>
<td></td>
<td>• Responds in thoughtful and sensitive way</td>
</tr>
<tr>
<td></td>
<td>• Attends to speaker</td>
</tr>
</tbody>
</table>

### Interpersonal understanding/cultural safety

**Element: Seek to understand and be understood by others**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands where an individual is coming from</td>
<td>• Shows consideration, concern and respect for others</td>
</tr>
<tr>
<td></td>
<td>• Shows interest in other opinions</td>
</tr>
<tr>
<td></td>
<td>• Facilitates the patient’s access to services and resources</td>
</tr>
<tr>
<td>Sees issues from the perspective of people of other cultures</td>
<td>• Observes cultural etiquette where appropriate</td>
</tr>
<tr>
<td></td>
<td>• Considers cultural perspective in decision making</td>
</tr>
<tr>
<td></td>
<td>• Practises in a way which respects each patient’s identity</td>
</tr>
<tr>
<td></td>
<td>• Facilitates the patient’s access to services and resources</td>
</tr>
<tr>
<td>Adheres to Treaty of Waitangi</td>
<td>• Shows an understanding of the principles of the Treaty of Waitangi</td>
</tr>
<tr>
<td></td>
<td>• Demonstrates awareness of New Zealand’s bicultural society and ensures that Māori receive dental therapy services that meet their needs</td>
</tr>
</tbody>
</table>
### Teamwork and co-operation

#### Element: Obtain professional support

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeks ‘oversight’ (see definitions)</td>
<td>• Obtains professional support and assistance from a ‘professional peer’ (see definitions) for the purposes of professional development</td>
</tr>
<tr>
<td></td>
<td>• Documents instance and reason for seeking professional advice from ‘professional peer’</td>
</tr>
<tr>
<td></td>
<td>• Participates in training to increase skills within the Dental Therapy Scope of Practice</td>
</tr>
<tr>
<td></td>
<td>• Documents ‘oversight’ provision whilst working towards competency achievement in an area of additional training</td>
</tr>
</tbody>
</table>

#### Element: Co-operate and work well with others

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pursues team goals</td>
<td>• Demonstrates team player attributes</td>
</tr>
<tr>
<td></td>
<td>• Participates in team meetings</td>
</tr>
<tr>
<td></td>
<td>• Demonstrates enthusiasm in team approach</td>
</tr>
<tr>
<td>Shares all relevant or useful information with team members</td>
<td>• Focuses on achievement of team objectives</td>
</tr>
<tr>
<td></td>
<td>• Values others’ input and expertise</td>
</tr>
<tr>
<td></td>
<td>• Actively promotes friendly climate and co-operation within the team</td>
</tr>
</tbody>
</table>

### Relationship building/patient management

#### Element: Build and maintain relationships/networks

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses relationships/networks to achieve work-related goals</td>
<td>• Accesses regular contact with work colleagues</td>
</tr>
<tr>
<td></td>
<td>• Shares ideas and experiences with work colleagues</td>
</tr>
<tr>
<td></td>
<td>• Actively involved in professional organisation</td>
</tr>
<tr>
<td>Establishes rapport with the patient</td>
<td>• Uses body language to establish empathy and rapport</td>
</tr>
<tr>
<td></td>
<td>• Uses body stance, facial expression</td>
</tr>
<tr>
<td></td>
<td>• Respects individual and cultural differences</td>
</tr>
<tr>
<td>Uses active listening and asks questions relevant to situation</td>
<td>• Attentive to patient</td>
</tr>
<tr>
<td></td>
<td>• Paraphrases to check information and clarify understanding</td>
</tr>
<tr>
<td></td>
<td>• Uses questions to ascertain necessary information and check patient understanding</td>
</tr>
</tbody>
</table>
Competency Cluster 3: Service provision

This competency standard covers the provision of dental therapy services to the patient. It encompasses the organisation and management actions and associated responsibilities of the dental therapist from enrolment, assessment, and treatment through to counselling the patient about oral health.

Range statement

Legislation applicable in this competency cluster includes the following:
- Health Information Privacy Code
- Health and Disability Commissioner Act 1994
- Health Practitioners Competence Assurance Act 2003
- New Zealand Dental Therapists Association Scope of Practice
- New Zealand Dental Therapists Association Code of Ethics and Codes of Practice
- DHB guidelines and protocols
- Health and disability sector standards (community)
- Infection control standards.

Documentation/information gathering and recording

Element: Maintain patient records

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records clinical decisions and recommendations</td>
<td>• Complies with workplace procedures to record patient information and maintain patient records</td>
</tr>
<tr>
<td>Records enrolment, treatment advice, medical/dental history update</td>
<td>• Records Care Plan, medical/dental history updated and parents advised of treatment requirements in accordance with protocols</td>
</tr>
<tr>
<td>Maintains privacy and security of patient records</td>
<td>• Complies with requirements of Health Information Privacy Code and workplace procedures required for security of patient information</td>
</tr>
<tr>
<td>Ensures informed consent</td>
<td>• Provides parents with full explanations and information to make informed decisions.</td>
</tr>
</tbody>
</table>

Element: Maintain data collection

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processes patient data for local and national requirements</td>
<td>• Adheres to local data collection procedures in a timely way</td>
</tr>
</tbody>
</table>
**Diagnosis/care plan**

**Element:** Provide an examination and diagnosis for individual patients

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
</table>
| Assesses teeth for:  
- present/missing  
- occlusion status  
- caries  
- other oral conditions  
- evidence of trauma (make written observations and diagnostic notations)  |
| Refers patients to the appropriate practitioner for oral health care that is beyond the clinical training and/or scope of practice of the dental therapist |
| • Assesses, in a clear and appropriate way, the conditions present  
• Refers as necessary  
• Notes observations  
• Records information on teeth present/missing or restored is recorded accurately  
• Diagnoses and records potentially harmful conditions (eg, enamel caries, gingivitis, calculus) |

**Element:** Plan the treatment for individual patients and fulfil requirements of informed consent and informed choice

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans and records the proposed care for the patient in the Care Plan</td>
<td></td>
</tr>
<tr>
<td>Obtains informed consent</td>
<td></td>
</tr>
</tbody>
</table>
| • Confirms Care Plan on patient record  
• Records period of recall/review has been recorded/ protocols followed  
• Follows treatment protocols in planning the care |
| • Provides necessary information to enable the family to make an informed decision on treatment required  
• Documents evidence of consent to treatment received |

**Preventive dentistry**

**Element:** Provide an individualised care/preventive plan for the patient.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tailors oral preventive techniques to the needs of the patient</td>
<td></td>
</tr>
</tbody>
</table>
| • Places fissure sealants and preventive coatings according to criteria  
• Applies topical fluorides based on the assessment of the caries risk of the patient and derived from set protocols |

**Restorative dentistry**

**Element:** Comply with protocols and procedures governing provision of operative care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides appropriate restorative intervention</td>
<td></td>
</tr>
</tbody>
</table>
| • Records decision as to need for restorative intervention  
• Records decision as to selection of materials  
• Considers current guidelines in decision making  
• Restores integrity and function of tooth  
• Alleviates pain |
### Radiography

**Element: Facilitate caries diagnosis in dental therapy practice**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complies with guidelines for use of bitewing/periapical radiography</td>
<td>• Takes posterior bitewing and periapical radiographs as appropriate</td>
</tr>
<tr>
<td></td>
<td>• Uses radiographs as a tool in the diagnosis and management of dental caries</td>
</tr>
<tr>
<td>Plans appropriate preventive or operative treatment for lesions disclosed</td>
<td>• Applies preventive treatment options based on depth of lesions identified on radiographs</td>
</tr>
</tbody>
</table>

### Oral health promotion

**Element: Provide oral health promotion**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocates for oral health prevention measures</td>
<td>• Works with other health personnel in promoting oral health</td>
</tr>
</tbody>
</table>

**Element: Provide ‘one on one’ counsel and advice to promote good oral health**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advises patient of behaviour changes to prevent/reduce dental caries</td>
<td>• Provides verbal and written advice and information to encourage sound attitudes and practices</td>
</tr>
<tr>
<td>Tailors advice/information to fit patient understanding</td>
<td>• Adapts information to patient level of comprehension</td>
</tr>
<tr>
<td></td>
<td>• Provides varied formats</td>
</tr>
<tr>
<td></td>
<td>• Speaks in language fit for patient</td>
</tr>
<tr>
<td>Checks patient understanding of information</td>
<td>• Listens, questions to ensure understanding</td>
</tr>
<tr>
<td></td>
<td>• Confirms with patient</td>
</tr>
<tr>
<td></td>
<td>• Asks patient to repeat back information</td>
</tr>
</tbody>
</table>

**Element: Provide information/resources about oral health care**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responds to queries from teaching staff with up-to-date and accurate oral health information</td>
<td>• Interacts with teaching staff over queries</td>
</tr>
<tr>
<td>Acts as resource person for classroom teachers when oral health is covered in the health curriculum</td>
<td>• Provides verbal and written information and assistance when required</td>
</tr>
</tbody>
</table>
Competency Cluster 4: Organisation and management of dental therapy environment

This competency standard covers the organisation and management skills common to all dental therapists. The dental therapist is responsible for the management and organisation of her/his own work and professional duties. It encompasses the ability to deal with contingencies as well as routine work.

Range statement

Legislation applicable in this competency cluster includes the following:

- Health Information Privacy Code
- Health and Disability Commissioner Act 1994
- Health Practitioners Competence Assurance Act 2003
- New Zealand Dental Therapists Association Code of Ethics and Codes of Practice
- DHB guidelines and protocols
- health and disability sector standards (community)
- infection control standards.

Equipment/stores management

Element: Clean and maintain equipment

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checks and maintains equipment according to manufacturer's instructions and workplace protocols</td>
<td>• Cleans all equipment after use</td>
</tr>
<tr>
<td></td>
<td>• Displays safe practice at all times</td>
</tr>
<tr>
<td></td>
<td>• Ensures all instruments and equipment are handled and cared for in a manner which prevents cross-infecting</td>
</tr>
<tr>
<td>Prepares requisitions to guideline requirements</td>
<td>• Monitors stock levels</td>
</tr>
<tr>
<td></td>
<td>• Orders in a timely way</td>
</tr>
<tr>
<td></td>
<td>• Rotates stock</td>
</tr>
</tbody>
</table>

Control of cross-infection

Element: Interpret Codes of Practice – responsibility/implementation

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensures procedures are followed and precautions are taken</td>
<td>• Treats all patient body fluids as potentially infectious</td>
</tr>
<tr>
<td></td>
<td>• Defines contaminated and uncontaminated work areas</td>
</tr>
</tbody>
</table>

Element: Comply with standard precautions and procedures

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtains medical history from all patients</td>
<td>• Completes forms, patient record updated</td>
</tr>
<tr>
<td>Ensures personal hygiene</td>
<td>• Demonstrates hand-washing protocols</td>
</tr>
<tr>
<td>Uses personal protective equipment</td>
<td>• Complies with wearing of gloves, masks, protective eyewear, protective clothing during treatment phase</td>
</tr>
</tbody>
</table>
Element: Apply work methods

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
</table>
| Displays work habits which minimise risks of cross infection            | • Demonstrates effective disinfection of potentially contaminated equipment and surfaces between all patients  
|                                                                         | • Keeps clean and contaminated surfaces separate                                   
|                                                                         | • Maintains personal infection control audit monthly                               |

Element: Facilitate effective sterilisation

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
</table>
| Follows correct decontamination and loading processes towards achieving effective sterilisation | • Uses chemical indicators with every autoclave cycle                              
|                                                                         | • Uses biological indicators (minimum weekly)                                      |

Element: Facilitate cleaning and disinfection procedures.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleans and disinfects all contaminated surfaces after each patient's treatment</td>
<td>• Follows between patient clean-up and disinfection process</td>
</tr>
</tbody>
</table>

Clinic environment/group organisation

Element: Take responsibility in the dental therapy workplace

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
</table>
| Organises own clinic group effectively                                  | • Applies requests/directives to own group situation: decides what to do, plans to get it done and does it  
|                                                                         | • Meets deadlines for data collection                                              
|                                                                         | • Keeps premises clean and functional                                              
|                                                                         | • Displays up-to-date and accurate information for parents/patients               |
| Supports the work of colleagues in the workplace                       | • Works constructively in a team approach                                         
|                                                                         | • Describes the dental therapist role and responsibilities in workplace           
|                                                                         | • Works with colleagues to ensure safe practice                                   
|                                                                         | • Provides day-to-day direction and supervision of the dental assistant           |
Element: Work effectively within workplace

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
</table>
| Works with documented procedures/         | • Identifies at-risk patients and assigns recall according to set criteria
| protocols/systems                         | • Obtains medical history and documents in patient notes for future reference
|                                            | • Plans treatment for medically compromised patients in consultation with service dentist
|                                            | • Works within organisational procedures
|                                            | • Works to maintain open and supportive team
|                                            | • Participates in workplace-based training                                                                                                       |

Occupational health and safety

Element: Comply with safe working environment regulations

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
</table>
| Complies with legislation relating to occupation health    | • Observes relevant regulations and codes of practice
| and safety                                                | • Discusses emergency plans and accident/incident protocols
|                                                            | • Controls identified hazards by using the protective measures supplied                                                                          |
| Ensures work areas are safe and hygienic                  | • Arranges equipment in the surgery to enable therapist and patients to be able to move safely within this environment                          |
| Ensures safe handling, storage and disposal of materials   | • Checks materials for expiry dates and rotates as required
|                                                            | • Keeps hazardous materials in secure area                                                                                                       |
| Addresses aspects in the Hazard Register                   | • Controls identified hazards by using/taking the protective measures supplied/identified                                                                 |
| Ensures safe handling, storage and disposal of materials   | • Places used needles in sharps disposal unit
| that notifies all reportable events in a timely manner      | • Places contaminated waste in a secure container
|                                                            | • Reports all actual and potential incidents                                                                                                     |

Quality improvement

Element: Participate in service quality initiatives

<table>
<thead>
<tr>
<th>Activity</th>
<th>Evidence examples</th>
</tr>
</thead>
</table>
| Contributes to continuous quality improvement through      | • Understands the quality improvement process
| dental therapy quality structure                            | • Contributes to quality improvement project                                                                                                    |
## Appendix 3: Ministry of Health Stocktake, 2003

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>DTs employed</th>
<th>Full-time DTs</th>
<th>Part-time DTs</th>
<th>Casuals</th>
<th>FTEs</th>
<th>NZ/Euro</th>
<th>Miari</th>
<th>Pacific</th>
<th>Asian</th>
<th>Other</th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50+</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland</td>
<td>24.0</td>
<td>18.0</td>
<td>6.0</td>
<td>20.0</td>
<td>2.6</td>
<td>21.0</td>
<td>3.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.0</td>
<td>1.0</td>
<td>10.0</td>
<td>12.0</td>
<td>0.0</td>
<td>1 OT</td>
</tr>
<tr>
<td>Auckland</td>
<td>157.0</td>
<td>127.0</td>
<td>28.0</td>
<td>1.0</td>
<td>140.6</td>
<td>6.6</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>7.0</td>
<td>20.0</td>
<td>58.0</td>
<td>72.0</td>
<td>4.0</td>
<td>153.0</td>
<td></td>
</tr>
<tr>
<td>Waikato</td>
<td>55.0</td>
<td>39.0</td>
<td>14.0</td>
<td>2.0</td>
<td>49.2</td>
<td>2.8</td>
<td>45.0</td>
<td>9.0</td>
<td>0.0</td>
<td>1.0</td>
<td>1.0</td>
<td>8.0</td>
<td>25.0</td>
<td>21.0</td>
<td>0.0</td>
<td>55.0</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>39.0</td>
<td>35.0</td>
<td>4.0</td>
<td>37.5</td>
<td>2.0</td>
<td>35.0</td>
<td>4.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>2.0</td>
<td>5.0</td>
<td>23.0</td>
<td>9.0</td>
<td>0.0</td>
<td>39.0</td>
</tr>
<tr>
<td>Taranaki</td>
<td>8.0</td>
<td>4.0</td>
<td>4.0</td>
<td>7.0</td>
<td>0.0</td>
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Note: Not all DTs are employed fully in treating children.

% of therapist workforce in each age group:

- 20–29: 4.9
- 30–39: 14.8
- 40–49: 40.7

% of therapist workforce in each ethnic group:

- Maori: 21.0
- Pacific: 13.0
- Asian: 11.0
- Other: 8.0
- NZ/Euro: 56.7
References


