



Guidelines on Supervision of Qualified Orthodontic Therapists

2012

Please note these guidelines relate to qualified orthodontic
therapists only

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1 INTRODUCTION

Orthodontic Therapists (OT) are a relatively recent addition to the range of Dental Care Professionals but have already proved to be valuable members of the dental team and following a prescription, are permitted to undertake reversible orthodontic procedures. The first OT's qualified in 2007 having undertaken courses approved by the GDC and with adherence to the principles set out in the GDC - *Developing the Dental Team* document (2004). This document has been superseded by later publications of the GDC including the revised *Developing the Dental Team* (2009), which specified the learning outcomes for DCPs, and the *Scope of Practice* (2009). It is within the *GDC Learning Outcomes document* that the specific capabilities of all divisions of DCPs are listed.

It is the professional responsibility of dental team leaders and OT's to be aware of what constitutes good, ethical clinical practice and follow these principles in their care of patients. The skills of an OT are defined, as for all registered groups, by the GDC and these explicitly state what a therapist can and cannot do. As the practice of Orthodontics develops it is appropriate that the roles and responsibilities of individual OT's will also evolve and change.¹

The purpose of this guidance document from the British Orthodontic Society and the Orthodontic National Group is to provide guidance on best practice in this area so OTs are not asked to act outside their competency and to ensure that patients receive the best standard of care and treatment possible.

2 PROFESSIONAL RESPONSIBILITIES OF THE REFERRING DENTIST

The referring practitioner is in a powerful position, not only being the supervising dentist but often also being the OT's employer. It is imperative and their professional responsibility that they should not use this position to abuse this relationship and compromise the care of the patient.

The GDC's *Scope of Practice* guidance (2009) explicitly states "You should only ask someone else to carry out a task or type of treatment or make decisions about a patient's care if you are confident that they have the necessary skills."³

It is also relevant to note that paragraph 5.4 of GDC's *Principles of Dental Team Working* guidance (2006) which is addressed to dental team leaders and states "If you employ, manage or lead a team, you should make sure that:.... you do not take advantage of your position if another member of the team says that they do not feel that they should carry out a particular task because they are not trained or competent to do it"

3 ROLE OF THE ORTHODONTIC THERAPIST

3.1 THE SCOPE OF PRACTICE OF ORTHODONTIC THERAPISTS:²

OT's are registered dental professionals who carry out certain parts of orthodontic treatment under prescription from a dentist. **They should only work within their competence and their scope of practice as defined by the GDC.**

Changes to the roles of Orthodontic Therapists in the GDC Learning Outcomes document (2011):

1.5.2 – Obtain valid consent: The obtaining of valid consent was previously not in the list of permitted procedures. Guidance regarding the Orthodontic Therapists role in this regard is detailed below.

1.5.3. – Plan the delivery of care: This does not indicate that it is appropriate for an Orthodontic Therapist to have any involvement in either the formulation or alteration of a patient's treatment plan. It does instead refer to the determining of the most appropriate way to deliver the care that has been prescribed by the referrer e.g. the way in which the placement of appliances is undertaken.

3.2 PROFESSIONAL RESPONSIBILITIES OF THE ORTHODONTIC THERAPIST

Changing practice

This scope of practice is likely to change over the course of a career. Developing new skills may expand it, or it may narrow in scope but deepen by gaining knowledge of a particular area by choosing a more specialised practice³

Ethical Practice

Working in the absence of a dentist or orthodontist after the initial treatment plan could be potentially harmful to patients. An OT should only see a patient without the referring dentist present if they are a confident that they are working within their competence and as discussed and agreed with the supervising dentist.

Raising concerns

In paragraph 3.9 of *Principles of Dental Team Working*, DCPs are instructed that "As a team member, you have a responsibility to raise any concern you have that patients might be at risk because of... any action you have been asked to carry out that you believe conflicts with your main duty to put patients' interests first and act to protect them."

4 CONSENT

The *GDC Learning Outcomes* (2011) document states that OT's are able to take consent.

The gaining of valid consent is not a one off event and is an on going process at each visit and as such this duty falls to the OT during active treatment when they are seeing the patient. The taking of consent **before** treatment begins should be undertaken only by an individual who is aware of the options available, together with the likely result if no treatment is undertaken and the risks and benefits of all treatment options.

Provided that the OT is experienced enough and has the necessary competency to understand **fully** the treatment that is being proposed, its pros and cons and those of any alternative treatment that may be available, then it is appropriate for them to carry out this task. The onus then would be on the dentist to be sure of the OT's competence, experience and training before making the referral.

Difficulty would arise in two particular situations:-

- Where the treatment is quite complicated and the OT perhaps does not have the necessary knowledge or competency to understand fully why the dentist has chosen this treatment plan over and above a different treatment plan. Without this knowledge it would be impossible to appropriately discuss any alternatives.
- Where following discussion the patient for one reason or another decides not to accept the treatment or an aspect of that treatment (i.e. the use of headgear).

In both of these situations the OT is unlikely to be able to undertake the task and the patient would need to be referred back to the dentist.

Thus, much depends on the knowledge and competency of the OT. As the experience and competency of the OT develops, more of the consent process can be delegated to the OT, provided that they are comfortable with this. It would be wrong for the dentist to make the diagnosis and treatment plan and simply give treatment responsibilities to the OT on the assumption that all would be well.

If the proposed treatment is relatively simple then it is possible, but only if the OT is in agreement, and agreed with the supervising dentist for consent to be obtained by the OT. If however the treatment options are complex then only the referring dentist would be in a position to take valid consent.

5 SUPERVISION

5.1 APPROPRIATE SUPERVISION

Whenever practicable it is best that patients are seen with the supervising dentist present. It is obvious that this is not always practical or desirable, but **the supervising dentist should see the patient at least every other visit.**

5.2 REASSESSMENT SCHEDULE

The general guidelines for dental team working are set out in the GDC document *Principles of Dental Team Working* where point 2.5 states:

The treatment plan (whether an outline plan or full treatment plan) should include:

- recall intervals, depending on the patient's clinical needs
- a date for a full mouth reassessment by a dentist
- a referral if necessary

The reassessment date is defined as the date when the patient must return to be seen by a dentist for a full-mouth examination and treatment plan whereas the recall interval is how often the patient should return to be seen by a member of the dental team.

In orthodontic treatment, the direction and practical details of the treatment plan is **not** a once only event but a continuing process that needs to be re-assessed throughout treatment and at each visit. It should be considered unacceptable to leave the OTs unsupervised but the degree of supervision may evolve with the experience of the OT.

5.3 RECOMMENDATION ON SPECIFIC TASKS

SUPERVISION RECOMMENDED

An OT should see a patient unsupervised only where the dentist writes a clear prescription in the notes and the OT should not change this. In the event of any query then no treatment should be undertaken and a further appointment made to see the supervising dentist.

- After the treatment plan appointment the OT can place fixed appliances to the precise prescription of the dentist. The prescription should include:
 - Bracket type including the type and prescription
 - Any special instructions for specific bracket positioning
 - Specific arch wires to be used
 - Instructions regarding use of auxiliaries and requirements for ligation
 - An appropriate interval until the next visit. The notes should indicate all that is required including when the patient needs to be seen next.
 - It would be inappropriate for the OT to make a decision on the type of appliance and then place the appliance of their choice and complete the treatment with no further input from the supervising dentist.
- At recall specific instruction should be given in relation to re-ligation or changing arch wires and ligation

- Procedures that require clear written prescription but no direct supervision also include:
 - Fitting bite opening blocks and turbos
 - Taking alginate/PVS impressions
 - Fitting aligners and pressure/vacuum formed retainers
 - Taking records (including X-rays if suitably qualified)
 - Repairing appliances making them safe and the patient pain free
 - Debonding fixed appliances when agreed in advance.

SUPERVISION REQUIRED

OTs should have direct supervision by the dentist for the following procedures:

- Fitting or adjusting steel/TMA archwires
- Fitting bonded retainers
- Designing, fitting or adjusting headgear
- Fitting active removable appliances adjusted by a dentist
- Changing or fitting elastics or space opening/closing springs and other active auxiliary components.
- Fitting space opening springs
- Debonds if not agreed in advance

ORTHODONTIC EMERGENCIES

In circumstances where a patient presents as an orthodontic emergency, the OT may be required to carry out limited treatment in the absence of a dentist. Instruction should be provided to enable the student OT to identify damaged or distorted orthodontic appliances and to carry out limited treatment in order to relieve pain or make an appliance safe.

5.4 REFERENCES

1. Preparing for Practice : Dental Team Learning Outcomes for Registration GDC (2011)
2. Outcomes for Registration GDC - Table (2011)
3. Principles of Dental Team Working GDC (2006)
4. Scope of Practice GDC (2009)