AUSTRALIAN
DENTAL COUNCIL

Report on the consultation of proposed changes to the ADC Professional Competencies of the newly qualified dental practitioner paper

Proposed changes to the Professional competencies of the newly qualified dental practitioner

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1. Introduction

1.1 The Professional competencies of the newly qualified dental practitioner ('the Competencies') are reference points for the dental professions. The Competencies were last reviewed in 2015, with updates published in February 2016.

1.2 The Competencies are outcomes-focused, threshold statements. They provide an overview of what is expected, with respect to attributes, knowledge and skill capabilities, at the threshold level of dental practitioners upon graduation from an Australian Dental Council (ADC) accredited program or completion of the ADC's assessment and examinations process for overseas trained dental practitioners. The Competencies are **NOT** a scope of practice and should not be read as such.

1.3 The Competencies have been reviewed to ensure that they remain contemporary, fit for purpose, and aligned with the expectations and needs of the Australian population. It is important the Competencies accurately articulate the knowledge and skills needed by the newly qualified dental practitioner to practise safely and ethically.

1.4 As part of the review process, the ADC invited comment from stakeholders on proposed changes to the Competencies through a public consultation process. This public consultation opened on **27 September 2021** and closed on **5 November 2021**.

1.5 This paper provides a summary of the responses received and outlines the changes made to the draft Competencies in response to the public Consultation process.

About this document

1.6 This document must be read in conjunction with the *Professional Competencies for newly qualified dental practitioners – September 2021*

1.7 This document includes the following sections:

- Section **one** introduces the document.
- Section **two** provides information about the Competencies.
- Section **three** explains the review process.
- Section **four** summarises the responses received.
- Section **five** explains the changes made following consideration of the consultation responses.

1.8 There are two appendices:

- Appendix 1 provides a summary of feedback provided during the ADC's initial stakeholder consultation to commence the review process.
- Appendix 2 sets out the members of the Professional competencies advisory committee who provided feedback and advice on the proposed changes.

About the ADC

1.9 The ADC is the independent accreditation authority appointed by the Dental Board of Australia (DBA) to undertake the accreditation functions for the dental professions under the National Registration and Accreditation Scheme (NRAS).

1.10 The accreditation functions undertaken by the ADC are discharged in accordance with the Health Practitioner Regulation National Law Act (the National Law). These functions include:

- developing accreditation standards for approval by the DBA;
- accrediting programs of study which lead to eligibility to apply for registration or endorsement of registration against those standards;
- assessment of overseas qualified dental practitioners who wish to register to practise in Australia; and
- providing advice to the DBA on accreditation and assessment matters.

1.11 The ADC is a not-for-profit company limited by guarantee under the Australian Securities and Investments Commission. It holds charity status under the Australian Charities and Not-for-profits Commission and is funded by a grant from the DBA and fee for service activities.[1]

2. About the Competencies

Structure of the current Competencies

2.1 The Competencies were last revised throughout 2015 and published in February 2016. The Competencies are statements outlining the behaviours, skills, ethical values, diagnostic and technical and procedural skills expected of newly qualified dental practitioners.

2.2 The Competencies, as currently worded, comprise 6 Domains:

1. Professionalism
2. Communication and Leadership
3. Critical Thinking
4. Health Promotion
5. Scientific and Clinical Knowledge
6. Patient Care – Including the following sub domains:
   - 6.1 Clinical Information Gathering
   - 6.2 Diagnosis and Management Planning
   - 6.3 Clinical Treatment and Evolution

2.3 The domains represent the broad categories of professional activity and concerns that occur in the practice of dentistry. There is a degree of artificiality in the classification, as effective professional performance requires the integration of multiple competencies.

2.4 Each domain contains descriptions of competencies. The descriptions are presented in one of two formats:

- descriptions for "a dental practitioner" are where the application of the knowledge and skills are the same for all divisions of registration.

[1] For more information about the ADC: www.adc.org.au/

- descriptions for a specific division of dental practitioner(s) that may be worded the same or in a similar manner, although the application of the knowledge and skills may vary between the different divisions of dental practitioner under the category of general registration.

2.5 The statements are clear and concise, providing flexibility for, and innovation in, program development, and are used in the development of tasks for the assessment of overseas trained dental practitioners. An outcome focused approach to the Competencies was adopted during the 2015-2016 review process, with the number of statements rationalised. As outcomes-focused statements, the Competencies focus on what is required of a newly qualified practitioner, rather than how the knowledge or skills are obtained or acquired.

2.6 Since the last revision, the Competencies have been well received by stakeholders, with feedback provided during initial stakeholder consultation indicating that, overall, the Competencies remain relevant. The feedback indicates that there are opportunities for improvement to ensure the Competencies are contemporaneous and remain 'fit-for-purpose'.

Application of the current Competencies

2.7 The ADC develops the Competencies on behalf of and in consultation with dental stakeholders. The ADC is the custodian of the competencies, so it is important to recognise each dental stakeholder adopts and uses the Competencies for its own purposes.

2.8 The ADC uses the Competencies in its work to accredit dental practitioner programs, as well as in the assessment and examination of overseas trained dental practitioners.

2.9 In program accreditation, the Competencies are important reference points for the development of curricula for dental practitioner programs and have been embedded in the accreditation process since 2016. For a program to be accredited it must demonstrate to the ADC that students achieve the required competencies on graduation, and map how the program's assessment tools and strategies ensure this has occurred.

2.10 In the ADC's role of assessing overseas trained dental practitioners, the Competencies are an important reference point for mapping and blueprinting examinations. The ADC's written and practical examinations are standardised to ensure overseas trained practitioners meet the same threshold competence expected of a newly qualified graduate of an accredited Australian program.

2.11 Education providers use the Competencies as reference points in developing dental curricula and assessments. The DBA also references the Competencies in a range of documents including the Guidelines for Scope of Practice and within the Reflective practice tool. The Entry-level competencies for dental specialties also build on the Professional Competencies of the newly qualified dentist.

2.12 Although referenced by the DBA in the Guidelines for Scope of Practice it is important to note that the Competencies are **NOT** a scope of practice for dental practitioners and should not be read as such. More information relating to scope of practice is available from the DBA's website, www.dentalboard.gov.au.

3. About the review

3.1 The Competencies review undertaken in 2015 and 2016 resulted in the publication of three documents, a reduction from the previous five. The Competencies for dental hygienists, dental therapists and oral health therapists were combined into one document.

3.2 At the commencement of this review, several initial focus areas were identified to inform potential changes to the Competencies. These focus areas were identified by considering changes in Government policy and directives, including multiple Royal Commissions; changes to practice; experience of using the Competencies in the work of the ADC; and the research commissioned by the ADC and completed by the University of Melbourne titled, Preparation for practice of newly qualified dental practitioners in Australia.

3.3 The review included the following steps:

- Benchmarking the existing Competencies against other relevant competencies nationally and internationally.
- A stakeholder survey to seek feedback on the existing Competencies, including how they are working and how they might be improved. The survey was open from **26 April 2021** until **31 May 2021**. A summary of the outcomes of the stakeholder survey is provided in **Appendix 1.** The full report on the feedback provided by the stakeholder survey feedback is available from the ADC's website or via the following link.
- An Advisory Committee was convened to provide expert advice about possible changes to the Competencies. The results of the benchmarking, stakeholder survey, and stakeholder engagement informed the work plan and papers considered by the Advisory Committee and the changes proposed to the Competencies for consultation. A list of the Advisory Committee members is provided in **Appendix 2.**

Consultation on the draft Competencies

3.4 The ADC undertook a wide-ranging Consultation survey that was open from **27 September 2021** until **5 November 2021**. Stakeholders were asked to answer a series of questions on the proposed changes to the Competencies.

3.5 Responses to the Consultation were invited from anyone with an interest in the Competencies.

3.6 Questions were included in the Consultation document released as was a rationale for changes made to the Competencies. The Consultation questions were replicated in an online survey tool (Survey Monkey) to assist stakeholders in providing their input and comments.

3.7 The Consultation questions were not exhaustive and comments on any component of the draft Competencies were welcomed. The Consultation questions are shown at **Appendix 3**.

3.8 Following the closure of the Consultation period and taking into consideration the feedback received across the dental professions, employers, regulators, government and the wider community, the responses were used to help refine changes to the Competencies to ensure they remain fit for purpose.

Promotion of the Consultation on the draft Competencies

3.9 The ADC used multiple channels and means by which to promote the release of the draft Competencies for consultation, including direct emails to stakeholders inviting responses to the Consultation. In total, there were 259 recipients of a direct invitation to participate in the Consultation survey. Stakeholders included all education providers, state and territory health authorities and dental associations/organisations. Letters were sent directly to government health departments, health and education regulators, other accrediting bodies, (both nationally and internationally), Aboriginal and Torres Strait Islander community organisations and bodies, and consumer health organisations.

3.10 The ADC also promoted the consultation through its website and social media platforms (i.e. LinkedIn), as well as through dental association publications and communication channels and by presenting at multiple fora to raise awareness of the consultation process.

4. Summary of responses

4.1 This section provides both a brief overview and a detailed summary of the feedback received from the consultation process.

4.2 All proposed changes to the Competencies were provided in the paper accompanying the Consultation paper, the *Draft Professional Competencies for newly qualified dental practitioners – September 2021*.

4.3 Section 5 of this report outlines changes made to the Competencies in response to the feedback provided during the consultation process. Commentary is also provided on the rationale for any changes or inaction on responses received during the consultation process.

4.4 75 responses (87%) were made by individuals and 11(13%) responses were made on behalf or organisations (Table 1). Five respondents did not answer this question.

The analysis included in the following section is based on the 86 respondents that provided an answer to the category of respondent.

Table 1: Category of respondent by response method

Category of respondent	Response by online survey	Response by email	Total
Individual	75		
Organisation	11	12	
Total	**86**	**12**	**98**

Note: There were some organisations that completed the online survey and also provided a direct response to ADC.

The outcomes of the consultation process can be summarised as follows;

- In total, there were 98 responses to the Consultation. Of these, 86 respondents provided feedback via the online survey, where a individual or organisation was supplied and/or one or more questions were answered. There was a completion rate of 35% for the online survey. The remaining 12 responses were

submitted by individuals or on behalf of an organisation, by email or postal mail directly to the ADC.

- The main response areas were either in support of the proposed changes to the terminology, structure and/or content of the Competencies. Respondents were given the option to leave a response or suggestion if required. Of the responses received:
    - 80% of respondents considered the draft Competencies outline what is required of a newly qualified dental practitioner to practice safely and ethically
    - 65% of respondents agreed with the proposal to combine the Competencies for all five divisions of general registration into one document
    - There was broad support for the proposed amendments presented within Question 4 of the survey (specific proposals incorporated into the draft competencies) and to the addition, amendment or deletion of competency statements as outlined.
    - 50% of respondents did not suggest any additional competencies should be added. The remaining 50% of respondents suggested either additional competencies or amendments to the Competencies and of these, six respondents answered that they 'did not know.'
    - 66% of respondents did not suggest deletion or rewording of Competencies and of the ten respondents who suggested that they would support deletion and/or rewording of Competencies, nine respondents provided a response and suggestions to support their answer.

4.5 Feedback emailed directly to the ADC varied in its format. Some responses provided only direct feedback related to specific questions or areas of the draft Competencies. Others answered all consultation questions and some respondents made general statements regarding the draft Competencies, either of overall support for the draft Competencies, or advising that they had no comment or comments related to the draft Competencies.

4.6 Where possible, the summarised data in the following section combines the responses received.

Interaction with the ADC

4.7 Respondents who indicated they were responding on behalf of themselves using the online survey tool were asked 'What is your interaction with the ADC? Check all that apply?

4.8 In total, 59 respondents answered this question. Respondents could tick multiple options from a prepared list. Responses are shown in table 2.

Table 2: Respondent type versus number and percentage of responses (n=59)

Respondent type	Number	%
Assessor of education programs	**8**	**14%**
Committee / Board member	**5**	**8%**
Consumer / community representative	**0**	**0%**
Dental student	**5**	**8%**
Education provider	**11**	**19%**

Employer of dental graduates	**4**	**7%**
Examiner of overseas trained dental practitioners	**4**	**7%**
Member of professional association/academy/society	**13**	**22%**
Overseas trained dental practitioner	**32**	**54%**
Representative of state/territory health service	**0**	**0%**
Other	**7**	**12%**

Note: some respondents ticked more than one category. The percentages were rounded to the nearest whole number. There were seven organisations who responded to the survey who were not included in the categories in Table 1, as they provided feedback directly to ADC, independent of the online survey. They are listed in Appendix 4 of this paper.

Overall comments

4.9 Overall, there is broad support for the changes proposed to the Competencies, as indicated in Table 3 (Question 1).

4.10 Of the 20 respondents (40%) that provided overall comments of support for the changes, comments included statements such as:

> 'The competencies are a clear articulation of the expectations of dental professionals, and are thorough, both in the amount of individual detail provided per competence, and also in terms of their overall reach within the six suggested overarching competency headings.'
>
> 'The competencies outline at a threshold level what is expected of a newly qualified dental practitioner to practice safely and ethically.'
>
> 'The draft competencies cover all aspects of dental practice and related activities. The proposed changes are appropriate and achievable for education providers.'
>
> 'I think the amendments draw more clearly on what is expected of newly qualified practitioners in this space.'
>
> 'The competencies are broad on scope and comprehensive.'
>
> 'The draft builds on a solid foundation of competencies that has been broadly accepted by the profession and dental education providers.'
>
> 'Clearly articulated and consistent with current expectations.'
>
> 'The draft competencies generally cover all the expectations of a newly qualified dental practitioner.'
>
> 'The draft competencies has addressed almost all aspects of dental work. I think it will be a great guideline for the newly graduated dental practitioner.'
>
> 'There is greater emphasis on vulnerable patient groups.'
>
> '(organisation name) would consider the competency standards to be largely reflective of what is required for safe and ethical practice, and that no major gaps are evident……cultural and clinical safety are inextricably linked, and clinically safe practice cannot occur in the absence of cultural safety.'
>
> 'Our school has identified some of the key areas that have been updated in the competencies through a recent curriculum review, so having these areas reinforced through recognitions as graduate competencies provides further backing about their importance in dental curricula. The integration of person-centred care into the competencies is a welcome improvement. Clustering the domains into generic and specific signifies that the expectations about social responsibility, communication and leadership and critical thinking are shared. The updated definitions provide further clarification for the intentions of the statements.'

4.11 Three respondents provided comments and suggestions to the wording or content of some competency statements. These comments will be addressed in the following analysis.

4.12 A further detailed analysis of responses is arranged by consultation question in the following sections.

Responses to consultation questions

4.13 Table 3 provides a summary of the responses received to the consultation questions.

Table 3. Responses to the Consultation survey questions

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q1 Do you consider the draft Competencies outline what is required of a newly qualified dental practitioner to practice safely and ethically?	50	40 (80%)	1 (2%)	7 (14%)	2 (4%)	20
Q2 Do you agree with the proposal to combine the Competencies for all five divisions of registration into one document?	43	28 (65%)	3 (7%)	9 (21%)	3 (7%)	21
Q3 Do you have any comments on the format or structure of the draft Competencies?	23	N/A	N/A	N/A	N/A	23
Q4(a) A change of name to Domain 1 from 'Professionalism' to 'Social responsibility and professionalism'	36	32 (89%)	2 (5%)	1 (3%)	1 3%)	18
Q4(b) The introduction of a definition of 'Cultural safety for Aboriginal and Torres Strait Islander people' into the Terminology section consistent with the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025	36	30 (83%)	1 (3%)	3 (8%)	2 (6%)	15
Q4(c) The introduction of a definition for At-risk groups or populations into the Terminology section of the introduction and the use of the term 'at-risk' within the Competency statements	35	23 (66%)	3 (9%)	9 (25%)	0 (0%)	19
Q4(d) The introduction of a definition of interprofessional collaborative practice and the use of term within the Competency statements	35	30 (86%)	0 (0%)	5 (14%)	0 (0%)	13
Q4(e) The change of terminology from 'patient-centred care' to 'person-centred care', including the updated definition and the use of the terms 'person' or 'individual' within the Competency statements	35	25 (71%)	4 (12%)	5 (14%)	1 (3%)	16

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(f) The revisions to Competency statements in Domain 1, which are consistent with the National Scheme's definition of cultural safety for Aboriginal and Torres Strait Islander people, specifically Competency statements 2 to 5	35	30 (86%)	1 (2%)	2 (6%)	2 (6%)	9
Q4(g) The inclusion in Domain 1 of Competency 11 which requires the practitioner to 'understand the environmental impacts of health care provision and use resources responsibly, making decisions that support environmentally sustainable healthcare'	32	26 (82%)	3 (9%)	3 (9%)	0 (0%)	13
Q4(h) The revision of communication related Competencies in Domain 2 and Domain 6, which aim to better reflect the needs of those receiving care	32	25 (78%)	0	7 (22%)	0	10
Q4(i) The inclusion in Domain 2 of Competency 4 which requires the practitioner be able to 'recognise, assess and respond to domestic and family violence risk, prioritise safety, provide information, and refer as required'	32	23 (72%)	2 (6%)	6 (19%)	1 (3%)	13
Q4(j) The inclusion in Domain 2 of identifying opportunities for improvement and advocating for improved oral health outcomes	31	26 (84%)	1 (3%)	3 (10%)	1 (3%)	8
Q4(k) The revision of terminology used in Domain 5 to require the application and demonstration of knowledge	32	26 (81%)	2 (7%)	3 (9%)	1 (3%)	10
Q5 Are there any additional Competencies that should be added?	32	7 (22%)	16 (50%)	3 (9%)	6 (19%)	13
Q6 Are there any Competencies that should be deleted or reworded?	32	8 (25%)	21 (66%)	2 (6%)	1 (3%)	9
Q7 Do you have any other comments on the Competencies?	23	N/A	N/A	N/A	N/A	23

Notes to table

- 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.

Question 2 Do you agree with the proposal to combine the Competencies for all five divisions of registration into one document?

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q2 Do you agree with the proposal to combine the Competencies for all five divisions of registration into one document?	43	28 (65%)	3 (7%)	9 (21%)	3 (7%)	21

4.14 There is broad support for the proposal to combine the Competencies for all five divisions of registration into one document. 28 respondents (65%) agreed with this proposal.

4.15 Examples of comments by those answering 'yes' in response to this question included statements such as:

> 'There are a number of advantages to this proposal; assist with streamlining of education for the full dental team. Harmonisation of the expectations of each member of the dental team, and enhanced understanding of the strengths and obligations of colleagues within the team. Support for a positive dental team 'identity' by consolidating materials into a single document.'
>
> 'They are clear and easy to use for all divisions and encourage interprofessional collaborative practice.'
>
> 'We believe combining the competencies for all five divisions of registration into one document demonstrates support for and appropriately models intra-professional practice between all members of the dental team.'
> This will bring more synergy and cohesive understanding and practice across the profession.
>
> '…are supportive of the approach taken, and the intent to highlight common competencies across the five divisions.'
>
> 'The document enables clarity in articulating the different scopes of practice between the dental practitioner divisions.'
>
> 'Signifies the 'core' graduate expectations of dental/oral health practitioners regardless of the specific type of practitioner.'
>
> 'Making them more streamlined.'
>
> 'Practicality and the registrations share many of the competencies.'
>
> 'Makes logical sense and avoids duplication.'
>
> 'Tidier and more coherent document.'

4.16 Nine respondents (21%) answered 'Partly' in response to this question. One respondent suggested a combined document for reference and specific documents for each of the five divisions of registration.

4.17 In response to this question, it was also suggested that 'early intervention' is stated in the competency statement for dentists but not the other divisions of registration and that it could be an amendment. Similarly, that there should be more

clarification surrounding indirect restorative treatments and minimally invasive treatments, and that this may be relevant across other divisions.

4.18 Of the three respondents (7%) that answered 'No' to this question, one suggested that the combined document was not supported because different divisions carry out different roles at different times and that there are different levels of competence. Another respondent suggested that combining the documents makes the document lengthy and complex and that few institutions have multiple programs across the five divisions of registration.

4.19 Another respondent found the combined document hard to read and stated that, as an assessor, they would struggle with the document.

4.20 In addressing these responses and ensuring that the documents are fit for purpose, it is proposed that the documents can be provided in different formats, for example, a combined document and also individual documents.

Question 3: Do you have any comments on the format or structure of the draft Competencies?

Question	Respondents (Total)	Responses with comments
Q3 Do you have any comments on the format or structure of the draft Competencies?	23	23

4.21 Of the 23 respondents providing comments, eight respondents answered 'No', 'Nil', and 'as above' and three comments were not related to the Consultation paper.

4.22 There was support for the format and/or structure from 12 respondents with comments and suggestions, including:

> 'The overarching six competency headings are well considered and provide a solid framework within which additional competences could be added to over time. The proposal to confirm the three competences that apply to all professions is excellent and should help to ensure that these common expectations are widely understood by the dental team and the public.'
>
> 'The overall format is fine, I appreciate the direction and some relevant wording changes, for example one that is driving more formally towards practicing within one's expertise, as outlined in the 2020 scope of practice guideline….'
>
> 'The majority of competencies listed are identical for dentists, dental prosthetists, dental hygienists/therapists and oral health therapists. It would make more sense to have a single list of shared competencies and then highlight the differences for brevity.'
>
> 'Having prosthetist between Dental Hygienist and Dental therapist makes reading the competencies confusing. We would recommend moving Dental Prosthetist to the far-right column,'
>
> 'The format is simple and appropriate for the intended purpose.'
>
> 'The domains work well and maintaining a structure that is familiar to consumers of the competencies provides continuity and visibility about what has changed.'
>
> 'The proposed revision is an improvement in structure, format and language and contemporizes the competencies.'
>
> 'Combining of competencies into one document is a good idea.'

4.23 Comments have been addressed in Section 5 of this paper including the consideration to provide fit for purpose documents where all divisions of registration can be considered side by side in the one document and other stand-alone documents per division.

Question 4(a): A change of name to Domain 1 from 'Professionalism' to 'Social responsibility and professionalism.'

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(a) A change of name to Domain 1 from 'Professionalism' to 'Social responsibility and professionalism'	36	32 (89%)	2 (5%)	1 (3%)	1 3%)	18

4.24 Of the 36 respondents to this question, 32 respondents (89%) supported the change of name to Domain 1 from 'Professionalism' to 'Social responsibility and professionalism.' The comments included:

> 'It more accurately reflects the range of competencies that comfortably sit together as a theme that encompasses societal and individual aspects.'
>
> 'It reflects the changes in the profession, widening the scope from performing merely clinical procedures and being polite.'
>
> 'Per the comment made in response to the first question, (name withheld for privacy) would consider cultural safety, social responsibility, and similar attributes to be heavily liked [sic] to the clinical and professional skills, knowledges and attributes of clinicians, particularly with respect to access to care and services for Aboriginal and Torres Strait Islander peoples and the outcomes of care. The updated domain name also aligns with the edits made to strengthen this section of the competencies.
>
> 'These changes indicate the importance of advocacy by dental professions in the wider community, as well as the importance of interprofessional education and practice.'
>
> 'In line with contemporary thinking and societal expectations.'
>
> 'Signifies that at the heart of dental work is social responsibility.'
>
> 'The name change reflects and supports the revised and proposed competency statements in that domain.'
>
> 'This highlights the ethical and community aspects of dental practice.'

4.25 One respondent (3%) answered 'Do not know' to this question.

4.26 Of the three respondents (8%) that answered either 'No' or 'Partly', one comment suggested that the Domain should be 'Professionalism and social responsibility', another comment was that it 'was not clear', another respondent suggested that 'professionalism already entails social responsibility' and that 'this proposal weakens the definition of professionalism and achieves nothing of value…'.

4.27 All responses are acknowledged. Amendment to the title of Domain 1 from 'Professionalism' to 'Social responsibility and professionalism' is addressed in Section 5 of this report.

Question 4(b): The introduction of a definition of 'Cultural safety for Aboriginal and Torres Strait Islander people' into the Terminology section consistent with the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025.

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(b) The introduction of a definition of 'Cultural safety for Aboriginal and Torres Strait Islander people' into the Terminology section consistent with the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025	36	30 (83%)	1 (3%)	3 (8%)	2 (6%)	15

4.28 Out of 36 respondents to this question, the introduction of a definition of 'Cultural safety for Aboriginal and Torres Strait Islander people' into the Terminology section of the Competencies was supported by 32 (89%) respondents. Comments of support included:

> 'Consistent with social standards for inclusion and engagement.'
>
> 'Appears to be a proportionate and appropriate reflection of the obligations that tall to health professionals in this important area. Language and framing is important and a mutually agreed set of key definitions is vital.'
>
> 'This is much needed. There are many studies that show First Nations people's oral health to be worse than average in Australia, and distrust of the system is always stated as a factor in the under-utilisation of services.'
>
> 'It is appropriate for the terminology employed in the competencies to be consistent with the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025.'
>
> '…strongly support the inclusion of cultural safety, with a focus on Aboriginal and Torres Strait Islander people, into the terminology section. It is important to support a shared understanding of cultural safety and the roles and responsibilities of practitioners (considering also historical confusion around related terminology such as cultural awareness and competence). Consistency with the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 supports alignment across professions and utilised an Aboriginal and Torres Strait Islander led definition of cultural safety.'
>
> 'Important to maintain consistency with national documents/strategies.'
>
> 'Signals the way cultural safety for Aboriginal and Torres Strait Islander people is an essential aspect of safe and inclusive practice.'
>
> 'The primacy of the use of the competency statements is as a regulatory tool in support of the accreditation of approved programs of study. As such, it is essential that they reflect the NRAS framework and strategic direction.

4.29 One respondent (3%) answered 'No' and two respondents (6%) answered 'Don't know' to this question, with no comments provided.

4.30 Of the three respondents (8%) to answer 'Partly' to this question, one provided a response as follows:

'This is supported as long as other vulnerable communities are equally highlighted. It is consistent with wider health service emphasis and the Cultural Safety Strategy. I think, however, that there needs to be work done to identify suitable educators in this area who understand the challenges of dental practice alongside the cultural safety issues.'

4.31 Consideration of these comments are reflected in Section 5 of this report.

Question 4(c): The introduction of a definition of 'at-risk groups or populations' into the Terminology section of the introduction and the use of the term 'at-risk' within the Competency statements.

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(c) The introduction of a definition for At-risk groups or populations into the Terminology section of the introduction and the use of the term 'at-risk' within the Competency statements	35	23 (66%)	3 (9%)	9 (25%)	0 (0%)	19

4.32 The majority of respondents, 23 out of 35 (66%) supported the introduction of the definition 'at-risk groups and populations' into the Terminology section. Out of the respondents answering 'Yes' to this question, seven respondents provided a reason for their response, including:

'Risk based dental care is supported.'

'It minimizes the chance of subjective interpretation, and the risk that particular cohorts of patient could be underserved or overlooked.'

'Yes, care and treatment of people experiencing domestic and family violence at risk groups, including those living with a disability is appropriate under at risk groups.

'The term 'priority populations groups' could be considered as an alternative to 'at-risk'.

'This immediately flags the need for practitioners to be alert to vulnerable groups.'

'In line with current National Oral Health Plan which is Australia's dental focus and directional document.'

'Important to define 'at-risk', so that there is no ambiguity'.

4.33 Nine respondents (25%) answered 'Partly' to this question, with eight respondents providing further comment with their response including:

> 'The definition does not reference these groups as 'at-risk' but instead as 'at an increased risk'. Consideration should be given to aligning the key concept terminology with the definition supplied. Individuals may be at an increased risk due to personal circumstances but does not mean they are part of an at-risk population. Comments on the following groups:- 'People who are ageing', suggest rewording to 'ageing persons requiring additional care or residing in residential and aged care facilities'…..'
>
> 'The term 'priority populations groups' could be considered as an alternative to 'at-risk'.
>
> '(Organisation name) support the inclusion, however, it may be worthwhile revisiting the definition to: a) contextualise inequity and risk (for example system factors, social determinants of health etc.) b) recognize intersectionality, in that people may belong to one or more of these groups which will influence the unique needs of an individual.'
>
> 'I think the terminology needs to be checked to ensure it is contemporary and appropriate to use'.
>
> 'Again, creates visibility, however the use of deficit and risk approach can diminish, rather than, for instance taking a strength-based and agency approach. The associated competency is a step in the right direction but could be taken further than identify opportunities for improvement in care delivery and advocate for improved oral health outcomes, including for at-risk groups or populations. For practitioners to know about lived experience of people they serve is one of the bases for holding person-centred care approach.'
>
> 'Who is 'at-risk' is contestable… i.e. include additional groupings.'

4.34 Two out of the three respondents to answer 'No' to this question provided reasons for their response, one respondent suggested that the use of the term 'at-risk' was impolite and the other respondent suggested that the list 'can never be comprehensive' and that 'attempts, such as this to detail each and every 'at-risk' group creates blind spots towards other groups which are more likely to be overlooked if they do not slot easily into the existing definitions or 'fashionable' areas of concern'. These concerns were noted.

4.35 Acknowledging comments of support or support with amendments for the definition of 'at-risk' populations and groups, some modifications to the definition and the rationale for the changes are addressed in Section 5 of this report.

Question 4(d): The introduction of a definition of interprofessional collaborative practice and the use of the term within the Competency statements.

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(d) The introduction of a definition of interprofessional collaborative practice and the use of term within the Competency statements	35	30 (86%)	0 (0%)	5 (14%)	0 (0%)	13

4.36 No respondents answered "No' to this question.

4.37 30 of 35 respondents (86%) supported the introduction of interprofessional collaborative practice and the use of the term within the Competency statements. Of these respondents, 12 provided a reason for their response and comments of support included:

> 'Supports team-based care and (organisation) strategic direction to integration of oral health into broader health.'
>
> 'This is the definition employed by the World Health Organisation.'
>
> 'This is where Dental practitioners need to be, influencing systemic health and not in silos.'
>
> 'Interprofessional collaboration, including across health and non-health sectors, is essential to improve quality of care and to deliver on principles such as holistic and person and family centred care.'
>
> 'Raises attention to dentistry and oral health as sitting within the health system.'
>
> 'The primacy of the use of the competency statements is as a regulatory tool in support of the accreditation of approved programs of study. As such, it is essential that they reflect the NRAS framework and strategic direction.'
>
> 'The definition for interprofessional collaborative practice is now much clearer.'

4.38 Of the five respondents (14%) that answered 'Partly' to this question, one respondent provided a comment and stated that 'it would be important to reach a consensus of this definition with the other professions with whom the dental team are likely to engage'.

4.39 The above responses indicated broad support for the definition without amendment.

Question 4(e): The change of terminology from 'patient-centred care' to person-centred care', including the updated definition and the use of the terms 'person' or 'individual' within the Competency statements.

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(e) The change of terminology from 'patient-centred care' to 'person-centred care', including the updated definition and the use of the terms 'person' or 'individual' within the Competency statements	35	25 (71%)	4 (12%)	5 (14%)	1 (3%)	16

4.40 25 out of 35 respondents (71%) answered 'Yes' to this question in support of the change in terminology from 'patient-centred care' to 'person-centred care', including the updated definition and the use of the terms 'person' or 'individual' within the Competency statements. Ten out of the 16 respondents provided support for the changes. Comments received included:

> 'aligns with modern practice to support shared decisions making and greater involvement of people in their oral health and oral health care.'
>
> 'this is an appropriate change for the updated competency document.'
>
> 'in line with contemporary practice and societal voice.'
>
> '(Organisation name) are supportive of the change and the shift in terminology, particularly to use of 'person' (as opposed to individual in most circumstances). It is worth acknowledging also that health and social and emotional wellbeing in Aboriginal and Torres Strait Islander contexts extends beyond the health and wellbeing of the individual and includes family, community, Country and other interrelated factors. It is also important that this is linked to cultural safety as care needs to be contextualized and understanding of the lived experience and realities of the individual and their family, highlighting the need to establish trust, report and relationship.'
>
> 'Strongly support the approach to use the term person as it reflects the contemporary direction and emphasis globally and nationally in safety and quality.'
>
> 'Recognises that it's not only the 'patient' that is involved in decision making.'
>
> 'This term (person) considers the background and thoughts and expectations of our patients.'

4.41 Four respondents (12%) answered 'No' to this question, five respondents (14%) answered 'Partly' and one respondent answered "Do not know.' Comments and suggestions included:

> 'We are dealing with patients. Why change?'
>
> 'Understand the rationale for this but still prefer to acknowledge those we care for as 'patients' as I believe that it gives a greater sense of a caring and expert clinician focus on those who are potentially vulnerable individuals and seek expert advice. At least it is not 'client', which I would strongly oppose.'
>
> 'This will be confusing, however the distinction between patient-centred care and people-centred care is an important one. The definition could emphasis more that people are at the centre of the health system and that people-centred care is an ethos, a way of thinking/being that guide what is done and how it is done.'
>
> 'The term 'patient' implies a special relationship with the professional, very different from 'customer' or even 'client'. There is an added level of responsibility and care implicit in this term. In a world where dentistry is becoming increasingly commoditized, it is important to maintain a professional, caring medical relationship, and to change the term from patient to person could weaken this relationship. The term 'patient' may imply a unidirectional relationship, but the relationship is bidirectional by nature.'

4.42 Consideration of these comments are reflected in Section 5 of this report.

Question 4(f): The revisions to Competency statements in Domain 1, which are consistent with the National Scheme's definition of cultural safety for Aboriginal and Torres Strait Islander people, specifically Competency statement 2 to 5.

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(f) The revisions to Competency statements in Domain 1, which are consistent with the National Scheme's definition of cultural safety for Aboriginal and Torres Strait Islander people, specifically Competency statements 2 to 5	35	30 (86%)	1 (2%)	2 (6%)	2 (6%)	9

4.43 There was strong support for the changes to the Competency statements in Domain 1, with 30 out of 35 respondents (86%) answering 'Yes' to this question. The comments of support included:

> 'A positive move to embrace inclusive and respectful language and terminology.'
>
> 'These are appropriate and achievable competencies for education providers and may contribute to improved oral health care and working environments for Aboriginal and Torres Strait Islander people and colleagues.'
>
> '(organisation) support this inclusion for two main reasons, being the ability to lead change and embed cultural safety within the profession, through professional competencies and associated processes (and the accountability this brings) and the alignment with the National Scheme. While it is important to provide culturally sage newly registered practitioners, it is essential that cultural safety and responsiveness is understood to be a process of ongoing and lifelong learning.'
>
> 'A positive move to embrace inclusive and respectful language and terminology.'
>
> 'These are appropriate and achievable competencies for education providers and may contribute to improved oral health care and working environments for Aboriginal and Torres Strait Islander people and colleagues.'
>
> 'This gives imperative for these to be positively incorporated in the Dental School syllabus.'

4.44 Of the three respondents who answered either 'No' or 'Partly' only one comment was provided which was unrelated to the question. Two respondents answered that they 'Did not know.'

4.45 There were no suggestions provided for further amendments to the revisions or wording of the Competency statements.

Question 4(g): The inclusion in Domain 1 of Competency 11 which requires the practitioner to 'understand the environmental impacts of health care provision and use resources responsibly, making decisions that support environmentally sustainable healthcare.'

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(g) The inclusion in Domain 1 of Competency 11 which requires the practitioner to 'understand the environmental impacts of health care provision and use resources responsibly, making decisions that support environmentally sustainable healthcare.'	32	26 (82%)	3 (9%)	3 (9%)	0 (0%)	13

4.46 26 of 32 respondents (82%) supported the inclusion of this Competency statement into Domain 1 with comments including:

> 'Aligns with societal values'
>
> 'Reflects the increased general visibility and awareness in this area, and reflects the traditional environmental impact of dental care e.g. mercury use.'
>
> 'It is the 21st century and we all have to take responsibility.'
>
> 'This is an appropriate and timely addition to the Competencies. We would recommend a change of wording of this competency to match wording in the remaining document by replacement of 'understand' with 'recognise'.
>
> 'Dentistry needs to be aware of environmental impact and sustainability in health care delivery.'
>
> 'Strongly support the inclusion as it reflects and is consistent with contemporary direction and emphasis globally and nationally in safety and quality.'
>
> 'This is increasingly important on a national level and has particular relevance with increased PPE requirements post COVID-19.'

4.47 Of the three respondents (9%) to answer 'No' and three respondents (9%) to answer 'Partly' to this question, two comments were provided, one that suggested 'it is almost impossible for a practitioner to practice sustainably without any guidance as to how it is even practicably possible to practice more sustainably'. The other suggested a change of wording of this competency to match wording in the remaining document by replacement of 'understand' with 'recognise'. Consideration of this response is reflected in Section 5 of this report.

4.48 Consideration of amendments to the competency statement is reflected in Section 5 of this report.

Question 4(h): The revision of communication related Competencies in Domain 2 and Domain 6, which aim to better reflect the needs of those receiving care.

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(h) The revision of communication related Competencies in Domain 2 and Domain 6, which aim to better reflect the needs of those receiving care	32	25 (78%)	0	7 (22%)	0	10

4.49 All respondents answered either 'Yes' or 'Partly' to this question.

4.50 25 out of the 32 respondents (78%) supported the revision of communication related Competencies in Domain 2 and Domain 6. The responses that were provided included:

> 'All good improvements.'
>
> 'As part of communication competencies, consideration for the newly qualified practitioner's ability to understand and account for the persons level of comprehension to ensure effective communication, is necessary.'
>
> 'Strongly support the inclusion as it reflects and is consistent with contemporary direction and emphasis globally and nationally in safety and quality.'
>
> 'Changes are necessary and appropriate'

4.51 Seven out of the 32 respondents (22%) 'Partly' supported the revision with comments including:

> 'As part of communication competencies, consideration for the newly qualified practitioner's ability to understand and account for the persons level of comprehension to ensure effective communication is necessary.'
>
> '(Organisation) support the changes, although the language could be stronger in some instances to ensure that people are supported to have ownership of their care and decision making.'
>
> 'We would recommend rewording the new Competency 2.6. It may be challenging for students and graduates to 'help colleagues and team members to maintain good health'. Consider rewording to: 'maintain one's own health and wellbeing and support the health and wellbeing of colleagues and team members.'
>
> 'There could still be some refinement of the terms 'patient', 'person' and 'individual' as the terms are used interchangeably and only the terms 'patient' and 'person-centred' care are defined. For instance, is it to be assumed that 'person' is defined according to the definition of 'person-centred care'? The way communication is presented in Domain 2 is narrowly focused on interactions with patients. Other forms of communication and contexts for communication are important for dental practice.'

4.52 Consideration of amendments to Competencies in Domain 2 and Domain 6 are outlined in Section 5 of this report.

Question 4(i): The inclusion in Domain 2 of Competency 4 which requires the practitioner be able to 'recognise, assess and respond to domestic and family violence risk, prioritise safety, provide information, and refer as required.'

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(i) The inclusion in Domain 2 of Competency 4 which requires the practitioner be able to 'recognise, assess and respond to domestic and family violence risk, prioritise safety, provide information, and refer as required'	32	23 (72%)	2 (6%)	6 (19%)	1 (3%)	13

4.53 23 out of 32 respondents (72%) answered 'Yes' to this question. 8 respondents provided a reason for their answer including;

'Family violence is prevalent and health professionals need the skills to refer or assist.'

'Agreed and in line with what is expected of an Australian Citizen and Health Practitioner.'

'Essential requirements'

'Dental practitioners have an importance role in recognizing and preventing family violence.'

'As noted in the Consultation paper, the profession provides an important opportunity to provide a supportive referral pathway to services for people experiencing domestic and family violence, and newly registered practitioners need the skills to recognize, assess and respond to domestic and family violence risk. However, practitioners should also be supported by employers and workplaces with respect to practices, procedures and referral pathways, and it will be important that this is supported by employers and workplaces with respect to practices, procedures and referral pathways, and it will be important that this is supported within the remit of influence of the profession.'

'The practitioner needs to not only identify risk but also to act on it in an appropriate and safe manner in the best interests of the victim.'

'I fully agree with the need to recognize. Response and referral are the trickiest parts of this statement for a young practitioner on graduation.'

'Strongly support the inclusion as it reflects and is consistent with contemporary direction and emphasis globally and nationally in safety and quality as well as Health Council's direction to Ahpra and the National Boards.'

4.54 Six respondents (19%) 'Partly' supported the inclusion of this statement into Domain 2 by offering comments and suggestions, including:

> 'On the likelihood that this competence is tacitly making reference to specific (but non-dental specific) obligations that fall to those in public facing care roles, it may be worthwhile to name the specific legislation, initiative or framework in question.'
>
> 'Consider adding the need for 'sensitive inquiry.'
>
> 'It is good to see the inclusion of domestic/family violence in the competencies. The statement about recognizing, assessing, and responding to domestic and family violence risk could be broadened to also refer to situations where vulnerable people may be at risk of harm, but not confined to the 'family'.
>
> 'Complex and fraught space, and potentially difficult to ensure graduates meet this competency.'

4.55 The two respondents (6%) who answered 'No' to this question did not provide any further comment.

4.56 Amendments made or actions taken on consideration of the above comments are reflected in Section 5.

Question 4(j): The inclusion in Domain 2 of identifying opportunities for improvement and advocating for improvement and advocating for improved oral health outcomes.

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(j) The inclusion in Domain 2 of identifying opportunities for improvement and advocating for improved oral health outcomes	31	26 (84%)	1 (3%)	3 (10%)	1 (3%)	8

4.57 26 of 30 respondents (84%) supported the inclusion to Domain 2 and all of the eight comments provided in response to this question were supportive, including:

> '(organisation) supports linking oral health outcomes and at-risk groups and populations and aligns with value based health care principles.'
>
> 'The role of the health workforce as trusted advocates is important, and it is valuable for dental practitioners to have the skills to advocate for the needs and outcomes of people, families and communities. Similarly, self-reflective practice and a continuous quality improvement approach is important to ensure that practitioners are responding to the needs of the communities they serve.
>
> 'This addition highlights dental professionals have an important role to play in advocacy for oral health, particularly relating to priority populations and at-risk groups.'
>
> 'Advocacy is a core capability of dentists and this competency links to the health determinants.'

4.58 There were no responses provided from respondents who answered 'No' to this question. There was one response provided from the three out of 31 respondents (10%) who 'Partly' supported the inclusion, which was a comment regarding how providers would teach and assess an advocacy-based competency.

4.59 Consideration of the inclusion of advocating for improved oral health outcomes is addressed in Section 5.

Question 4(k): The revision of terminology used in Domain 5 to require the application and demonstration knowledge.

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q4(k) The revision of terminology used in Domain 5 to require the application and demonstration of knowledge	32	26 (81%)	2 (7%)	3 (9%)	1 (3%)	10

4.60 26 out of 32 respondents (81%) provided a 'Yes' response to this question. Of the ten respondents to leave a further reason for their response, seven of these were in support of the revision, including:

> 'Application and/or demonstration of theoretical knowledge is much better than understand. This is a welcomed improvement in the description.'
>
> '…support putting knowledge into practice and out approach to education is based on knowing, being and doing, that is what we know, our attitudes and behaviours. With respect to Domains 5 and 6, we would comment that the evaluation of knowledges should also include value for Aboriginal and Torres Strait Islander ways of knowing, being and doing, and that as a profession there are opportunities to increase teaching and understanding of Indigenous knowledges.'
>
> 'The verbs apply and demonstrate refer to what a graduate can do with the knowledge/skills, so the statements more clearly indicate that application is required.'
>
> 'Highlights the application of knowledge, not just an understanding.'

4.61 Out of the two respondents (7%) who answered 'No' to this question, one reason for their answer was provided and questioned 'why practitioners would assemble knowledge such as this if not to interpret, understand and apply – this is a core competency for tertiary education and I suspect practitioners do not lose this ability, inclination after graduation….'

4.62 Three out of 32 respondents (9%) answered 'Partly' to this question, with two comments provided:

> 'The shift to using terms as application and demonstration may place considerable burden or challenges for education providers in providing satisfactory evidence of assessment.'
>
> 'I have issues with the demonstration of knowledge in a document that deals with competencies. Better a graduate knows where to find the knowledge than to know half of it to pass an examination…The competency should be based on analysis and critical thinking not a regurgitation of facts.'

4.63 These and other comments were considered and addressed in Section 5.

Question 5: Are there any additional Competencies that should be added?

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q5 Are there any additional Competencies that should be added?	32	7 (22%)	16 (50%)	3 (9%)	6 (19%)	13

4.64 16 out of 32 respondents (50%) answered 'No' to this question. Comments that suggested that no additional Competencies should be added included:

> 'The proposed competences are comprehensive and well-articulated.'
>
> 'The competencies are comprehensive and the current proposed updates relevant and timely.'
>
> 'Happy with current draft and ability to review and modify in the coming years.'
>
> 'Demonstrated evidence of evidence-based practice.'

4.65 Seven out of 32 respondents (22%) answered 'Yes' and three respondents (9%) answered 'Partly' to this question. Suggestions included;

> '…., the competencies appear to be largely complete, noting comments elsewhere and below. Under domain 4, health promotion, and domain 6, person-centred care, there is no obvious reference/capability about supporting the person to manage their long term oral health. Whether this requires a stand-alone competency or amendment to an existing, it would be good for the workforce to recognize their role in support agency and self-determination for people to lead in their care and wellbeing.'
>
> 'As previously stated, considering that dental caries is one of the most common chronic diseases globally and in Australia, and given what is known about the reversibility of early carious lesions and the negative long-term consequences of direct and indirect restorative procedure, there is need to include a competency in the medical (non-restorative) management of such lesions. Management of other conditions separately, for example, periodontal, pulp and tooth loss. It is concerning that caries is not addressed similarly in these competencies. Item 6.3. One important competency is missing for dentists, dental therapists, dental hygienists and oral health therapists which is: 'manage the disease of dental caries including early carious lesions using a non-operative approach and prevention of further disease.'
>
> '…6.1 really should be clinical information gathering and interpretation. For radiography it should be take or request….6.2 suggest that the practitioner present a range of options rather than just one treatment plan. 6.3 implants need to be included…'
>
> 'Specific knowledge about nutrition is central for practitioners conducting a diet-focused interview and providing targeted self-care strategies for patients. We suggest specifying this in the scientific and clinical knowledge and adding it to domain 6.1. Frequently, this essential aspect of many dental/oral health consultations is overlooked. The effect of naming nutrition knowledge as essential signifies that diet-focused consultations are integral to the dental/oral health consultation. Domain 6.1: Add diet history to: obtain and record a relevant history of the patient's individual's medical, social and oral health status.'
>
> 'Critical thinking neither has sufficient emphasis critical appraisal skills nor includes evaluative judgement. Two things critical for all graduates to support practitioners in inter-professional practice and life-long learning….'

4.66 These comments were considered and any amendments to the Competencies or actions taken are reflected in Section 5 of this report.

Question 6: Are there any Competencies that should be deleted or reworded?

Question	Respondents (Total)	Yes (%)	No (%)	Partly (%)	Do not know (%)	Responses with comments
Q6 Are there any Competencies that should be deleted or reworded?	32	8 (25%)	21 (66%)	2 (6%)	1 (3%)	9

4.67 21 out of 32 respondents (66%) answered 'No' to this question, supporting no further changes or amendments to the Competencies. Only one of these respondents provided further comment, stating that 'all are valid'.

4.68 Eight out of 32 respondents (25%) supported some changes to the wording and/or deletions relating to some Competencies. Two respondents were 'Partly' supportive of changes to wording and/or deletions of some Competencies. Comments included:

> '….6.3.1 "Apply the principles of….disease prevention and early intervention' is only included in dentist competencies. This should be included in all divisions. For dental therapists, 6.3.6. and oral health therapists, 6.3.5 – manage the loss of tooth structure by restoring the definition with 'direct restoration' should include or be replaced by 'minimally invasive techniques' and in dentist, 6.3.6, minimally invasive techniques should be included. In the Terminology section, at risk groups or population please include pregnant women on list…6.1 Clinical information gathering competency statement 4 should include take and interpret radiographs relevant to dental practice.'
>
> 'Some minor changes for consideration include: 1.6 could be expanded to identify "culturally safe and trauma informed care", aligning with earlier recognition of the impact of trauma on oral health outcomes and access to care. 2.5 could be amended to include leadership with respect to cultural safety. 3.1 could encourage evaluation of knowledge in a critical and culturally safe way, to increase recognition of and value for Indigenous knowledges.'
>
> 'Some minor changes have been suggested in previously in this survey. In addition 6.3.3 'manage anxiety and pain' is included for dentists only – it is not clear why this is.'
>
> 'Some competencies can be simplified to refer to 'at-risk populations'. For example, under social responsibility and professionalism, subsection 6 "provide culturally safe care to diverse groups and populations, recognizing barriers to accessing care and responding to the distinct needs of those at greatest risk of poor oral health", this could be revised as "provide culturally safe care to diverse groups and populations, recognizing barriers to accessing care and responding to the distinct needs of at-risk populations.'
>
> 'As mentioned, the way the competency applicable to endodontics is worded is not good:'…manage diseases and conditions of the pulp, root canal and per-radicular tissues." This is not an existing entity, there are no conditions of the root canal. The term peri radicular, while not wrong, is not used anymore. The original description is actually better and in keeping with what other organisations say. I strongly suggest to change.'

4.69 Consideration of these comments and any actions taken are reflected in Section 5 of this report.

Question 7: Do you have any other comments on the Competencies?

Question	Respondents (Total)	Responses with comments
Q7 Do you have any other comments on the Competencies?	23	23

4.70 Two of the 23 respondents to this question indicated that their major comment had already been included as part of a response to previous questions. Five other respondents stated that they had no further comments.

4.71 There were a range of comments supporting the work that has been undertaken in reviewing the Competencies, including:

> 'It is a significant body of work that has been undertaken…'

'With minor modifications these are appropriate for the current times.'

'As a registered Dental Practitioner, Health Leader, Educator and regulator, I endorse and support these changes which will reflect current practice and contemporary thinking of the modern Australian Dental Practitioner.'

'(name) appreciates the comprehensiveness of the document, with strengthened competencies around cultural safety and to meet the needs of the population.'

'This is a sound document that will particularly serve to emphasise the role that all dentists have in treating the vulnerable patient.'

4.72 There were two respondents that only supported some aspects of the Competencies. One respondent supported the changes to cultural safety stating that they are 'overdue and welcome', however they stated that the remaining changes are distractions and that they are of 'very little practical value' and more 'an expression of contemporary politics, not an expectation of professional competency. The other respondent argued that '80-90% of graduates have their careers in a business-driven private sector, providing care to those who can afford their services…and seldom patients are from many of the 'at-risk' groups, located mainly in urban settings.'

4.73 Several additions and amendments are proposed to the Competencies as worded and detailed consideration was given to the responses from the survey and from direct communication with the ADC by stakeholders.

5. Changes made following consideration of the consultation responses

5.1 This section details the changes made to the Competencies following the Consultation process.

5.2 Changes that were proposed by respondents are listed against the relevant section of the document or competency statement. The ADC has also highlighted what action has been taken after consideration of all feedback and in considering this document in its entirety.

5.3 There was broad support for revisions to the Competencies that reflect the broader societal and regulatory changes that have occurred since the previous iteration of the Competencies was published.

5.4 Additions and amendments to some Domains and/or Competency statements resulted from stakeholder feedback regarding certain focus areas outlined in the Consultation paper.

5.5 This section provides information about the more significant changes proposed at the completion of the Consultation period in response to the Consultation survey and also the stakeholder responses that were sent directly to ADC. You can see a list of organisations and individuals that responded to the public consultation in **Appendix 4**.

5.6 If feedback relates to competencies included in Domains 4, 5 and 6 (including sub-domains) and is relevant to multiple divisions, this feedback has been captured against the competencies for the newly qualified dentist only. However, actions taken, and any changes made are highlighted throughout these sections.

Actions and amendments to introductory text and terminology

Proposed definitions	Comments/responses	Actions
Introductory text	Nil received	**No change required**
1.1 Divisions of dental practitioners	Nil received	**No change required**
1.2 Scope of practice This document is **NOT** a scope of practice for dental practitioners and should not be read as such. The ~~scope of practice for dental practitioners is defined by the DBA as the regulator of the dental professions~~ **DBA's *Scope of practice registration standard* and *Guidelines for scope of practice* outline that a practitioner's scope is individual to them and is dependent not only on their division of registration, but also their education, training, and competence. The DBA publishes a range of regulatory instruments and resources to assist dental practitioners in understanding their individual scope of practice. For further information, please refer to www.dentalboard.gov.au**.	Comment 1 (organisation) recommends that this is amended to ensure greater alignment with information and requirements as contained in the Scope of practice registration standards and Guidelines for the scope of practice. For example, the section could explain that an individual's scope of practice is unique to that practitioner and depends not only on their division but also on their education, training and competence. For more information, the Competencies could refer the reader to the Board's regulatory instruments as outlined above.	**Accepted –** Amendment has been made to better reflect the information and resources available.
1.3 This document Retitled **1.3 Understanding the purpose of** this document	Nil received	**Amendment –** the section has been retitled to better reflect its purpose. No changes have been made to the text within this section.

2. Use of the Competencies The ADC will use this document as a reference point in carrying out its key functions of: • accreditation of education and training programs for dental practitioners • developing accreditation standards for the approval of the DBA, and • assessing overseas qualified dental practitioners to ensure they possess the professional qualities, knowledge, judgement, and clinical skills required for practice in Australia. ~~Since 1 January 2016, E~~**e**ducation providers seeking to have their education and training programs accredited by the ADC have been required to demonstrate that the program enables students to achieve the required professional competencies. **This requirement has been in place since 1 January 2016**. While this document does not prescribe the curricula of dental practitioner programs, for a program to be accredited it must demonstrate that the learning outcomes address the competencies as outlined in section 4. The program must also demonstrate that there is a clear relationship between those learning outcomes and the assessment tools and strategies used. This does not restrict a program from providing its students with **learning opportunities to develop** other competencies. In the ADC's role of assessing overseas trained dental practitioners, the competencies are an important reference point for mapping and blueprinting examinations. The ADC's written and practical examinations are standardised to ensure overseas trained practitioners meet the same threshold competence expected of a newly qualified graduate of an **accredited** Australian program.	Nil received	**Amendment –** Slight wording amendments made to improve readability and ensure clarity.

Proposed definitions	Comments/responses	Actions
Other organisations will use the competencies in different ways and for different purposes.		
3. Terminology Second paragraph: The term "competency" has traditionally been associated with technical training. It is important therefore to clarify how it is being used in this document and to caution against reducing the framework to a checklist of competencies, ~~each of which is~~ dealt with in isolation from the others, as this does not do justice to the relationship between knowledge, skills, attitudes and experience ~~in the hands~~ of a practising dental practitioner. Problem-solving skills, professionalism, empathy, ethics and other higher order attributes are just as important to professional clinical practice as technical abilities. While challenging to measure, these attributes are a vital component of current dental education curricula.[2]	Nil received	**Amendment –** language has been simplified to ensure ease of readability.
Competency includes knowledge, experience, critical thinking and problem-solving skills, professionalism, ethical values, diagnostic and technical and procedural skills. These components ~~become an~~ **are** integrated ~~whole~~ during the delivery of patient care by the competent practitioner. Competency assumes that all behaviours are performed with a degree of quality consistent with patient wellbeing and that the practitioner self-evaluates treatment effectiveness.2 The term covers the complex combination	Nil received	**Amendment –** language clarified to align with other amendments made within the document based on feedback provided.

[2] Adapted from Universities Australia's response to A Healthier Future for All Australian's report (March 2009)

Proposed definitions	Comments/responses	Actions
of knowledge and understanding, skills and attitudes needed by the graduate. Competencies are outcomes of clinical training and experience.		
Competent the behaviour expected of the beginning practitioner. This behaviour incorporates understanding, skill, and values in an integrated response to the full range of requirements presented in practice.	Nil received	**No change required**
Groups or populations at increased risk of harm or poor oral health the demonstration of all professional competencies must take into account ~~of~~ people, **groups and populations** ~~who are~~ at ~~an increased~~ **greater** risk of ~~developing poor oral health and face greater challenges in accessing oral health care~~ **harm and/or poorer oral health outcomes** and **that** face greater challenges in accessing oral health care, **as existing systems, policies and processes may not meet their needs. Individuals may intersect with several groups or populations at increased risk of poorer oral health. These groups or populations are likely to include:** • those who are socially disadvantaged or on low incomes; • people with sensory, psycho-social, progressive, physical, and intellectual disability, and people with Acquired Brain Injury ; • autistic and neurodiverse people;	Comment 1 (organisation) The definition does not reference these groups as 'at-risk' but instead as 'at an increased risk'. Consideration should be given to aligning the key concept terminology with the definition supplied. Individuals may be at increased risk due to personal circumstances but does not mean they are part of an at-risk. Comment 2 'People who are ageing', suggest rewording to 'ageing persons requiring additional care or residing in residential and aged care facilities'. Comment 3 'Children and adolescents', suggest focusing on 'early childhood'.	**Accepted with amendment** to the proposed definition of at-risk groups or populations Amendments have been made in response to feedback regarding; • clarification of the definition of 'at-risk' to address those groups and populations at an increased risk of poorer oral health outcomes. • people who are ageing to include ageing persons requiring additional care, or residing in residential and aged care facilities. • to recognise intersectionality, in that people may belong to one or more of these groups which will influence the unique needs of the individual

Proposed definitions	Comments/responses	Actions
• those living in regional and remote areas; • Aboriginal and Torres Strait Islander people; • people with Culturally and Linguistically Diverse Backgrounds • Lesbian, Gay, Bisexual+, Transgender and gender diverse, Intersex, Queer, and Asexual+ people • ~~people who are aging~~ **ageing person requiring additional care or residing in residential and aged care facilities** • children and adolescents • **pregnant women** • people who have experienced trauma, and people who have experienced violence and abuse including sexual abuse	Comment 4 'priority populations groups' could be considered as an alternative to 'at-risk' Comment 5 (organization) support the inclusion, however it may be worthwhile revisiting the definition to: a) contextualise inequity and risk (for example system factors, social determinants of health, etc.) b) recognize intersectionality, in that people may belong to one or more of these groups, which will influence the unique needs of an individual Comment 6 Again, creates visibility, however the use of deficit and risk approach can diminish, rather than, for instance taking a strengths-based and agency approach. The associated competency is a step in the right direction but could be taken further than identify opportunities for improvement in care delivery and advocate for improved oral health outcomes, including for at-risk groups or populations. Comment 7 the term is received by those groups as being deficit-driven and marginalising language. I would suggest a change of	• the term 'at-risk' being perceived by those groups as being deficit-driven and marginalising language • a change in discourse from a deficit narrative that represents people or groups in terms of deficiency rather than address the larger socio-economic systems, policies and processes in which they are embedded. The definition has been changed based on the feedback groups and populations at greater risk of harm or poor oral health in conjunction with the definition for person-centred care and their inclusion throughout the Competencies have addressed comments regarding: • the inclusion of 'priority groups' into the definition • Inclusion of pregnant women into the definition Moved to align with alphabetical ordering of definitions.

Proposed definitions	Comments/responses	Actions
	language to groups at greater risk of harm	
	Comment 8 Is everyone clear about "at-risk" – at risk of what	
	Comment 9 Suggest reframing language used for 'at-risk groups or populations' throughout the document. Current wording implies these groups are high risk, rather than the systems and circumstances surrounding these groups that can lead to avoidable differences in health outcomes. Current language reflects a deficit narrative, or deficit discourse, which refers to discourse that represents people or groups in terms of deficiency – absence, lack or failure. It particularly denotes discourse that narrowly situates responsibility for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded (https://apo.org.au/sites/default/files/resource-files/2018-05/apo-nid172676_1.pdf)	
	Comment 10 Although the use of the term 'at-risk' is currently well recognised and widely used by political and social and health sectors, the term is received by those	

Proposed definitions	Comments/responses	Actions
	groups as being deficit-driven and marginalising language. I would suggest a change of language to groups at greater risk of harm.	
	(organisation) is in agreement overall with the format/structure of the draft competencies, however, the members have concerns that, as the definition of the 'at risk' groups are included in a separate section from the Competency statements, this may lead to the dilution of specific populations identified as being ' at risk' from the Competency statements and that 'people with disability' (and other at risk groups) may become invisible to the educational providers and therefore not included in their curricula and student learning outcomes.	
	Comment 11 (organisation) Regarding the list of at-risk populations, whether or not a person has intellectual disability, acquired brain injury (ABI), is neurodiverse, etc is less material than how the person's attributes or diverse needs or communication styles interacts with oral health practitioners before, during and after treatment. The categories that need to be considered when it comes to at risk groups are: a. Anyone whose communication style means they are at risk of being seen as lacking the ability to make decisions –	

Proposed definitions	Comments/responses	Actions
	even if they actually can make decisions but need some third-party support to do this and to communicate the decisions. b. Anyone whose physical impairments means they are more likely to be subject to restrictive practices that could be replaced with less restrictive practices if a bit of additional interprofessional communication occurred (or communication with appropriate supporters). c. Anyone whose behaviour may elicit premature reactions or responses that result in the use of unnecessary restrictive practices. d. Anyone with a disability whose document plans regarding support needs, communication style, and treatment preferences may be well documented but not readily accessible to oral health practitioners, causing the professional to make discretionary decisions during treatment. Comment 12 (organisation) please include pregnant women on the list.	
Critical Thinking The process of assimilating and analysing information, encompassing an interest in finding new solutions, a professional curiosity with an ability to admit to any lack of understanding, a willingness to examine beliefs, biases,	Nil received	**No change required**

Proposed definitions	Comments/responses	Actions
and assumptions and to search for evidence that supports the acceptance, rejection or suspension of those beliefs, biases, and assumptions, and the ability to distinguish between fact and opinion.		
Cultural safety for Aboriginal and Torres Strait Islander people ~~cultural safety~~ is determined by Aboriginal and Torres Strait Islander individuals, families and communities culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.	This is supported as long as other vulnerable communities are equally highlighted. It is consistent with wider health service emphasis and the Cultural Safety Strategy. I think, however, that there needs to be work done to identify suitable trained educators in this area who understand the challenges of dental practice alongside the cultural safety issues.	**No change required** Addressed by the addition of a definition for populations or groups at greater risk of harm or poor oral health and the definition for 'person-centred' care.
Evidence-based dentistry An approach to oral health care that requires judicious integration of systematic assessments of clinically relevant scientific evidence relating to the patient's oral and medical condition, history, oral health literacy, and integrated with the practitioner's clinical expertise and the person's treatment needs and preferences	Nil received	**No change required**
Financial consent is part of informed consent and requires a person being made aware of and agreeing to all the fees and charges involved in a course of treatment, preferably before the health service is provided. If consent cannot be obtained before care is provided, information should be provided as soon as practicably possible after the service is provided.	Nil received	**No change required**

Proposed definitions	Comments/responses	Actions
Health promotion the process of enabling people to increase control over the determinants of health and thereby improve their health. Health promotion not only embraces actions directed at strengthening the skills and capabilities of individuals but also actions directed towards changing social, environmental, political and economic conditions to alleviate their impact on populations and individual health.	Nil received	**No change required**
Information management Information management concerns the acquisition of information from one or more sources, the custodianship and the distribution of that information to those who need it, and its ultimate disposition through archiving or deletion	Nil received	**No change required**
Informed consent a person's voluntary decision about health care that is made with knowledge and understanding of the benefits and risks involved and of the treatment options available, including the potential financial costs	Nil received	**No change required**
Interprofessional collaborative practice is when multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care across settings	It would be important to reach a consensus of this definition with the other professions with whom the dental team are likely to engage (Organisation) The definition of interprofessional collaborative practice should be refined to emphasise that the aim of the interprofessional collaborative practice is to reach an agreed decision,	**No change required** The stakeholder survey, and the Consultation process supported consensus on this definition Using interprofessional collaborative practice is expected to be undertaken to provider person-centred care,

Proposed definitions	Comments/responses	Actions
	by all involved, on the highest quality of care that needs to be implemented to achieve the best overall health outcome for the patient, their family/ carers. There should be a distinction from multidisciplinary care.	achieving the outcome expected in the feedback provided.
Leadership requires reflection and improvement of self, fostering growth in and influencing others, and communicating a vision for the future and enabling decisions to align with the goal. To achieve outcomes, leaders embrace the spirit of change and innovation and strategically understand and align complex systems with the goal	Nil received	**No change required**
Manage to "manage" the oral health care needs of a patient includes all actions performed by practitioners within their, abilities, competence and experience that are designed to alter the course of a patient's condition. Such actions may include providing education, advice, diagnosis, treatment by the practitioner, treatment by the practitioner after consultation with another health care professional, referral of a patient to another health care professional monitoring treatment provided and evaluating oral health outcomes; it may also include observation or providing no treatment. "Manage" assumes the use of appropriate diagnostic processes and planning.	Nil received	**No change required**
Patient is the person receiving health care and also those assisting or supporting the individual to make decisions about their	Nil received	**No change required**

Proposed definitions	Comments/responses	Actions
care. Those assisting may include parents, guardians, family, carers**,** support workers, or substitute decision makers for a person that has been assessed as not having the capacity to make their own decisions. A substitute decision maker may be a parent or carer or a legally appointed decision maker.		
Person-centred care is recognised as a foundation to safe, high-quality healthcare. It is care that is respectful of, and responsive to, the preferences, needs and values of the individual patient. It involves seeking out, and understanding, what is important to the individual receiving care, fostering trust, establishing mutual respect and working together to share decisions and plan care. Key dimensions of person centred care include respect, dignity, emotional support, physical comfort, open and honest communication, continuity and transition, care coordination, involvement of carers**,** ~~and~~ family, **and community**, and access to **culturally safe** care.	Comment 1 (Organisation) The term "patient" implies a special relationship with the professional, very different from "customer" or even "client." There is an added level of responsibility and care implicit in this term. In a world where dentistry is becoming increasingly commoditised, it is important to maintain a professional, caring medical relationship, and to change the term from patient to person could weaken this relationship. The term 'patient' may imply a unidirectional relationship, but the relationship is bidirectional by nature Comment 2 (Organisation) are supportive of the change and the shift in terminology, particularly to use of 'person' (as opposed to individual in most circumstances). It is worth acknowledging also that health and social and emotional wellbeing in Aboriginal and Torres Strait Islander contexts extends beyond the health and wellbeing of the individual and includes family, community, Country and other	**Accepted with amendments** While support for the previous terminology used in the competencies is acknowledged, the broad consensus from the stakeholder survey and public consultation is to incorporate person-centred care within the Competency statements. Changes have been made to incorporate culturally safe care within the definition.

Proposed definitions	Comments/responses	Actions
	interrelated factors. It is also important that this is linked to cultural safety, as care needs to be contextualised and understanding of the lived experiences and realities of the individual and their family, highlighting the need to establish trust, report and relationship.	
	Comment 3 It would be good to link person centred with outcome-based care. e.g. 'person centred &outcome based care'	
	Comment 4 Understand the rationale for this but still prefer to acknowledge those we care for as 'patients' as I believe that it gives a greater sense of a caring and expert clinician focus on those who are potentially vulnerable individuals and seek expert advice. At least it is not 'client', which I would strongly oppose.	
	Comment 5 (Organisation) This will be confusing, however the distinction between patient centred care and people centred care is an important one. The definition could emphasise more that people are at the centre of the health system and that people centred care is an ethos, a way of thinking/being that guides what is done and how it is done.	

Proposed definitions	Comments/responses	Actions
Self-reflexive **the ability of a person to reflect on one's own actions while consciously taking a proactive approach to self-improvement, collaboration and life long learning**	Comment 1 that Reflective learning/practice should be included as this seems to be the way forward as part of registration. Comment 2 self-reflexive' may not be a term that has shared understanding. A definition may help to distinguish reflexive and reflective – both are important	**Actioned – new definition included** Definition included following comments related to statement 1.8.
Structure of the statements The range of ~~personal qualities, cognitive abilities, applied knowledge and skills~~ **competencies** expected of the newly qualified practitioner has been clustered into the following six domains: Competencies for all divisions of general registration 1. Social responsibility and professionalism 2. Communication and leadership 3. Critical thinking Competencies specific to each division of general registration 4. Health promotion 5. Scientific and clinical knowledge 6. Person-centred care (which has sub-domains of Clinical information gathering, Diagnosis and management planning, Clinical treatment and evaluation).	Comment 1 (Organisation) The majority of competencies listed are identical for dentists, dental prosthetists, dental hygienists/therapists and oral health therapists. It would make more sense to have a single list of shared competencies and then highlight the differences for the sake of brevity. The clarification of competency for the purposes of the document is helpful as this term has variable meanings. However, for consistency, it may be helpful to align the terminology used throughout the document. For example, the paragraph at the start of page 8 of the Competencies refers to the clustering of personal qualities, applied knowledge and skills into domains. The concepts of personal qualities and applied knowledge and skills are helpful but are not used as part of the definitions of	**Accepted with amendments** Changes made to introductory text to ensure consistency of definition. Consideration to be to be given to presentation of competency statements for each of reference and brevity during final document design.

Proposed definitions	Comments/responses	Actions
	competency under the key concepts on page 5 of the document.	

Domain 1. Professionalism

Proposed changes	Comments/responses	Actions
Domain Name Social responsibility and professionalism	Comment 1 feel it should be "Professionalism and social responsibility" Comment 2 Professionalism already entails social responsibility – this proposal weakens the definition of professionalism an achieves nothing of value – this appears to be written to assuage or placate special interest groups rather than achieve anything of value.	**Not actioned** While the comments are acknowledged, the consensus of respondents supported this change.
Domain description covers personal values, attitudes and behaviours	Nil received	**No change required**
Introductory sentence A newly qualified dental practitioner must be able to:	Nil received	**No change required**
Competency statements		
1. Demonstrate that the interests of the person receiving care **are** paramount in all decisions and actions	Minor typographical error: Page 10 of draft: Item 1: '...care ARE paramount...'	**Accepted**

Proposed changes	Comments/responses	Actions
2. acknowledge colonisation, and systemic racism, social, cultural, behavioural, and economic factors which impact individual and community health	Nil received	**No change required**
3. acknowledge and address individual racism, your own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism	Nil received	**No change required**
4. recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community	Nil received	**No change required**
5. foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues	Nil received	**No change required**
6. provide culturally safe care to diverse groups and populations, recognising barriers to accessing care and responding to the distinct needs of those at greatest risk of poor oral health	Comment 1 (Organisation)- 1.6 could be expanded to identify "culturally safe and trauma informed care", aligning with earlier recognition of the impact of trauma on oral health outcomes and access to care Comment 2 this could be revised as “provide culturally safe care to diverse groups and populations, recognising barriers to	**Not actioned** This is addressed in the definition for Groups or populations at increased risk of harm or poor oral health.

Proposed changes	Comments/responses	Actions
	accessing care and responding to the distinct needs of at-risk populations".	
7. recognise professional and individual scopes of practice and work to one's own abilities and competency	Recognize problems that are beyond their scope of care and be prepared to refer these to those who can provide safe and appropriate care.	**No change required**
8. incorporate a self-reflexive approach to dental practice that recognises and supports life-long learning for all members of the dental team	Comment 1 that Reflective learning/practice should be included as this seems to be the way forward as part of registration. Comment 2 self-reflexive' may not be a term that has shared understanding. A definition may help to distinguish reflexive and reflective – both are important	**Accepted** A definition of self-reflexive is included under Terminology. The definition has been adapted from: Iedema. R. (2010) Creating safety by strengthening clinicians' capacity for reflexivity, BMJ Qual Saf, 20(Suppl 1):i83-i86.
9. practise in an ethical and professional manner consistent with the Dental Board of Australia's *Code of conduct*	Nil received	**No changes required**
10. comply with Commonwealth, State and Territory legislation and regulatory requirements relevant to the dental practitioner and the provision of dental care	Nil received	**No changes required**
11. ~~understand~~ **Recognise** the environmental impacts of health care provision and use resources	This is an appropriate and timely addition to the competencies. We would	**Accepted**

Proposed changes	Comments/responses	Actions
responsibly, making decisions that support environmentally sustainable healthcare	recommend a change of wording of this competency to match wording in the remaining document by replacement of 'understand' with 'recognise'.	Amendment is consistent with other text changes made with the Competencies.
12. **demonstrate familiarity with national standard for safety, quality and clinical care developed by the Australian Commission on Safety and Quality in Health Care that are relevant to the services and systems in which they will be working**	Comment 1 (Organisation) Replace with A newly qualified dental practitioner must be able to: 12. demonstrate familiarity with national standard for safety, quality and clinical care developed by the Australian Commission on Safety and Quality in Health Care that are relevant to the services and systems in which they will be working. Specific reference should be made to knowledge of relevant safety and quality standards developed by the Commission, including the National Safety and Quality Health Service Standards and National Safety and Quality Primary and Community Health Service Standards, which are person-centred and describe key aspects of health care related to quality and safety. While these documents specify the standards for health services, the capacity of health services to meet them depends on the knowledge, skills and behaviours of clinicians working within the services. This is not just confined to	**Accepted** A new competency statement has been added into the domain in recognition of practitioner requiring a broader understanding of safety and quality system and approaches.

Proposed changes	Comments/responses	Actions
	actions within the standards that address areas of high risk clinical care (preventing and controlling infections, medication safety, and comprehensive care, communicating for safety, and recognising & responding to deterioration). There are relevant sections in the overarching standards for Clinical Governance and Partnering with Consumers that also have direct application for dental practitioners. As well as understanding how clinical governance systems and patient partnering can support inter-disciplinary teams to improve safety and quality, graduates should understand the responsibilities of practitioners within clinical governance systems. The Clinical Governance Standard has a specific section on clinical performance and effectiveness (including for example, requirements for review of variation in clinical practice against external measures) and the Partnering with Consumers Standard includes actions that relate to the interaction between patients and clinicians when care is provided.	

Domain 2. Communication and leadership

Proposed changes	Comments/responses	Actions
Domain Name Communication and leadership	Nil received	**No change required**
Domain description covers the ability to work cooperatively and to communicate in a manner appropriate to the individual receiving care	Nil received	**No change required**
Introductory sentence A newly qualified dental practitioner must be able to:	Nil received	**No change required**
Competency statements		
1. engage respectfully with the person receiving care, their families, carers, and communities in relation to oral health	Comment 1 actively listen to patients and respond to concerns in a professional and empathetic manner Comment 2 (Organisation) suggested 'understand an apply Medical Treatment Planning and Decisions Act in dental treatment settings. This includes presumption of decision-making capacity unless there is evidence supporting limitations to decision making capacity. Comment 3 (Organisation) support the changes, although the language could be	**Not actioned** Comments were acknowledged, however, the statement needs to be broad enough to encompass the person and those who are involved in the care and decision making of the person. The Medical Treatment Planning and Decisions Act acknowledged but not accepted, as the act is Victorian based, and competencies must have applicability nationally. Several comments are also addressed in changes made to Domain 1 under competency statement 10.

Proposed changes	Comments/responses	Actions
	stronger in some instances to ensure that people are supported to have ownership of their care and decision making.	
	Comment 4 There could still be some refinement of the terms 'patient', 'person' and 'individual' as the terms are used interchangeably and only the terms 'patient' and 'person-centred care' are defined. For instance, is it to be assumed that 'person' is defined according to the definition of 'person centred care'? The way communication is presented in domain 2 is narrowly focused on interactions with patients. Other forms of communication and contexts for communication are important for dental practice.	
	Comment 5 (Organisation) As part of communication competencies, consideration for the newly qualified practitioner's ability to understand and account for the persons level of comprehension to ensure effective communication is necessary.	
	Comment 6 (Organisation) The categories that need to be considered when it comes to at risk groups are: a. Anyone whose	

Proposed changes	Comments/responses	Actions
	communication style means they are at risk of being seen as lacking the ability to make decisions – even if they actually can make decisions but need some third-party support to do this and to communicate the decisions. b. Anyone whose physical impairments means they are more likely to be subject to restrictive practices that could be replaced with less restrictive practices if a bit of additional interprofessional communication occurred (or communication with appropriate supporters). c. Anyone whose behaviour may elicit premature reactions or responses that result in the use of unnecessary restrictive practices. d. Anyone with a disability whose document plans regarding support needs, communication style, and treatment preferences may be well documented but not readily accessible to oral health practitioners, causing the professional to make discretionary decisions during treatment.	
2. present information in a manner that enable the person to understand the care and treatment options to be available, the risks and benefits, and to be involved in decision making about their care	Nil received	**No change required**

Proposed changes	Comments/responses	Actions
3. engage in interprofessional collaborative practice to provide person-centred care	Nil received	**No change required**
4. recognise, assess, and respond to domestic and family violence risk, prioritise safety, provide information, and refer as required	Comment 1 Consider adding the need for 'sensitive inquiry'. Comment 2 It is good to see the inclusion of domestic/family violence in the competencies. The statement about recognising, assessing, and responding to domestic and family violence risk could be broadened to also refer to situations where vulnerable people may be at risk of harm, but not confined to the 'family'.	**Not actioned** The definition of domestic and family violence covers the situation where the risk of harm is not confined to family.
5. engage in mentor/mentee activities and leadership within a healthcare team	2.5 could be amended to include leadership with respect to cultural safety	**No change required** Addressed within statements elsewhere within the Competencies.
6. maintain one's own health and wellbeing and ~~help~~ **support the health and wellbeing of** colleagues and team members	We would recommend rewording the new Competency 2.6. It may be challenging for students and graduates to 'help colleagues and team members to maintain good health'. Consider rewording to: 'maintain one's own health and wellbeing and support the health and wellbeing of colleagues and team members.	**Accepted** Changes have been made to the statement, with a focus on supporting others

Proposed changes	Comments/responses	Actions
7. utilise digital technologies and informatics to manage health information and inform person-centred care	Nil received	**No change required**
8. apply the principles of open disclosure in incident management, review adverse events, and implement changes to reduce the risk of reoccurrence	Nil received	**No change required**
9. identify opportunities for improvement in care delivery and advocate for improved oral health outcomes, including for ~~at-risk~~ groups or populations **at increased risk of harm or poor oral health**	Refer comments related to 'At-risk'	**Accepted with amendment** Changes made to the statement to reflect changes to the definition.

5.7 A comment was received regarding the addition of a competency around the need to 'understand and apply relevant legislation in dental treatment settings' including 'the presumption of decision-making capacity unless there is evidence supporting limitations to decision-making capacity'. This is addressed in competency statements regarding scope of practice and legislation in Domain 1.

Domain 3. Critical thinking

Proposed changes	Comments/responses	Actions
Domain Name Critical thinking	Nil received	**No change required**
Domain description covers the acquisition and application of knowledge	Nil received	**No change required**
Introductory sentence A newly qualified dental practitioner must be able to:	Nil received	**No change required**
Competency statements		
1. Locate, ~~and~~ **critically appraise** and evaluate evidence in a ~~critical manner~~ scientific manner to support and deliver oral health care	Comment 1 Critical thinking neither has sufficient emphasis critical appraisal skills nor include evaluative judgment. Two things critical for all graduates to support practitioners in inter-professional practice and life-long learning. Critical appraisal is the process of carefully and systematically examining research evidence to judge its trustworthiness, its value and relevance in a particular context. Evaluative judgement is the capability to make decisions about the quality of work of self and others. Tai, J., Ajjawi, R., Boud, D. et al. Developing evaluative judgement: enabling students	**Accepted with amendment** Changes have been made to increase the emphasis on critical appraisal. The introduction of the definition of self-reflexive also focuses on judgment about self and planning for improvement.

Proposed changes	Comments/responses	Actions
	to make decisions about the quality of work. High Educ 76, 467–481 (2018). https://doi.org/10.1007/s10734-017-0220-3	
	Comment 2 (organisation) 3.1 could encourage evaluation of knowledge in a critical and culturally safe way, to increase recognition of and value for Indigenous knowledges	
2. apply clinical reasoning and judgement in a reflective practice approach to oral health care	Nil received	**No change required**
3. demonstrate an understanding of research processes and the role of research in advancing knowledge and clinical practice	Nil received	**No change required**

Competencies of the newly qualified dentist - Domain 4. Health promotion

Proposed changes	Comments/responses	Actions
Domain Name Health promotion	Nil received	**No change required**
Domain description covers health education and the promotion of health in the community	Nil received	**No change required**
Introductory sentence A newly qualified dental practitioner must be able to:	Nil received	**No change required**
Competency statements		
1. understand the **social** determinants of health, risk factors and behaviours that influence health	Comment 1 revision to competency 1 in Domain 4 is suggested, "understand the **social** determinants of health, risk factors and behaviours that influence health". Comment 2 An understanding of the social determinants of health may assist practitioners to recognise and respond to the needs of priority populations including those who experience barriers to accessing health care.	**Accepted** Change is consistent with focus on person-centred care

Proposed changes	Comments/responses	Actions
2. understand the connection between health promotion and health policy development	(Organisation) perspective, the competencies appear to be largely complete, noting comments elsewhere and below. Under domain 4, health promotion, and domain 6, person centred care, there is no obvious reference / capability about supporting the person to manage their long-term oral health. Whether this requires a standalone competency or amendment to an existing, it would be good for the workforce to recognise their role in support agency and self-determination for people to lead in their care and wellbeing.	**Not actioned** Acknowledged, however, addressed by the definition of person-centred care.
3. apply the theories and principles of health promotion to improve oral and general health	Nil received	**No change required**
4. design, implement and evaluate evidence-based health promotion strategies and programs	Nil received	**No change required**

Competencies of the newly qualified dentist - Domain 5. Scientific and clinical knowledge

Proposed changes	Comments/responses	Actions
Domain Name Scientific and clinical knowledge	Nil received	**No change required**
Domain description covers the application of knowledge base required by dental practitioners	Nil received	**No change required**
Introductory sentence A newly qualified dental practitioner must be able to:	Nil received	**No change required**
Competency statements		
1. apply the social, cultural, **biological**, biomedical, physical, and behavioural sciences in relation to oral health care provision and disease prevention	Comment 1 The use of the term 'biomedicine' knowledge for dentists and 'biological' for other oral health practitioners can downplay the necessary knowledge that practitioners need to care for the types of patients listed in 'at-risk' groups – eg. Aged, people with disabilities. Comment 2 specific knowledge about nutrition is central for practitioners conducting a diet-focused interview and providing targeted self-care strategies for patients.	**Accepted with amendments** Nutrition has not been included in this statement, as is already addressed under risk factors and behaviours in Domain 4. Health Promotion.

Proposed changes	Comments/responses	Actions
	We suggest specifying this in the scientific and clinical knowledge.	
2. apply the theories and principles of population oral health	Nil received	**No change required**
3. apply the scientific principles of infection prevention and control	Nil	**No change required**
4. understand the scientific basis, risks and demonstrate the **safe** use of ionising radiation	competency 4 could be further strengthened, for example, "understand the scientific basis, application, and risks and demonstrate the **safe** use of ionising radiation".	**Accepted**
5. understand the scientific basis, limitations, risks, of dental materials and demonstrate their use	Nil received	**No changes required**
6. apply the principles of pharmacology, understanding the limitations and risks of use of therapeutic agents, including polypharmacy and overuse, and the implication of the Prescribing Competencies Framework on dental practice	Nil received	**No changes required**
7. apply the principles of risk management and quality improvement	Nil received	**No changes required**
~~8. recognise and comply with local clinical governance and health and safety processes and policies~~	(Organisation) Replace with *A newly qualified dental practitioner must be able to:* *12*. demonstrate familiarity with national standard for safety, quality and clinical care developed by the Australian	**Accepted** New statement added to Domain 1. Refer new statement in Domain 1 for rationale.

Proposed changes	Comments/responses	Actions
	Commission on Safety and Quality in Health Care that are relevant to the services and systems in which they will be working. Specific reference should be made to knowledge of relevant safety and quality standards developed by the Commission, including the National Safety and Quality Health Service Standards and National Safety and Quality Primary and Community Health Service Standards, which are person-centred and describe key aspects of health care related to quality and safety.	

5.8 One respondent suggested that the evaluation of knowledge in Domains 5 and 6 'should also include value for Aboriginal and Torres Strait Islander ways of knowing, being and doing, and that as a profession there are opportunities to increase teaching and understanding of indigenous knowledge'. This comment is already addressed in the additional competencies included within Domain 1.

5.9 There was support for putting knowledge into practice and a suggestion that the approach to education should be based on 'knowing, being and doing; what we know, our attitudes and our behaviours.' It was further suggested that Domain 5 and 6 should include the evaluation of knowledge to include value for Aboriginal and Torres Strait Islander ways of knowing, being and doing and that 'there are opportunities to increase teaching and understanding of indigenous knowledges'. Terminology introduced regarding Cultural safety, person-centred care and additional competencies added into Domain 1 address these suggestions.

5.10 A further general comment was made that the demonstration of knowledge in a document that deals with competencies should ensure that graduate competencies are based on analysis and critical thinking, not a regurgitation of facts. This was not actioned as this was a more general statement across the Domains rather than on a specific term or competency and is already highlighted in the introductory text, including the definition of competency and competent.

Competencies of the newly qualified dentist - Domain 6. Person-centred care

Proposed changes	Comments/responses	Actions
Domain Name **Person-centred care**	Nil received	**No change required**

6.1 Clinical information gathering

Proposed changes	Comments/responses	Actions
Sub-Domain Name Clinical information gathering	Under dentist 6.1 really should be clinical information gathering and interpretation.	**Not actioned** Interpretation is addressed in sub-Domain 6.2.
Domain description covers the collection and recording of information that is necessary and relevant	Nil received	**No change required**
Introductory sentence A newly qualified dental practitioner must be able to:	Nil received	**No change required**
Competency statements		
1. obtain and record a relevant history of the individual's medical, social, **dietary,** and oral health status	Comment 1 add diet history to: obtain and record a relevant history of the patient's individual medical, social and oral health status. Comment 2	**Accepted** The introduction of dietary history has been included and is relevant to all divisions of registration.

Proposed changes	Comments/responses	Actions
	The effect of naming nutrition knowledge as essential signifies that diet-focused consultations are integral to the dental/oral health consultation.	
2. perform an examination for health, disease and abnormalities of the dentition, mouth and associated structures	Nil received	**No change required**
3. select necessary clinical, pathology and other diagnostic procedures and interpret results	Nil received	**No change required**
4. **Request and/or** take radiographs relevant to dental practice	Comment 1 For radiography it should be take or request. Comment 2 (organisation) competency 4 should include take and interpret radiographs relevant to dental practice.	**Accepted** Practitioner may not be taking the radiograph, rather they may be required to request other radiological imaging.
5. evaluate individual patient risk factors for oral disease	Nil received	**No change required**
6. maintain accurate, consistent, legible and contemporaneous records of patient management and protect patient privacy	Nil received	**No change required**

6.2 Diagnosis and management planning

Proposed changes	Comments/responses	Actions
Sub-Domain Name Diagnosis and management planning	Nil received.	**No change required**
Domain description covers the identification of disease or abnormalities that require treatment or investigation	Nil received	**No change required**
Introductory sentence A newly qualified dental practitioner must be able to:	Nil received	**No change required**
Competency statements		
1. recognise health as it relates to the individual, taking into consideration medical, social and cultural contexts	We believe there is a need for better communication and planning with oral health professionals. We therefore suggest the addition of this competency: Understand and develop dental treatment plans for people with special needs.	**Acknowledged but not actioned** Terminology including within the definition of person-centred care and groups or populations at increased risk of harm or poor oral health to address these requirements.
2. Diagnose disease or abnormalities of the dentition, mouth and associated structures and identify conditions which require management	Nil received	**No change required**
3. determine the impact of risk factors, systemic disease and medications on oral health and treatment planning	Nil received	**No change required**

Proposed changes	Comments/responses	Actions
4. formulate and record a comprehensive, person-centred, evidence-based oral health treatment plan	Nil received	**No change required**
5. determine when and how to refer to the appropriate health and or care professional	Nil received	**No change required**
6. obtain and record-informed consent and financial consent for treatment	Nil received	**No change required**

6.3 Clinical treatment and evaluation

Proposed changes	Comments/responses	Actions
Sub-Domain Name Clinical treatment and evaluation	Nil received.	**No change required**
Domain description covers the provision of evidence-based person-centered care	Nil received	**No change required**
Introductory sentence A newly qualified dental practitioner must be able to:	Nil received	**No change required**
Competency statements		

Proposed changes	Comments/responses	Actions
1. apply the principles of disease and trauma prevention and early intervention in the management of the dentition, mouth and associated structures	In 6.3, relating to dentist, dental therapist and oral health therapist, a requirement concerning the application of minimum intervention principles may be worth inclusion, e.g.: 'manage the individual's oral status using the principles of evidence-based minimum intervention'.	**Accepted with amendment** New competency statement included within the domain related to dental caries management (see statement 4). No changes made to introduce minimum intervention principles, as this is already consistent with an environmentally sustainable approach to healthcare that is person-centre.
2. ~~apply~~ **ensure** the principles of **supported decision making** and positive behaviour support **are incorporated into the** ~~to provide~~ **provision of** person-centred care	Comment 1 The Draft Competencies have 6.3.2: "apply the principles of positive behaviour support to provide person-centred care" replacing "Apply the principles of behaviour management". We cautiously recommend change to the draft competency to read: Understand and apply positive behaviour practice framework that supports effective and ethical dental service consistent with person-centred care. Comment 2 (group) - We cautiously recommend change to the draft competency to read: Understand and apply positive behaviour practice framework that supports effective and ethical dental service consistent with person-centred care. The basis for caution and inclusion of words effective and ethical is drawn from a University of Melbourne PhD Completion Seminar titled Positive behaviour support (PBS) in Australian disability services: Social network perspectives on policy and people was held	**Accepted with amendments** Not all comments or suggestions are consistent with a national scheme, (e.g. reference to state or territory legislation) and so have not been included. The shift to ensuring the principles are incorporated recognises that it may not be the dental practitioner that provides these supports, but that they recognize when they are needed and how to seek further advice and guidance to implement such approaches.

Proposed changes	Comments/responses	Actions
	on 4 November 2021. The presenter was Brent Hayward and Chair was A/Professor Helen Stokes. Hayward cautioned that PBS was not being implemented as it should be. There were unfortunate practices in Australia of it being presented as a "menu of options" and as being very closely aligned with restrictive practices. The definition of PBS in the context of Australian disability services was stated to be 'confusing' and poorly articulated in NDIS. In a brief discussion of implementing PBS in dental services In Australia, Hayward's recommendation was that Behaviour Intervention was probably a more practical avenue than PBS because current Australian systems are not set up for it. Hayward noted risks in NDIS choosing PBS to provide behaviour support even though PBS has been widely operationalized in policies across Australia. Fundamentally, the problem with PBS	
	Comment 3 (Organisation) Understand and apply positive behaviour practice framework that supports effective and ethical dental service consistent with person-centred care (Domain 6). Understand and develop dental treatment plans for people with special needs (Domain 6). Yes, the (organisation) suggests that some rewording is necessary for some of the new items added to the competencies specifically with respect to supported decision making (SDM), positive behaviour support (PBS), and person-centred planning (PCP). 1. Identifying the required third parties to support with supported decision making, minimising restrictive	

Proposed changes	Comments/responses	Actions
	practices, and understanding how to achieve least restrictive practice, understanding how to develop person centred plans in a way that is in line with best practice in a given sector/population context, etc. are perhaps more useful targeted techniques that could be highlighted. The broad names of the models of SDM and PBS should be included, but a little more specificity is needed. 2. Understanding how to identify adequate resources or third parties to ensure principles of supported decision making, positive behaviour support, and communication. Oral health practitioners should not be expected to understand best practice disability planning, SDM or PBS. However, they should know a few core techniques and how to efficiently locate the supports, resources and expertise that is needed for each of these things. 3. The need for oral health practitioners to actively seek to avoid 'substitute decision making' and to instead seek appropriate resources or advice to ensure supported decision making. Similar language could be used to favour least restrictive practices over and above more restrictive practices (such as anaesthetics/types of anaesthetic). In other words, oral health professionals should not just understand supported decision making or PBS, but they should actively resist substitute decision making and undertaking (or referral for) more restrictive practices. That is the mark of the competencies in question. 4. In essence, some of the statements related to creating plans, using positive behaviour support, and supported decision making are missing half of the necessary content. The statements need to actively	

Proposed changes	Comments/responses	Actions
	outline the practices or strategies that are currently far too prevalent and need to be actively avoided.	
3. manage the individual's anxiety and pain related to the dentition, mouth and associated structures	6.3.3 'manage anxiety and pain' for is included for dentists only - it is not clear why this is.	**Not actioned** Statements related to pain are already included within other divisions and in approaches to care that are person-centred. The statement recognizes that the dentist may have other options for addressing anxiety that are within their knowledge, skills and training (e.g. prescribing) that are not available to other divisions of registration.
4. **manage dental caries**	One important competency is missing for dentists, dental therapists, dental hygienists and oral health therapists which is: 'manage the disease of dental caries including early carious lesions using a non-operative approach and prevention of further disease'. Considering that dental caries is one of the most common chronic diseases globally and in Australia, and given what is known about the reversibility of early carious lesions and the negative long term consequences of direct and indirect restorative procedures, there is need to include a competency in the medical (non-restorative) management of such lesions. Management of other conditions are mentioned separately, for example, periodontal, pulp, and tooth loss. It is concerning that caries is not addressed similarly in these competencies.	**Addition of new competency statement** The additional statement recognises the burden of disease associated with dental caries and the importance of appropriate management.

Proposed changes	Comments/responses	Actions
5. manage diseases and conditions of the periodontium and supporting tissues of the teeth and their replacements	Nil received	**Number change after the addition of statement 4**
6. manage diseases and conditions of ~~the~~ **pulpal**, ~~root canal and~~ and ~~peri-radicular~~ **periapical** tissues	Comment 1 Suggest add root to cover the many resorptive lesions	**Accepted with amendment** Wording of the statement revised based on feedback provided. **Number change after the addition of statement 4**
	Comment 2 the way the competency applicable to endodontics is worded is not good: "…manage diseases and conditions of the pulp, root canal and peri-radicular tissues" This is not an existing entity, there are no conditions of the root canal. The term periradicular, while not wrong, is not used any more. The original description is actually better and in keeping with what other organisation say. I strongly suggest to change, perhaps a view of the ASA description published recently in the Aus Endod J can help here.	
7. manage the loss of tooth structure by restoring the dentition with direct and indirect restorations	minimally invasive techniques should be included Page 6 Terminology: at risk groups or population please include pregnant women on list	**Not actioned** **Number change after the addition of statement 4**
8. utilise removable prostheses to rehabilitate, restore appearance and function, prevent injury and stabilise occlusion	Nil received	**Number change after the addition of statement 4**
9. utilise fixed prostheses to rehabilitate, restore appearance and function and stabilise the occlusion	Nil received	**Number change after the addition of statement 4**

Proposed changes	Comments/responses	Actions
10. manage ~~oral conditions~~**diseases**, pathology and ~~medically related disorders and diseases~~**conditions** associated with the dentition, ~~mouth~~**orofacial complex,** and associated structures	Comment 1 Add understand, diagnose and manage odontogenic and non-odontogenic orofacial pain. Comment 2 Under 6.3 Add manage acute dentoalveolar injuries and their long term sequelae.	**Number change after the addition of statement 4** Statement reworded to ensure consistency of approach with other statements in the domain. Specific mention of odontogenic and non-odontogenic has not been made, as this is incorporated within the terminology and the use of the word 'conditions' addressed injuries as well as conditions that require long term management.
11. manage skeletal and dental occlusal discrepancies	Nil received	**Number change after the addition of statement 4**
12. manage the removal of teeth and oral surgical procedures	Nil received	**Number change after the addition of statement 4**
13. administer, apply and prescribe medicines	Nil received	**Number change after the addition of statement 4**
14. evaluate and monitor the progress of treatment and oral health outcomes	Nil received	**Number change after the addition of statement 4**
15. manage dental emergencies	Nil received	**Number change after the addition of statement 4**
16. manage medical emergencies	Nil received	**Number change after the addition of statement 4**

Competencies of the newly qualified dental hygienist - Domain 4. Health promotion

Proposed changes	Comments/responses	Actions
Domain Name Health promotion	Nil received	**No change required**
Domain description covers health education and the promotion of health in the community	Nil received	**No change required**
Introductory sentence A newly qualified dental hygienist must be able to:	Nil received	**No change required**
Competency statements		
1. understand the **social** determinants of health, risk factors and behaviours that influence health	For comments received refer to Competencies of the newly qualified dentist - Domain 4. Health promotion	**Accepted** Change is consistent with focus on person-centred care
2. understand the connection between health promotion and health policy development	For comments received refer to Competencies of the newly qualified dentist - Domain 4. Health promotion	**Not actioned** Acknowledged, however, addressed by the definition to person-centred care.
3. apply the theories and principles of health promotion to improve oral and general health	Nil received	**No change required**
4. design, implement and evaluate evidence-based health promotion strategies and programs	Nil received	**No change required**

Competencies of the newly qualified dental hygienist- Domain 5. Scientific and clinical knowledge

Proposed changes	Comments/responses	Actions
Domain Name Scientific and clinical knowledge	Nil received	**No change required**
Domain description covers the application of knowledge base required by dental practitioners	Nil received	**No change required**
Introductory sentence A newly qualified dental hygienist must be able to:	Nil received	**No change required**
Competency statements		
1. apply the social, cultural, **biological**, biomedical, physical, and behavioural sciences in relation to oral health care provision and disease prevention	For comments received refer to Competencies of the newly qualified dentist - Domain 5. Scientific and clinical knowledge	**Accepted with amendments** Nutrition has not been included in this statement, as is already addressed under risk factors and behaviours in Domain 4. Health Promotion.
2. apply the theories and principles of population oral health	Nil received	**No change required**
3. apply the scientific principles of infection prevention and control	Nil received	**No change required**
4. understand the scientific basis, risks and demonstrate the **safe** use of ionising radiation	For comments received refer to Competencies of the newly qualified dentist - Domain 5. Scientific and clinical knowledge	**Accepted** Practitioner may not be taking the radiograph, rather they may be required to request other radiological imaging.

Proposed changes	Comments/responses	Actions
5. understand the scientific basis, limitations, risks, of dental materials and demonstrate their use	Nil received	**No changes required**
6. apply the principles of pharmacology, understanding the risks of using therapeutic agents, including polypharmacy and overuse	Nil received	**No changes required**
7. apply the principles of risk management and quality improvement	Nil received	**No changes required**
8. ~~recognise and comply with local clinical governance and health and safety processes and policies~~	For comments received refer to Competencies of the newly qualified dentist - Domain 5. Scientific and clinical knowledge	**Accepted** New statement added to Domain 1. Refer new statement in Domain 1 for rationale.

Competencies of the newly qualified dental hygienist - Domain 6. Person-centred care

Proposed changes	Comments/responses	Actions
Domain Name **Person-centred care**	Nil received	**No change required**

Competencies of the newly qualified dental hygienist- 6.1 Clinical information gathering

Proposed changes	Comments/responses	Actions
Sub-Domain Name Clinical information gathering	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering	**Not actioned** Interpretation is addressed in sub-Domain 6.2.
Domain description covers the collection and recording of information that is necessary and relevant	Nil received	**No change required**
Introductory sentence A newly qualified dental hygienist must be able to:	Nil received	**No change required**
Competency statements		

Proposed changes	Comments/responses	Actions
1. obtain and record a relevant history of the individual's medical, social, **dietary,** and oral health status	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering.	**Accepted** The introduction of dietary history has been included and is relevant to all divisions of registration.
2. perform an examination for health, disease and abnormalities of the dentition, mouth and associated structures	Nil received	**No change required**
3. select necessary clinical, pathology and other diagnostic procedures and interpret results	Nil received	**No change required**
4. **Request and/or** take radiographs relevant to dental practice	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering	**Accepted** Practitioner may not be taking the radiograph, rather they may be required to request other radiological imaging.
5. evaluate individual patient risk factors for oral disease	Nil received	**No change required**
6. maintain accurate, consistent, legible and contemporaneous records of patient management and protect patient privacy	Nil received	**No change required**

Competencies of the newly qualified dental hygienist - 6.2 Diagnosis and management planning

Proposed changes	Comments/responses	Actions
Sub-Domain Name Diagnosis and management planning	Nil received.	**No change required**

Proposed changes	Comments/responses	Actions
Domain description covers the identification of disease or abnormalities that require treatment or investigation	Nil received	**No change required**
Introductory sentence A newly qualified dental hygienist must be able to:	Nil received	**No change required**
Competency statements		
1. recognise health as it relates to the individual, taking into consideration medical, social and cultural contexts	For comments received refer to Competencies of the newly qualified dentist - Domain 6.2 Diagnosis and management planning	**Acknowledged but not actioned** Terminology including within the definition of person-centred care and groups or populations at increased risk of harm or poor oral health to address these requirements.
2. diagnose disease or abnormalities of the dentition, mouth and associated structures and identify conditions which require management	Nil received	**No change required**
3. determine the impact of risk factors, systemic disease and medications on oral health and treatment planning	Nil received	**No change required**
4. formulate and record a comprehensive person-centred, evidence-based oral health treatment plan	Nil received	**No change required**
5. determine when and how to refer-to the appropriate health and or care professional	Nil received	**No change required**
6. obtain and record informed consent and financial consent for treatment	Nil received	**No change required**

Competencies of the newly qualified dental hygienist 6.3 Clinical treatment and evaluation

Proposed changes	Comments/responses	Actions
Sub-Domain Name Clinical treatment and evaluation	Nil received.	**No change required**
Domain description covers the provision of evidence-based person-centered care	Nil received	**No change required**
Introductory sentence A newly qualified dental hygienist must be able to:	Nil received	**No change required**
Competency statements		
1. apply the principles of disease and trauma prevention **and early intervention i**n the management of the dentition, mouth and associated structures	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Accepted with amendment** New competency statement included within the domain related to dental caries management (see statement 4). No changes made to introduce minimum intervention principles, as this is already consistent with an environmentally sustainable approach to healthcare that is person-centred
2. ~~apply~~ **ensure** the principles of **supported decision making** and positive behaviour support **are incorporated into the** ~~to provide~~ **provision of** person-centred care	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Accepted with amendments** Not all comments or suggestions are consistent with a national scheme, (e.g.

Proposed changes	Comments/responses	Actions
		reference to state or territory legislation) and so have not been included. The shift to ensuring the principles are incorporated recognises that it may not be the dental practitioner that provides these supports, but that they recognize when they are needed and how to seek further advice and guidance to implement such approaches.
3. manage non-surgical treatment of diseases and conditions of the periodontium and supporting tissues of the teeth or their replacements	Implants need to be included in this day and age (also should be added for hygienist and oral health therapists).	**Not actioned** Already addressed within broader statements.
4. **manage dental caries**	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Addition of new competency statement** The additional statement recognises the burden of disease associated with dental caries and the importance of appropriate management.
5. manage oral conditions and diseases, pain and pathology of the dentition, mouth and associated structures	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Not actioned** **Number change after the addition of statement 4**
6. perform orthodontic procedures as directed by the treating dentist or othodontist	Nil received	**Number change after the addition of statement 4**
7. administer pharmaceutical agents	Nil received	**Number change after the addition of statement 4**

Proposed changes	Comments/responses	Actions
8. evaluate and monitor the progress of treatment and oral health outcomes	Nil received	**Number change after the addition of statement 4**
9. manage dental emergencies	Nil received	**Number change after the addition of statement 4**
10. manage medical emergencies	Nil received	**Number change after the addition of statement 4**

Competencies of the newly qualified dental prosthetist- Domain 4. Health promotion

Proposed changes	Comments/responses	Actions
Domain Name Health promotion	Nil received	**No change required**
Domain description covers health education and the promotion of health in the community	Nil received	**No change required**
Introductory sentence A newly qualified dental prosthetist must be able to:	Nil received	**No change required**
Competency statements		
1. understand the **social** determinants of health, risk factors and behaviours that influence health	For comments received refer to Competencies of the newly qualified dentist - Domain 4. Health promotion	**Accepted** Change is consistent with focus on person-centred care
2. understand the connection between health promotion and health policy development	For comments received refer to Competencies of the newly qualified dentist - Domain 4. Health promotion	**Not actioned** Acknowledged, however, addressed by the definition to person-centred care.
3. apply the theories and principles of health promotion to improve oral and general health	Nil received	**No change required**
4. understand the design, implementation and evaluation of evidence-based health promotion	Nil received	**No change required**

Competencies of the newly qualified dental prosthetist - Domain 5. Scientific and clinical knowledge

Proposed changes	Comments/responses	Actions
Domain Name Scientific and clinical knowledge	Nil received	**No change required**
Domain description covers the application of knowledge base required by dental practitioners	Nil received	**No change required**
Introductory sentence A newly qualified dental prosthetist must be able to:	Nil received	**No change required**
Competency statements		
1. ~~understand~~ **apply** the social, cultural, **biological**, biomedical, physical, and behavioural sciences in relation to oral health care provision and disease prevention	For comments received refer to Competencies of the newly qualified dentist - Domain 5. Scientific and clinical knowledge	**Accepted with amendments** Nutrition has not been included in this statement, as is already addressed under risk factors and behaviours addressed in Domain 4. Health Promotion.
2. apply the theories and principles of population oral health	Nil received	**No change required**
3. apply the scientific principles of infection prevention and control	Nil received	**No change required**
4. understand the scientific basis, limitations and risks of dental materials and demonstrate their use	Nil received	**No changes required**
5. apply the principles of pharmacology, understanding the risks of using therapeutic agents	Nil received	**No changes required**

Proposed changes	Comments/responses	Actions
6. apply the principles of risk management and quality improvement	Nil received	**No changes required**
7. ~~recognise and comply with local clinical governance and health and safety processes and policies~~	For comments received refer to Competencies of the newly qualified dentist - Domain 5. Scientific and clinical knowledge	**Accepted** New statement added to Domain 1. Refer new statement in Domain 1 for rationale.

Competencies of the newly qualified dental prosthetist - Domain 6. Person-centred care

Proposed changes	Comments/responses	Actions
Domain Name **Person-centred care**	Nil received	**No change required**

Competencies of the newly qualified dental prosthetist - 6.1 Clinical information gathering

Proposed changes	Comments/responses	Actions
Sub-Domain Name Clinical information gathering	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering	**Not actioned** Interpretation is addressed in sub-Domain 6.2.
Domain description covers the collection and recording of information that is necessary and relevant	Nil received	**No change required**
Introductory sentence A newly qualified dental prosthetist must be able to:	Nil received	**No change required**
Competency statements		
1. obtain and record a relevant history of the individual's medical, social, **dietary,** and oral health status	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering	**Accepted** The introduction of dietary history has been included and is relevant to all divisions of registration.

Proposed changes	Comments/responses	Actions
2. perform an examination for health, disease and abnormalities of the dentition, mouth and associated structures	Nil received	**No change required**
3. select necessary clinical, pathology and other diagnostic procedures and interpret results	Nil received	**No change required**
4. evaluate individual patient risk factors for oral disease	Nil received	**No change required**
5. maintain accurate, consistent, legible and contemporaneous records of patient management and protect patient privacy	Nil received	**No change required**

Competencies of the newly qualified dental prosthetist 6.2 Diagnosis and management planning

Proposed changes	Comments/responses	Actions
Sub-Domain Name Diagnosis and management planning	Nil received.	**No change required**
Domain description covers the identification of disease or abnormalities that require treatment or investigation	Nil received	**No change required**
Introductory sentence A newly qualified dental prosthetist must be able to:	Nil received	**No change required**

Proposed changes	Comments/responses	Actions
Competency statements		
1. recognise health as it relates to the individual, taking into consideration medical, social and cultural contexts	For comments received refer to Competencies of the newly qualified dentist - Domain 6.2 Diagnosis and management planning	**Acknowledged but not actioned** Terminology including within the definition of person-centred care and Groups or populations at increased risk of harm or poor oral health to address these requirements.
2. diagnose disease or abnormalities of the dentition, mouth and associated structures and identify conditions which require management	Nil received	**No change required**
3. determine the impact of risk factors, systemic disease and medications on oral health and treatment planning	Nil received	**No change required**
4. formulate and record a comprehensive, person-centred, evidence-based oral health treatment plan	Nil received	**No change required**
5. determine when and how to refer to the appropriate health and or care professional	Nil received	**No change required**
6. obtain and record informed consent and financial consent for treatment	Nil received	**No change required**

Competencies of the newly qualified dental prosthetist 6.3 Clinical treatment and evaluation

Proposed changes	Comments/responses	Actions
Sub-Domain Name Clinical treatment and evaluation	Nil received.	**No change required**
Domain description covers the provision of evidence-based person-centred care	Nil received	**No change required**
Introductory sentence A newly qualified dental prosthetist must be able to:	Nil received	**No change required**
Competency statements		
1. apply the principles of disease and trauma prevention **and early intervention i**n the management of the dentition, mouth and associated structures	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Accepted with amendment** New competency statement included within the domain related to dental caries management. No changes made to introduce minimum intervention principles, as this is already consistent with an environmentally sustainable approach to healthcare that is person-centred
2. ~~apply~~ **ensure** the principles of **supported decision making** and positive behaviour support **are incorporated into the** ~~to provide~~ **provision of** person-centred care	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Accepted with amendments** Not all comments or suggestions are consistent with a national scheme, (e.g.

Proposed changes	Comments/responses	Actions
		reference to state or territory legislation) and so have not been included. The shift to ensuring the principles are incorporated recognises that it may not be the dental practitioner that provides these supports, but that they recognize when they are needed and how to seek further advice and guidance to implement such approaches.
3. apply pharmaceutical agents	Nil received	**No changes required**
4. manage oral conditions and diseases, pain and pathology of the dentition, mouth and associated structures	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Not actioned**
5. utilise patient removable prostheses to rehabilitate, restore appearance and function, prevent injury and stabilise the occlusion	Nil received	**No change required**
6. evaluate and monitor the progress of treatment and oral health outcomes	Nil received	**No change required**
7. manage medical emergencies	Nil received	**No change required**
8. manage dental emergencies	Nil received	**No change required**
9. manage medical emergencies	Nil received	**No change required**

Competencies of the newly qualified dental therapist - Domain 4. Health promotion

Proposed changes	Comments/responses	Actions
Domain Name Health promotion	Nil received	**No change required**
Domain description covers health education and the promotion of health in the community	Nil received	**No change required**
Introductory sentence A newly qualified dental therapist must be able to:	Nil received	**No change required**
Competency statements		
1. understand the **social** determinants of health, risk factors and behaviours that influence health	For comments received refer to Competencies of the newly qualified dentist - Domain 4. Health promotion	**Accepted** Change is consistent with focus on person-centred care
2. understand the connection between health promotion and health policy development	For comments received refer to Competencies of the newly qualified dentist - Domain 4. Health promotion	**Not actioned** Acknowledged, however, addressed by the definition to person-centred care.
3. apply the theories and principles of health promotion to improve oral and general health	Nil received	**No change required**
4. design, implement and evaluate evidence-based health promotion strategies and programs	Nil received	**No change required**

Competencies of the newly qualified dental therapist - Domain 5. Scientific and clinical knowledge

Proposed changes	Comments/responses	Actions
Domain Name Scientific and clinical knowledge	Nil received	**No change required**
Domain description covers the application of knowledge base required by dental practitioners	Nil received	**No change required**
Introductory sentence A newly qualified dental therapist must be able to:	Nil received	**No change required**
Competency statements		
1. apply the social, cultural, **biological**, biomedical, physical, and behavioural sciences in relation to oral health care provision and disease prevention	For comments received refer to Competencies of the newly qualified dentist - Domain 5. Scientific and clinical knowledge	**Accepted with amendments** Nutrition has not been included in this statement, as is already addressed under risk factors and behaviours addressed in Domain 4. Health Promotion.
2. apply the theories and principles of population oral health	Nil received	**No change required**
3. apply the scientific principles of infection prevention and control	Nil received	**No change required**
4. understand the scientific basis, risks and demonstrate the **safe** use of ionising radiation		**Accepted with amendments**
5. understand the scientific basis, limitations, risks, of dental materials and demonstrate their use	Nil received	**No changes required**

Proposed changes	Comments/responses	Actions
6. apply the principles of pharmacology, understanding the risks of using therapeutic agents, including polypharmacy and overuse	Nil received	**No changes required**
7. apply the principles of risk management and quality improvement	Nil received	**No changes required**
8. ~~recognise and comply with local clinical governance and health and safety processes and policies~~	For comments received refer to Competencies of the newly qualified dentist - Domain 5. Scientific and clinical knowledge	**Accepted** New statement added to Domain 1. Refer new statement in Domain 1 for rationale.

Competencies of the newly qualified dental therapist - Domain 6. Person-centred care

Proposed changes	Comments/responses	Actions
Domain Name Person-centred care	Nil received	**No change required**

Competencies of the newly qualified dental therapist- 6.1 Clinical information gathering

Proposed changes	Comments/responses	Actions
Sub-Domain Name Clinical information gathering	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering	**Not actioned** Interpretation is addressed in sub-Domain 6.2.
Domain description covers the collection and recording of information that is necessary and relevant	Nil received	**No change required**
Introductory sentence A newly qualified dental therapist must be able to:	Nil received	**No change required**
Competency statements		
1. obtain and record a relevant history of the individual's medical, social, **dietary,** and oral health status	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering.	**Accepted** The introduction of dietary history has been included and is relevant to all divisions of registration.

Proposed changes	Comments/responses	Actions
2. perform an examination for health, disease and abnormalities of the dentition, mouth and associated structures	Nil received	**No change required**
3. select necessary clinical, pathology and other diagnostic procedures and interpret results	Nil received	**No change required**
4. **Request and/or** take radiographs relevant to dental practice	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering	**Accepted** Practitioner may not be taking the radiograph, rather they may be required to request other radiological imaging.
5. evaluate individual patient risk factors for oral disease	Nil received	**No change required**
6. maintain accurate, consistent, legible and contemporaneous records of patient management and protect patient privacy	Nil received	**No change required**

Competencies of the newly qualified dental therapist 6.2 Diagnosis and management planning

Proposed changes	Comments/responses	Actions
Sub-Domain Name Diagnosis and management planning	Nil received.	**No change required**
Domain description covers the identification of disease or abnormalities that require treatment or investigation	Nil received	**No change required**

Proposed changes	Comments/responses	Actions
Introductory sentence A newly qualified dental therapist must be able to:	Nil received	**No change required**
Competency statements		
1. recognise health as it relates to the individual, taking into consideration medical, social and cultural contexts	For comments received refer to Competencies of the newly qualified dentist - Domain 6.2 Diagnosis and management planning	**Acknowledged but not actioned** Terminology including within the definition of person-centred care and Groups or populations at increased risk of harm or poor oral health to address these requirements.
2. diagnose disease or abnormalities of the dentition, mouth and associated structures and identify conditions which require management	Nil received	**No change required**
3. determine the impact of risk factors, systemic disease and medications on oral health and treatment planning	Nil received	**No change required**
4. formulate and record a comprehensive, person-centred, evidence-based oral health treatment plan	Nil received	**No change required**
5. determine when and how to refer to the appropriate health and or care professional	Nil received	**No change required**
6. obtain and record informed consent and financial consent for treatment	Nil received	**No change required**

Competencies of the newly qualified dental therapist - 6.3 Clinical treatment and evaluation

Proposed changes	Comments/responses	Actions
Sub-Domain Name Clinical treatment and evaluation	Nil received.	**No change required**
Domain description covers the provision of evidence-based person-centred care	Nil received	**No change required**
Introductory sentence A newly qualified dental therapist must be able to:	Nil received	**No change required**
Competency statements		
1. apply the principles of disease and trauma prevention **and early intervention i**n the management of the dentition, mouth and associated structures	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Accepted with amendment** New competency statement included within the domain related to dental caries management (see statement 4). No changes made to introduce minimum intervention principles, as this is already consistent with an environmentally sustainable approach to healthcare that is person-centred
2. ~~apply~~ **ensure** the principles of **supported decision making** and positive behaviour support **are incorporated into the** ~~to provide~~ **provision of** person-centred care	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Accepted with amendments** Not all comments or suggestions are consistent with a national scheme, (e.g. reference to state or territory legislation) and so have not been included.

Proposed changes	Comments/responses	Actions
		The shift to ensuring the principles are incorporated recognises that it may not be the dental practitioner that provides these supports, but that they recognize when they are needed and how to seek further advice and guidance to implement such approaches.
3. **manage dental caries**	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Addition of new competency statement** The additional statement recognises the burden of disease associated with dental caries and the importance of appropriate management. **Number change after the addition of statement 3**
4. manage non-surgical treatment gingival diseases	Nil received	**No change required**
5. manage oral conditions and diseases, pain and pathology of the dentition, mouth and associated structures	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Not actioned** **Number change after the addition of statement 3**
6. manage pulpal diseases and conditions	Nil received	**Number change after the addition of statement 3**
7. manage the loss of tooth structure by restoring the dentition with direct restorations	Nil received	**Number change after the addition of statement 3**
8. evaluate and monitor the progress of treatment and oral health outcomes	Nil received	**Number change after the addition of statement 3**

Proposed changes	Comments/responses	Actions
9. manage dental emergencies	Nil received	**Number change after the addition of statement 3**
10. manage medical emergencies	Nil received	**Number change after the addition of statement 3**
11. evaluate and monitor the progress of treatment and oral health outcomes	Nil received	**Number change after the addition of statement 3**

Competencies of the newly qualified oral health therapist - Domain 4. Health promotion

Proposed changes	Comments/responses	Actions
Domain Name Health promotion	Nil received	**No change required**
Domain description covers health education and the promotion of health in the community	Nil received	**No change required**
Introductory sentence A newly qualified oral health therapist must be able to:	Nil received	**No change required**
Competency statements		
1. understand the **social** determinants of health, risk factors and behaviours that influence health	For comments received refer to Competencies of the newly qualified dentist - Domain 4. Health promotion	**Accepted** Change is consistent with focus on person-centred care
2. understand the connection between health promotion and health policy development	For comments received refer to Competencies of the newly qualified dentist - Domain 4. Health promotion	**Not actioned** Acknowledged, however, addressed by the definition to person-centred care.
3. apply the theories and principles of health promotion to improve oral and general health	Nil received	**No change required**
4. design, implement and evaluate evidence-based health promotion strategies and programs	Nil received	**No change required**

Competencies of the newly qualified oral health therapist - Domain 5. Scientific and clinical knowledge

Proposed changes	Comments/responses	Actions
Domain Name Scientific and clinical knowledge	Nil received	**No change required**
Domain description covers the application of knowledge base required by dental practitioners	Nil received	**No change required**
Introductory sentence A newly qualified oral health therapist must be able to:	Nil received	**No change required**
Competency statements		
1. apply the social, cultural, **biological**, biomedical, physical, and behavioural sciences in relation to oral health care provision and disease prevention	For comments received refer to Competencies of the newly qualified dentist - Domain 5. Scientific and clinical knowledge	**Accepted with amendments** Nutrition has not been included in this statement, as is already addressed under risk factors and behaviours in Domain 4. Health Promotion.
2. apply the theories and principles of population oral health	Nil received	**No change required**
3. apply the scientific principles of infection prevention and control	Nil received	**No change required**
4. understand the scientific basis, risks and demonstrate the **safe** use of using ionising radiation	For comments received refer to Competencies of the newly qualified dentist - Domain 5. Scientific and clinical knowledge	**Accepted** Practitioner may not be taking the radiograph, rather they may be required to request other radiological imaging.

Proposed changes	Comments/responses	Actions
5. understand the scientific basis, limitations, risks, of dental materials and demonstrate their use	Nil received	**No changes required**
6. apply the principles of pharmacology, understanding the risks of using therapeutic agents, including polypharmacy and overuse	Nil received	**No changes required**
7. apply the principles of risk management and quality improvement	Nil received	**No changes required**

Competencies of the newly qualified oral health therapist - Domain 6. Person-centred care

Proposed changes	Comments/responses	Actions
Domain Name Person-centred care	Nil received	**No change required**

Competencies of the newly qualified oral health therapist - 6.1 Clinical information gathering

Proposed changes	Comments/responses	Actions
Sub-Domain Name Clinical information gathering	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering	**Not actioned** Interpretation is addressed in sub-Domain 6.2.
Domain description covers the collection and recording of information that is necessary and relevant	Nil received	**No change required**
Introductory sentence A newly qualified oral therapist must be able to:	Nil received	**No change required**
Competency statements		
1. obtain and record a relevant history of the individual's medical, social, **dietary,** and oral health status	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering.	**Accepted** The introduction of dietary history has been included and is relevant to all divisions of registration.

Proposed changes	Comments/responses	Actions
2. perform an examination for health, disease and abnormalities of the dentition, mouth and associated structures	Nil received	**No change required**
3. select necessary clinical, pathology and other diagnostic procedures and interpret results	Nil received	**No change required**
4. **Request and/or** take radiographs relevant to dental practice	For comments received refer to Competencies of the newly qualified dentist - Domain 6.1. Clinical information gathering	**Accepted** Practitioner may not be taking the radiograph, rather they may be required to request other radiological imaging.
5. evaluate individual patient risk factors for oral disease	Nil received	**No change required**
6. maintain accurate, consistent, legible and contemporaneous records of patient management and protect patient privacy	Nil received	**No change required**

Competencies of the newly qualified oral health therapist - 6.2 Diagnosis and management planning

Proposed changes	Comments/responses	Actions
Sub-Domain Name Diagnosis and management planning	Nil received.	**Not actioned**
Domain description covers the identification of disease or abnormalities that require treatment or investigation	Nil received	**No change required**

Proposed changes	Comments/responses	Actions
Introductory sentence A newly qualified oral health therapist must be able to:	Nil received	**No change required**
Competency statements		
1. recognise health as it relates to the individual, taking into consideration medical, social and cultural contexts	For comments received refer to Competencies of the newly qualified dentist - Domain 6.2 Diagnosis and management planning	**Acknowledged but not actioned** Terminology including within the definition of person-centred care and Groups or populations at increased risk of harm or poor oral health to address these requirements.
2. diagnose disease or abnormalities of the dentition, mouth and associated structures and identify conditions which require management	Nil received	**No change required**
3. determine the impact of risk factors, systemic disease and medications on oral health and treatment planning	Nil received	**No change required**
4. formulate and record a comprehensive, person-centred, evidence-based oral health treatment plan	Nil received	**No change required**
5. determine when and how to refer patients to the appropriate health and or care professional	Nil received	**No change required**
6. obtain and record informed consent and financial consent for treatment	Nil received	**No change required**

Competencies of the newly qualified oral health therapist - 6.3 Clinical treatment and evaluation

Proposed changes	Comments/responses	Actions
Sub-Domain Name Clinical treatment and evaluation	Nil received.	**No change required**
Domain description covers the provision of evidence-based person-centered care	Nil received	**No change required**
Introductory sentence A newly qualified oral health therapist must be able to:	Nil received	**No change required**
Competency statements		
1. apply the principles of disease and trauma prevention **and early intervention i**n the management of the dentition, mouth and associated structures	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Accepted with amendment** New competency statement included within the domain related to dental caries management. No changes made to introduce minimum intervention principles, as this is already consistent with an environmentally sustainable approach to healthcare that is person-centre
2. ~~apply~~ **ensure** the principles of **supported decision making** and positive behaviour support **are incorporated into the** ~~to provide~~ **provision of** person-centred care	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Accepted with amendments** Not all comments or suggestions are consistent with a national scheme, (e.g. reference to state or territory legislation) and so have not been included.

Proposed changes	Comments/responses	Actions
		The shift to ensuring the principles are incorporated recognises that it may not be the dental practitioner that provides these supports, but that they recognize when they are needed and how to seek further advice and guidance to implement such approaches.
3. **manage dental caries**	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Addition of new competency statement** The additional statement recognises the burden of disease associated with dental caries and the importance of appropriate management. **Number change after the addition of statement 3**
4. manage non-surgical treatment of diseases and conditions of the periodontium and supporting tissues of the teeth or their replacements	Nil received	**Number change after the addition of statement 3**
5. manage pulpal diseases and conditions	Nil received	**No change required** **Number change after the addition of statement 3**
6. manage the loss of tooth structure by restoring the dentition with direct restorations	Nil received	**No change required**
7. manage the non-surgical removal of teeth	Nil received	**No change required** **Number change after the addition of statement 3**

Proposed changes	Comments/responses	Actions
8. manage oral conditions and diseases, pain and pathology of the dentition, mouth and associated structures	For comments received refer to Competencies of the newly qualified dentist - Domain 6.3 Clinical treatment and evaluation	**Not actioned** **Number change after the addition of statement 3**
9. perform orthodontic procedures as directed by the treating dentist or orthodontist	Nil received	**No change required** **Number change after the addition of statement 3**
10. administer pharmaceutical agents	Nil received	**No change required** **Number change after the addition of statement 3**
11. evaluate and monitor the progress of treatment and oral health outcomes	Nil received	**No change required** **Number change after the addition of statement 3**

Appendix 1: Feedback received on the Professional Competencies of the newly qualified dental practitioner 26 April 2021 until 31 May 2021

Key Points

Survey title: ADC Professional competencies review – stakeholder feedback survey.

Responses: 156 responses, where a name or organisations was supplied and/or one or more questions were answered. There was a completion rate of 34%.

Participants: A broad range of stakeholders: 131 responses (85%) were made by individuals and 23 (15%) were made on behalf of organisations. Two respondents did not answer this question.

Summary of responses:

92% respondents consider the Competencies are still partly or completely current

26% respondents considered that the Competencies should be deleted or reworded and 59% did not consider or were unsure that the Competencies needed deletion or rewording

26% respondents considered that Competencies could be added and 69% respondents did not consider or were unsure whether Competencies need to be added

29% respondents provided comments about the focus areas identified for the review and 71% respondents did not have, or were unsure, whether they had comment

Key point raised:

- Respondents indicated support for the proposed focus areas outlined including:
    - Cultural safety,
    - Interprofessional collaborative practice,
    - care and treatment of people experiencing domestic and family violence, at risk groups, including those living with a disability
    - preparedness to serve rural and remote communities
    - social accountability and environmental awareness

Other areas for consideration included:

- a move from a patient-centred to person-centred approach to care
- the role of the dental practitioner in the broader health-care team
- practitioner readiness to utilise emerging technologies, including telehealth
- Self-awareness, well-being, reflective practice and resilience of dental practitioners

The ADC welcomed responses to the survey from anyone with an interest in the Competencies. The responses were used to inform the review process. The survey was open from 26 April 2021 until 31 May 202.

The ADC asked the following questions:

Q1. Do you consider the Competencies are still current and outline what is expected of a newly qualified dental practitioner to practise safely and ethically in Australia? (Please give a reason for your answer.)

Q2. Are there any Competencies that should be added? (Please give a reason for your answer.)

Q3. Are there any Competencies that should be added? (Please give a reason for your answer.)

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

Q5. Are there any additional areas you think should be considered in the review?

Q6. Do you have any other comments?

Table 1: Respondent groups (n=98)

Respondent type	Number	%
Assessor	**11**	**11**
Committee / Board member	**3**	**3**
Consumer / community representative	**4**	**4**
Dental student	**16**	**16**
Education provider	**15**	**15**
Employer of dental graduates	**6**	**6**
Examiner of overseas trained dental practitioners	**20**	**20**
Member of professional association/academy/society	**18**	**18**
Other	**6**	**6**
Representative of state/territory/DHB based or other provider	**2**	**2**
Overseas trained dental practitioner	**50**	**15**

Note: some respondents ticked more than one category. The percentages were rounded to the nearest whole number. There were 4 organisations who responded to the survey who were not included in the categories in Table 1, bringing the total respondents to 102.

Appendix 2: Members of the Advisory Committee

Review ADC Professional Competencies of the newly qualified dental practitioner

Name	Role or Affiliation
Dr Chris Bourke	ADC Accreditation Committee
Ms Jenine Bradburn	Australian Dental Prosthetists Association
Dr Andrew Flatau	Australasian Council of Dental Schools
Ms Jacqui Gibson	Dental Board of Australia
Dr Melanie Hayes	Dental Hygienists Association of Australia
Dr Denise Higgins	Australian Dental and Oral Health Therapists' Association
Ms Susan Hopkins	TAFE SA
Dr Stephen Liew	Australian Dental Association
Ms Joanne Ling	Australian Dental Students Association
Dr Stuart Marshall	South Australian Dental Service
Ms Narelle Mills	Chief Executive Officer, ADC
Professor Chris Peck (Chair)	Director of the ADC
Ms Karleen Plunket	Consumer representative
Dr Felicia Valianatos	ADC Assessment Committee

Appendix 3: Consultation questions (27 September 2021 until 5 November 2021)

Consultation questions

Q1. Do you consider that the draft Competencies outline what is required of a newly qualified dental practitioner to practice safely and ethically? (Yes, No, Partly, Do not know)

Q2. Do you agree with the proposal to combine the Competencies for all five divisions of registration into one document? (Yes, No, Partly, Do not know)

Q3. Do you have any comments on the format or structure of the draft Competencies?

Q4. Do you agree with the following specific proposals as incorporated in the draft Competencies? (Yes, No, Partly, Do not know)

a. A change of name to Domain 1 from 'Professionalism' to 'Social responsibility and professionalism'

b. The introduction of a definition of 'Cultural safety for Aboriginal and Torres Strait Islander people' into the Terminology section consistent with the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025

c. The introduction of a definition for At-risk groups or populations into the Terminology section of the introduction and the use of the term 'at-risk' within the Competency statements

d. The introduction of a definition of interprofessional collaborative practice and the use of term within the Competency statements

e. The change of terminology from 'patient-centred care' to 'person-centred care', including the updated definition and the use of the terms 'person' or 'individual' within the Competency statements

f. The revisions to Competency statements in Domain 1, which are consistent with the National Scheme's definition of cultural safety for Aboriginal and Torres Strait Islander people, specifically Competency statements 2 to 5

g. The inclusion in Domain 1 of Competency 11 which requires the practitioner to 'understand the environmental impacts of health care provision and use resources responsibly, making decisions that support environmentally sustainable healthcare'

h. The revision of communication related Competencies in Domain 2 and Domain 6, which aim to better reflect the needs of those receiving care

i. The inclusion in Domain 2 of Competency 4 which requires the practitioner be able to 'recognise, assess and respond to domestic and family violence risk, prioritise safety, provide information, and refer as required'

j. The inclusion in Domain 2 of identifying opportunities for improvement and advocating for improved oral health outcomes

k. The revision of terminology used in Domain 5 to require the application and demonstration of knowledge

Q5. Are there any additional Competencies that should be added? (Yes, No, Partly, Do not know)

Q6. Are there any Competencies that should be deleted or reworded? (Yes, No, Partly, Do not know)

Q7. Do you have any other comments on the Competencies?

Appendix 4: Consultation respondents

Organisations (responded to online survey)

Indigenous Allied Health Australia
Australian Dental and Oral Health Therapists' Association
Australian Dental Prosthetists Association Ltd
ACFF
Dental Council of Ireland
Dental Health Services Victoria
Australian Dental Association
Latrobe University
Oral Health Services Tasmania, Department of Health
Public Health Association of Australia Oral Health Special Interest Group
Sydney Dental School
University of Queensland

Organisations (responded directly to ADC)

Australian Commission on Safety and Quality in Health Care
Dental Board of Australia
Disability Oral Health Collaboration
Geelong Parent Network
Queensland Health
Skills IQ
Northern Territory Health

Individuals (responded to online survey)

Alex Moule
Aparajita sharma
Blessing Charles Manyara
Leonie Short
Carol Tran
Carolina Carli
Chun-Chung Chu
Damaris (no surname provided)
Eima Naghavi
Gargi (no surname provided)
Girish Deshmukh
Gisele Khouri
Hafsa (no surname provided)
Helen Shah

Ivan Darby
Anuj Arora
Kuang Myat Win
Lyn Carman
Bilal Hares
Maham
Manisha (no surname provided)
Maria Evelina Brown
Martin Tyas
Meenu Shrestha
Michael (no surname provided)
Mrugeshkumar Patel
Eshan Verma
Neena sandhu
Viktor (no surname provided)
Janell Quarderer
Nishi Mittal
Not provided
Phyllis Lau
Poonam Mandaliya
Priyal (no surname provided)
Radhika Keshav Reddy
Marguerite Janet Reith
Samantha Byrne
Sara (no surname provided)
Shilpa Walia
Akshita Deverashetty
Siva shankar
Tushar Borania
Sukhdeep Sandhu
Margie Steffens OAM
Hadeel Al-younany
Tera (no surname provided)
Tony Skapetis
Vidushi Khanna
Wafa Hamid Mirgany
Yoshihiro Ito
Mustafa (no surname provided)
Zainab (no surname provided)