AUSTRALIAN DENTAL COUNCIL

Dental Council
Te Kaunihera Tiaki Niho

September 2019

# Feedback on the ADC/DC(NZ) Accreditation standards for dental practitioner programs

## 1. Introduction

1.1 The Australian Dental Council (ADC) and Dental Council (New Zealand) (DC(NZ) are reviewing the Accreditation standards for dental practitioner programs (2016) ('the Standards').[1]

1.2 A survey was carried out from 20 June 2019 and 12 August 2019 to gather stakeholder feedback about the existing Standards, how they are working and whether they might be improved.[2]

1.3 The survey was supported by a short paper which explained more about the accreditation standards and their review and outlined four 'focus areas' where changes to the standards were being contemplated, on which initial feedback was sought.[3]

1.4 Invitations to participate in the survey were sent out by email to a wide range of stakeholders in Australia and New Zealand, including, but not limited to, education providers, professional associations, employers, government departments and ADC and DC(NZ) accreditation assessors. Information was also published on the ADC website.

1.5 We will use the feedback gathered in the survey to inform the work of a Working Party. The Working Party will provide expert advice on any proposed changes to the Standards. We plan to consult on any proposed changes in early 2020.

---

[1] ADC/DC(NZ) (2016). Accreditation standards for dental practitioner programs. https://www.adc.org.au/sites/default/files/Media_Libraries/Accreditation/Accreditation%20Standards%20-%20From%201%20January%202016.pdf

[2] We were able to accept late responses up to 16 August 2019.

[3] ADC/DC(NZ) (2019). Review of the ADC/DC(NZ) Accreditation standards – stakeholder feedback survey. https://www.adc.org.au/sites/default/files/Media_Libraries/Accreditation_Standards_Review/Stakeholder_feedback_survey_covering_paper_FINAL.pdf

About this document

1.6 This document provides a summary of the responses received to the survey.

1.7 This document is divided into three sections:

- Section **one** introduces the document.
- Section **two** provides some overall statistics from responses.
- Section **three** summarises responses to the survey questions.

1.8 In this document, 'we' refers to the ADC and DC(NZ).

## 2. Analysis of responses

2.1 This section explains more about how we analysed the responses we received to the survey.

Data collection and analysis

2.2 The majority of respondents used an online survey tool ('Survey monkey') to respond to the consultation. They provided information about whether they were making an individual response or were responding on behalf of an organisation, and provided information about their interaction with the ADC and DC(NZ) (for example, assessor, examiner, education provider). They selected their response to each question from a list of options (e.g. yes, no, partly, unsure). Some questions allowed free text responses or asked for more information when certain responses were selected. Where we received emailed responses, we recorded each response in a similar way.

2.3 In preparing this document, we have produced statistics for quantifiable data (such as the number of 'yes' or 'no' responses) and identified themes in the free text responses. This document summarises themes across the responses we received and indicates the frequency of different comments made by respondents.

Statistics

2.4 We received 89 responses to the survey. 64 responses (72%) were made by individuals and 23 (26%) were made on behalf of organisations. (2 respondents did not answer this question.)

2.5 Table 1 below provides a breakdown of respondent groups. Respondents were asked to select their interaction with the ADC and/or DC(NZ) and could select multiple answers. The largest respondent group were members of a professional association, academy or society, followed by education providers and ADC or DC(NZ) assessors.

2.6 Table 2 below provides a breakdown of data in response to questions 1, 2, 3 and 6. Other questions invited free text responses.

**Table 1: Respondent groups**

| Respondent type | Number | % |
|---|---|---|
| Assessor | 21 | 33% |
| Committee / Board member | 4 | 6% |
| Consumer / community representative | 2 | 3% |
| Dental student | 7 | 11% |
| Education provider | 24 | 37% |
| Employer of dental graduates | 7 | 10% |
| Examiner of overseas trained dental practitioners | 18 | 28% |
| Member of professional association/academy/society | 32 | 50% |
| Other | 4 | 6% |
| Representative of state/territory/DHB based or other provider | 1 | 2% |

**Table 2: Responses to the survey questions**

| Question | Yes | No | Partly | Unsure |
|---|---|---|---|---|
| Q1. Do you consider the Standards are at the threshold level required for public safety? | 60 (67%) | 8 (9%) | 14 (16%) | 17 (8%) |
| Q2. Are there any Standards that should be deleted or reworded? | 17 (22%) | 33 (42%) | N/A | 29 (36%) |
| Q3. Are there any Standards that should be added? | 16 (23%) | 37 (52%) | N/A | 18 (25%) |
| Q6. Do you consider there to be duplication between the Standards and the standards / requirements of higher education and/or vocational education and training regulators in Australia and/or New Zealand? | 14 (23%) | 20 (33%) | N/A | 27 (45%) |

**Notes to tables**

- Percentages have been calculated based on actual responses to a question; data related to respondents that did not answer a question are not included.
- Percentages have been rounded.

## 3. Summary of responses to the survey questions

3.1 This section provides a summary of the responses we received, outlining the key themes in responses to each survey question.

3.2 We sometimes received the same or similar comments to different questions. Where helpful, we have summarised like responses together. Where we received comments which were not directly about the Standards, these have mainly been summarised in the section of this document on question seven.

### Q1. Do you consider the Standards are at the threshold level required for public safety?

3.3 The majority of respondents (67%) said that the Standards were at the threshold level required for public safety. Only 9% disagreed.

3.4 Where comments were made to support a positive assessment, they included that new graduates meet the required competencies; that the Standards or specific parts of the Standards were clearly articulated and benchmark well with other jurisdictions; and that patient safety is prominent in the Standards.

3.5 There were few recurrent themes in comments made by those respondents who selected 'partly' (16%). Comments included the following.

- Compliance with the Standards is too easily manipulated by education providers into appearing to be adequate.
- The importance of ensuring that cultural competence is a fundamental part of programs and not considered 'nice to have'.
- Infection control is not specifically cited in the Standards.
- The Standards are not clearly worded and/or lack sufficient detail about how they will be assessed, leading to differing interpretations by education providers and assessors.

3.6 Where respondents answered no (and some of those who answered 'partly'), comments generally indicated concerns about regulation or practice unrelated to the Standards. They included general dentists undertaking procedures considered to be specialist procedures; concerns about the scope of practice of oral surgery; and the ADC's examinations of overseas qualified dental practitioners.

**Q2. Are there any Standards that should be deleted or reworded?**

3.7 A majority of respondents (42%) did not identify any Standards that should be deleted or reworded. 36% said that they were unsure.

3.8 Appendix 1 includes all the specific suggestions we received (to this and other survey questions) about standards / criteria that should be deleted, reworded or reviewed.

3.9 Suggestions were generally made by respondents with the aim of improving clarity and reducing duplication in the Standards, which might help reduce repetition in accreditation submissions.

3.10 One organisation suggested that a further column should be added to the Standards to explain expectations of how each criterion should be met or how it will be assessed. An example was that there should be more guidance about what constitutes teaching staff being 'appropriately qualified and experienced'.

**Q3. Are there any Standards that should be added?**

**Q5. Are there any additional areas we should consider in the review?**

3.11 We have summarised responses to these questions together. Where comments were made in response these questions, they often covered similar ground.

3.12 The majority of respondents (52%) said that there were no standards that should be added. 25% were unsure. There were a relatively high number of respondents (54 of 89) that did not provide any answer to question five.

3.13 There were few recurrent themes in suggestions for standards / criteria that should or might be added. The following suggestions were made.

- Requiring a memorandum of understanding between the education provider and health services providing placements to better manage risk and assure the quality of care for patients and the learning experience for students.
- Clinical competency of teaching staff. We received a small number of responses which argued that teaching staff needed to have currency in clinical practice (and that some lacked this currently).
- Occupational health and safety including incidents in clinic involving students and medical emergencies.
- Complaints and compliments.
- Teaching staff should hold an annual practising certificate.
- Appropriately experienced and qualified laboratory staff support teaching.

- Program design complies with the Australian Qualifications Framework (AQF).
- Provision of and/or access to support for teachers and educators.

**Q4. Do you have any comments about the focus areas identified for the review?**

3.14 A summary is provided below of comments received against each of the focus areas. We received a small number of comments which said that they were in general agreement with the identified focus areas.

Aboriginal, Torres Strait Islander and Māori health outcomes

3.15 The supporting paper explained the focus on Indigenous health outcomes in both Australia and New Zealand. We suggested creating a dedicated domain in the Standards, with criteria covering areas such as input into programs; recruitment, admission, participation and completion of programs; and clinical experience in delivering culturally safe care.

3.16 Overall, where we received comments about this area, respondents were in positive agreement that this was an area that should be addressed in the Standards. There were very few dissenting comments – either about the premise of this area being included in the Standards, or about the specific suggestion that a dedicated domain should be created. We received a small number of comments which highlighted challenges around requirements in this area (although the majority of these responses were nonetheless supportive).

3.17 The following provides a short summary of the comments we received.

- A dedicated domain is required and will help improve health outcomes by ensuring that cultural safety is embedded throughout programs and not viewed as an 'add on'.
- There may be difficulties in meeting any new standard / criteria in areas such as clinical experience where student contact with Indigenous persons can be limited. The ability of small education providers including specialty colleges to meet any new requirements will also need to be considered during the review.
- There is a need to consider cultural safety or 'cultural understanding' as it applies to wider group of culturally diverse people and not only for Aboriginal and Torres Strait Islander Peoples and Māori.

3.18 Where a very small minority of respondents disagreed with any changes to the Standards in this area, they did so because they considered that this area was already adequately addressed and/or the suggested criteria were impractical and therefore no change was required. One respondent indicated that they

would want to hear more from representatives of Indigenous people before concluding whether this was required.

3.19 One respondent (an accreditation authority in the National Scheme in Australia) said that they had received feedback from their stakeholders which argued against creating a dedicated domain because this would be counterproductive. The concern was that a dedicated domain might disconnect Indigenous health outcomes from the core business of the education provider, isolating Indigenous staff in the process. The preferred approach was inclusion in domains throughout the Standards.

Consumer involvement

3.20 The supporting paper explained the ADC's and DC(NZ)'s commitment to involving consumers and the community in their work. It noted that some accreditation bodies who have adopted the Standards had amended them to refer to the external input of consumers, particularly in the design of curricula.

3.21 We received few specific comments about this area. A small number of respondents considered no change was required in this area or were unsure of the benefits. Reasons given included that there was no evidence of a problem that consumer input would address; that lay people without educational expertise would not be able to meaningfully contribute; and/or that consumer involvement would have little value generally.

3.22 Supportive comments said that consumer input was essential in programs to ensure that programs produce professionals that are competent and can meet patient needs. Two respondents said that there was a need to be clear about what is meant by 'consumer' and what we expected of education providers. With respect to the latter, one respondent reflected that similar requirements put in place by another accreditation authority in Australia were unclear.

Interprofessional learning and practice (IPL)

3.23 The supporting paper explained that to date programs are generally more successful in providing opportunities for students to learn and practice with other professions within dentistry and relatively weaker on opportunities for learning with, from and about other professions within healthcare. No suggestions were made. Instead, we indicated that we wanted to review the criterion in this area and consider whether any changes are required.

3.24 We received very few comments about this focus area. Supportive comments included that there needed to be greater emphasis on IPL to enhance patient case management. One respondent said that IPL needed to be vocationally relevant and should therefore focus on those professions that dentists were likely to work with in practice.

Assessment

3.25 The supportive paper said that our experience of using the Standards is that education providers, assessors and staff sometimes struggle to differentiate between some of the criteria in domain five of the Standards ('Assessment is fair, valid and reliable'). We said there may be the potential to reduce the number of criteria in this area and/or improve wording.

3.26 We received a small number of specific suggestions for rewording, deletion or review in domain five, which are outlined in Appendix 1.

3.27 Overall, where comments were made, there was agreement that there was scope to reduce duplication and improve clarity in this area.

**Q6. Do you consider there to be duplication between the Standards and the standards / requirements of higher education and/or vocational education and training regulators in Australia and/or New Zealand? If yes, can you please tell us about the areas that are duplicated and how to avoid this?**

3.28 A minority of respondents (23%) said that there was duplication between the Standards and other standards set by regulators of higher or vocational education and training in each jurisdiction. However, the majority (45%) said that they were unsure. We received few comments in response to this question.

3.29 A small number of comments focused on duplication with the standards of other accreditation organisations and/or internal duplication within the Standards (these comments are summarised elsewhere).

3.30 A small number of comments said that whilst there was some limited duplication as a result of similar aims, it was desirable because this meant that aims were reinforced by multiple bodies.

3.31 One respondent, with respect to higher education regulation in Australia, argued that 'self-regulation' of higher education providers may not identify governance issues in sufficient detail. In contrast, another said that duplication of some elements of higher education regulation in Australia should be addressed.

**Q7. Do you have any other comments?**

3.32 We received a range of other comments which were about topics other than the Standards from a small minority of respondents, including the following.

- In Australia, concern about staff leading and teaching on dento-maxillofacial radiology programs who are not fully registered general dentists with specialist registration in the specialty.

- The seven year accreditation cycle for dentistry programs is too long and should be shortened to a maximum of four to five years.

- We received a small number of comments that argued or appeared to argue for review or specific changes to the ADC's entry level professional competencies. Specific areas in comments included competency in treating disabled people, health literacy, communication skills and aged care.

- Concern that students and educators participating in accreditation site visits worry about remaining anonymous and this acts to limit their effective input.

- Regulatory issues including suggestions about the need for regulation of dental assistants; standards for the clinical use of Botox; and guidance on safe practice for practitioners and students.

## Appendix 1: Comments on specific standards

| Domain | Standard statement | Criteria | Comments |
|---|---|---|---|
| **1. Public Safety** | 1. Public safety is assured. | 1.1 Protection of the public and the care of patients are prominent amongst the guiding principles of the educational program, clinical training and student learning outcomes. | • Considered 'very general'; suggested the wording of the criterion could be moved to the standard statement.<br>• 'Protection of the public' should be deleted from the beginning of the criterion and the domain should be renamed 'Safety'. |
| | | 1.2 Student impairment screening and management processes are effective. | • 'Impairment' requires definition or explanation. |
| | | 1.3 Students achieve the relevant competencies before providing patient care as part of the program. | |
| | | 1.4 Students are supervised by suitably qualified and registered dental and/or health practitioners during clinical education. | • Change 'suitably' to 'clinically'. |
| | | 1.5 Health services and dental practices providing clinical placements have robust quality and safety policies and processes and meet all relevant regulations and standards. | • Add 'set by the training / education provider' to the end of the criterion. |

| | | | |
|---|---|---|---|
| | | 1.6 Patients consent to care by students. | |
| | | 1.7 Where required, all students are registered with the relevant regulatory authority/ies. | • Delete 'where required'.<br>• Reword to: 'Students meet all the requirements to be registered with their relevant educational institution and with their professional regulatory authority/ies.' |
| | | 1.8 The education provider holds students and staff to high levels of ethical and professional conduct. | |
| **2. Academic Governance and Quality Assurance** | 2. Academic governance and quality assurance processes are effective. | 2.1 The provider has robust academic governance arrangements in place for the program of study that includes systematic monitoring, review and improvement. | • Suggestion that 'robust academic governance' might be deleted as it is too abstract.<br>• Amend to 'education provider'. |
| | | 2.2 Quality improvement processes use student and other evaluations, internal and external academic and professional peer review to improve the program. | • Amend to say: 'Quality improvement processes use student feedback'<br>• Review components to reduce duplication in submissions. |
| | | 2.3 There is relevant external input to the design and management of the | • Add 'consumer' |

| | | | |
|---|---|---|---|
| | | program, including from representatives of the dental professions. | |
| | | 2.4 Mechanisms exist for responding within the curriculum to contemporary developments in health professional education. | • Amend to read: '…to contemporary developments <u>in clinical practice</u> and health professional education'. |
| **3. Program of Study** | 3. Program design, delivery and resourcing enable students to achieve the required professional attributes and competencies. | 3.1 A coherent educational philosophy informs the program of study design and delivery. | • Suggestion that 'coherent educational philosophy' is too abstract.<br>• Amend to read: 'A coherent ~~educational~~ philosophy of learning outcomes…' |
| | | 3.2 Program learning outcomes address all the relevant attributes and competencies. | • Add 'required of an independent practitioner upon graduation' to the end of the criterion. |
| | | 3.3 The quality and quantity of clinical education is sufficient to produce a graduate competent to practice across a range of settings. | • Suggestion that 'range of settings' could include examples. |

| | | | |
|---|---|---|---|
| | | | • Delete ‘education’ and replace with ‘practice’ |
| | | 3.4 Learning and teaching methods are intentionally designed and used to enable students to achieve the required learning outcomes. | |
| | | 3.5 Graduates are competent in research literacy for the level and type of the program. | • Delete ‘for the level and type of the program’ and replace with ‘and motivated to life-long learning’. |
| | | 3.6 Principles of inter-professional learning and practice are embedded in the curriculum. | • Include ‘multi-disciplinary’ somewhere in this criterion to reflect common terminology. |
| | | 3.7 Teaching staff are suitably qualified and experienced to deliver the units that they teach. | • Delete ‘to deliver the units that they teach’ and replace with: ‘in their subject and competent in contemporary clinical practice’.<br><br>• Reword: ‘Teaching staff is registered with ADC/DC(NZ), holds an Annual Practising Certificate and has robust experience within their scope of practice to be qualified to teach the units / subjects they teach (including external assessment moderators).’ |

| | | | |
|---|---|---|---|
| | | 3.8 Learning environments support the achievement of the required learning outcomes. | • 3.8, 3.9, 3.11 are overlapping and could be combined. |
| | | 3.9 Facilities and equipment are accessible, well-maintained, fit for purpose and support the achievement of learning outcomes. | |
| | | 3.10 Cultural competence is integrated within the program and clearly articulated as required disciplinary learning outcomes: this includes Aboriginal, Torres Strait Islander and Māori cultures. | • Query about what is meant by 'clearly articulated as required disciplinary learning outcomes'.<br>• Amend criterion to read: 'Clinical competence is integrated within the program to reflect the multi-cultural Australian community.' |
| | | 3.11 The dental program has the resources to sustain the quality of education that is required to facilitate the achievement of the necessary attributes and competencies. | |
| **4. The student experience** | 4. Students are provided with equitable and timely access | 4.1 Course information is clear and accessible. | • Amend to read: 'Course information and learning outcomes are clearly defined and accessible.' |

| | | | |
|---|---|---|---|
| | to information and support. | | |
| | | 4.2 Admission and progression requirements and processes are fair and transparent. | |
| | | 4.3 Students have access to effective grievance and appeals processes. | |
| | | 4.4 The provider identifies and provides support to meet the academic learning needs of students. | • Suggestion that 4.4 and 4.7 might be reworded to put the student first (like 4.5 for example).<br>• Delete 'identifies and'.<br>• Review elements to reduce duplication in submissions. |
| | | 4.5 Students are informed of and have access to personal support services provided by qualified personnel. | |
| | | 4.6 Students are represented within the deliberative and decision making processes for the program. | |

| | | | |
|---|---|---|---|
| | | 4.7 Equity and diversity principles are observed and promoted in the student experience. | |
| **5. Assessment** | 5. Assessment is fair, valid and reliable. | 5.1 There is a clear relationship between learning outcomes and assessment strategies. | • 5.1 could be clarified by referring to methods of assessment being appropriate for the outcomes being assessed.<br>• Reword to: 'There is a clear relationship between learning outcomes, assessments and moderation strategies.'<br>• Agrees that there is overlap between 5.1, 5.2 and 5.6 |
| | | 5.2 Scope of assessment covers all learning outcomes relevant to attributes and competencies. | • 5.2 and 5.6 below could be combined.<br>• Add 'specified and prescribed in the program' to the end. |
| | | 5.3 Multiple assessment tools, modes and sampling are used including direct observation in the clinical setting. | • Delete 'modes and sampling'.<br>• Reword to: 'Multiple assessment methods are used to assess students' clinical learning.' |
| | | 5.4 Program management and co-ordination, including moderation procedures ensure consistent and | • Reword to: 'Program management and co-ordination of assessments ensure consistent and appropriate feedback to students.' |

| | | | |
|---|---|---|---|
| | | appropriate assessment and feedback to students. | • Review elements to reduce duplication in submissions. |
| | | 5.5 Suitably qualified and experienced staff, including external experts for final year, assess students. | • Reword to refer to 'external examiners'.<br>• Delete as adequately covered by 3.7.<br>• Review elements to reduce duplication in submissions.<br>• There is lack of clarity about what is meant by 'external expert' in this criterion. |
| | | 5.6 All learning outcomes are mapped to the required attributes and competencies, and assessed | • Reword: 'All learning outcomes are mapped and assessed to the required attributes and competencies.' |