Dental Council
An Comhairle Fiaclóireachta

Dental Council Accreditation Manual
- January 2022 -

Introduction

1. The Dental Council has an obligation under the Dentists Act 1985 to satisfy itself as to the suitability of the dental education and training provided by approved bodies in Ireland and as to the standards of theoretical and practical knowledge and clinical experience required for the qualifying examinations.

2. The manner in which Council undertakes this key role is through the establishment of minimum requirements for bodies and programmes. Through an accreditation process, Council engages with bodies and programmes to establish whether these requirements are being met. This is in order to maintain the integrity of the dental registers through which the public are protected.

3. The Dental Council is also responsible for ensuring that the minimum requirements established by the Professional Qualifications Directive (PQD) 2005/36/EC are being met. The PQD provides for a system of free movement within the European Union for certain regulated professions including dentistry.

Purpose

4. The key purpose of the accreditation process is to confirm that minimum requirements are being met. It is an opportunity to establish how well programmes are performing and to learn about good practice and local innovations. It is also an opportunity to establish the challenges being faced by programmes, to address and resolve concerns, and to support programmes where possible.

Review

5. The Dental Council has availed of the expertise and resources provided by the Association of Dental Education in Europe (ADEE) since 2005, in particular the ADEE's publications regarding competences for dental graduates. The Dental Council continues to acknowledge the expertise, impact and influence of the ADEE and has updated its requirements of programmes to incorporate the ADEE's 2017 *Undergraduate Curriculum Framework*.

6. The Dental Council has undertaken a period of reflection to establish those aspects of our accreditation process that have worked well to date, and those aspects that would benefit from updating to reflect feedback from educators, analysis of approaches by peer organisations and direct observation of accreditation processes in other jurisdictions.

Ethos

7. The Dental Council's approach to accreditation is underpinned by the following ethos which is intended to set the tone of engagement and to maximise the benefit of the process for all parties involved: -

   - The Dental Council wishes to approach accreditation in the spirit of partnership. While the statutory remit of Council must be fulfilled, every effort will be made to approach this activity in a positive and non-confrontational manner.

   - There is an obligation on the Dental Council to make its expectations clear and to engage proactively with bodies and programmes to this end.

   - There is a corresponding obligation on bodies and programmes to demonstrate adherence to Council's requirements.

   - The accreditation process is intended to not only establish that minimum requirements are being met but to also add value overall through dialogue, analysis, critical appraisal, and peer feedback.

   - The requirements established by the Dental Council are mandatory but, for the most part, are not prescriptive. The Dental Council respects the academic autonomy of bodies and as such, the specific means by which Council's requirements are being met are likely to vary.

   - The conclusions reached through the accreditation process shall be evidence-based, and the sources of evidence will be confirmed alongside the conclusions.

   - The turnaround times in the production and consideration of the resultant accreditation reports will be such that the momentum of the overall process can be maintained, and the overall value of the process maximised for all parties.

Key Stages

8. The accreditation process will continue to follow a well-established and universal approach to healthcare & professional accreditation – *self-evaluation* within defined parameters, submission of *written assurances and supporting evidence* to demonstrate that requirements are being met, *site visit and engagement* with relevant stakeholders, production of an *accreditation report*.

9. The key stages are as follows: -

   A. Engagement will be initiated by the Dental Council to confirm the programme(s) due for accreditation and to confirm the process and accompanying requirements. A suggested timetable will be provided by Council to confirm the range of stakeholders to be met, the facilities to be visited and the anticipated sequencing and duration of each engagement. The final timetable will be arrived at through collaboration with the body.

   B. A date for the site visit will be mutually agreed. This date should be no earlier than 9 months from the date on which Council initiated the engagement.

C. A date for the receipt of the written submission from the body will be confirmed. This date will normally be 6-8 weeks before the site visit. The specific format of the submission will be confirmed by the Dental Council Executive but unless otherwise indicated, the format shall be electronic.

D. Initial scrutiny of the written submission will be undertaken by the Dental Council Executive in good faith to ensure that all anticipated material has been received and that there have been no accidental omissions or production errors. This scrutiny will take place within 7 days of receipt from the body and feedback will be provided to the body as and if necessary.

E. The submission will then be provided to the accreditation team who will meet within 14 days to exchange initial feedback and to consider whether any clarifications are necessary. Requests for clarifications or further information will be promptly raised with the body. The Executive and the accreditation team will endeavour to ensure that all preliminary queries are resolved before the visit in order to maximise the value of the time spent on site.

F. The site visit will be conducted as a means to engage with the body to explore the evidence provided in detail, to visit all relevant facilities, to engage with a full range of programme staff, students, and other stakeholders. This is intended to provide as broad a range of feedback as possible in order for the accreditation team to reach its conclusions.

G. The findings and conclusions of the accreditation team will be captured in an accreditation report, a draft of which will be prepared as contemporaneously as possible during the visit and immediately thereafter. The accreditation report will proceed through the Dental Council's governance arrangements towards finalisation.

Accreditation Team

10. An accreditation team shall be formed by the Dental Council whose role it shall be to evaluate programmes on Council's behalf and within the parameters established by the accreditation process. The team shall review and query evidence in order to establish whether the Dental Council's requirements of programmes and bodies have been met. The team's findings will be captured in an accreditation report which will be submitted to Council for consideration and final decision.

11. An accreditation team shall comprise the following: -

Chairperson – the Chairperson shall be a current or recent Dean (or equivalent Institutional Lead) of a peer institution. Given the relative size of the dental teaching profession in Ireland and to avoid conflicts of interest, it is appropriate to consider sourcing the Chairperson from a different jurisdiction. The Chairperson should not be a member of the Dental Council or one of its committees. Within these parameters, the Chair of the Education & Training Committee and the Head of Education shall identify the Chairperson of the visiting team.

Dental Council Representative – each team shall include a current or former member of the Education and Training Committee, or a current or former member of the Dental Council, to represent the Council itself, to attest to Council that agreed processes have been followed and to provide updates as necessary, to share their expertise with the team, and to demonstrate the high value that the Dental Council places on the accreditation process. This team member shall ordinarily be a current or former member of the Education and Training Committee but if logistical issues or conflicts of issue arise, a current or former member of Council shall be recruited.

Subject Matter Experts – each team shall include a minimum of two additional subject matter experts with direct expertise of undergraduate dental education and training. At least one of the subject matter experts shall be familiar with the operation of dental education and training *in Ireland.* This expertise and insight will be available to members of the accreditation team who may be unfamiliar with the operation of dental education and training in this jurisdiction.

12. Accreditation teams will be accompanied by the Head of Education and other members of the Education Section of the Dental Council. The role of the Executive in this instance is to support the smooth running of the process, to share their expertise with the team and to work closely with the team towards the production of the accreditation report. Members of the Executive in attendance shall not be considered members of the accreditation team.

13. Within the agreed parameters, the specific membership of an accreditation team (other than the Chairperson) shall be developed and proposed by the Chair of the Education & Training Committee and the Head of Education for approval by the Committee. Where conflicts of interest arise for the committee Chair in this area, the Education & Training Committee shall nominate a committee member with whom the Head of Education can liaise.

14. For the benefit of accreditation team members, and for the benefit of the process overall, early briefing and induction sessions shall be held to ensure a common understanding of the accreditation process, the underpinning accreditation requirements, and the expectations of the team. These sessions will also be used as an opportunity to confirm the specific context and operation of dental education and training in Ireland.

15. The opportunity exists for Council to retain the expertise of accreditation team members to assist in the consideration of formal responses to finalised accreditation reports and throughout subsequent monitoring activity. While decisions regarding the adequacy of responses to accreditation reports will be taken by the Dental Council, it shall be a matter for the Dental Council to avail of external expertise as necessary to assist in the decision-making process.

Distinct Teams

16. Fully distinct accreditation teams shall be formed to visit each undergraduate dental programme. The use of distinct teams is intended to achieve the following: -

    - Enable accreditation teams to focus entirely on the ability of a school and programme to meet Council's requirements on its own merits;
    - Support Council's long held view that academic judgement and autonomy should be respected once the relevant competences have been developed in graduates;
    - Render obsolete any perceived advantage (or disadvantage) arising from the sequence of the school visits; and
    - From a practical perspective, acknowledge the difficulty that could otherwise be faced in trying to seek a substantial time commitment from potential team members to support two visits in quick succession.

    In order to support the above approach, it is acknowledged that a significant degree of the consistency of the accreditation process will be derived from the briefing given to accreditation teams, the expertise residing within teams themselves, and the advice and overall input of the Executive at visits.

The Roles of Accreditation Teams and the Education and Training Committee

17. The role of an accreditation team in the preparation of an accreditation report is to: -

    a) Convey, through the main body of the report, its views on the strengths, shortcomings and/or vulnerabilities of the programme in question. The content of the main body of a report is not subject to alteration by committee or Council as it represents the experiences of the team throughout the accreditation process.
    b) Translate its experiences, interactions, and observations throughout the accreditation process into a series of commendations, conditions (must do), recommendations (should do) and observations (could do). It is acknowledged that the boundaries between conditions and recommendations can be porous at times.

18. The role of the Education and Training Committee in its consideration of an accreditation report is to consider whether the suggested conditions, recommendations and observations are: -

    a) consistent with the body of the report;
    b) appropriate/proportionate in terms of their suggested 'must do', 'should do', 'could do' designation;
    c) defensible;
    d) measurable and demonstrable in terms of future compliance/response;
    e) consistent with Council policy, national policy, other legislation;
    f) phrased in a useful way which will allow the institution to identify the response/corrective action required

The Accreditation Report

19. The accreditation report will be prepared by the accreditation team with the assistance of the Dental Council Executive. The collective experience of the accreditation team, assisted by the advice of the Executive, will help to ensure that the report is prepared with explicit reference to the Dental Council accreditation requirements and compatible with Council's legal remit.

20. The accreditation report will link the findings of the accreditation team to a suggested combination of conditions, recommendations, observations, and commendations. These are described as follows:

    Conditions – findings which lead to mandatory action by the body i.e. 'must do'. These are associated with fundamental quality and/or safety concerns which it is felt are incompatible with the accreditation requirements.

    Recommendations - findings which should be acted upon by the body unless there are valid reasons for not doing so i.e. 'should do' actions.

    Observations - advisory content provided to the body for its consideration and which it is felt could add value to the programme or body overall i.e. 'could do' actions.

    Commendations – instances of good practice, innovation, or quality of engagement which it is felt should be formally recorded.

The distinction between a condition and a recommendation (and potentially between an observation and a recommendation) will at times be matters of professional judgement. Council will place great weight on the feedback from its accreditation team should such matters arise.

21. The Dental Council, through its governance arrangements for decision-making in these areas, must consider whether conclusions associated with findings and reflected as conditions etc. are proportionate to the issue at hand, consistent with Dental Council policy and priorities, and are overall defensible. While the findings of an accreditation team are a matter for the team to present to Council, ultimately it is a matter for the Dental Council to act upon findings and to determine the most appropriate categorisation of those findings.

22. Before the accreditation report is presented to the Education and Training Committee, the report will be shared with the body without an indication of the conclusions. The body will be asked to comment on the factual accuracy of the report. This feedback will be provided to the accreditation team who will then consider whether the report would benefit from amendments. The (potentially amended) report will then be provided to the committee.

23. Reports shall carry an overall conclusion that a programme is either *approved* (or approved with conditions) or is *not approved*. In circumstances where concerns with a programme have indicated to Council that approval is not appropriate, a clear rationale will be provided. In circumstances where an existing programme has raised sufficient concerns that continued approval may not be appropriate, there will be significant engagement with the body, the parent institution, and other relevant stakeholders to consider whether remedial action is possible before the loss of approval.

24. Embedded in the overall conclusion shall be an explicit reference to the programme's compliance with the requirements of the Professional Qualifications Directive.

25. The typical approval/accreditation period shall be five years. However, this period could be shorter depending on the conclusions of the accreditation report and is a matter for the Dental Council to determine.

Sources of Evidence

26. The sources of evidence to support accreditation report content shall be confirmed in the report itself. Potential sources of evidence include, but are not limited to, the following: -

    - Documentary evidence provided by the body
    - Feedback from the body during the visit such as staff, programme leads, module leads etc.
    - Feedback from students during the visit
    - Direct observations e.g. during tour of facilities

27. The accreditation team shall make every effort to triangulate evidence as much as possible to ensure that the team's findings are well supported, and evidence-based. Where conflicting evidence arises, it shall be a matter for the team to consider how best to reflect the conflict in the report.

Timetable

28. The visit timetable will be drafted in partnership with the body in a way that minimises unnecessary disruption while at the same time providing the necessary access to key stakeholders and facilities during the visit. The key stakeholders which accreditation teams will wish to engage with include but are not limited to: -

    - Dean and Vice-Dean
    - Chief Executive Officer
    - Representatives of the Parent Institution and Faculty as appropriate
    - Students
    - Recent graduates
    - Programme leads
    - Committee Chairs
    - Module and discipline leads
    - Part-time teaching staff
    - Clinic managers
    - Auxiliary and support staff
    - Employer representatives

    A specific list of stakeholders will be provided to the body. Further suggestions from the body of additional stakeholders to engage with will be carefully considered. The expected duration of a visit is 4 days subject to finalisation of the timetable.

29. While the accreditation team will adhere as closely as possible to the agreed timetable, the team must reserve the opportunity to adjust the timetable in instances where the circumstances support such an adjustment. This could take the form of an unanticipated issue requiring attention or a matter which it is important to quickly resolve so as not to negatively impact the remainder of the engagement. By their very nature, it is expected that bodies would accommodate such additional requests to assist the team to resolve the query in the best interests of the process and the programmes in question

Institutional Approach

30. While the accreditation process default is the evaluation of a single programme in a single engagement, Council shall consider the merits of combining multiple programme visits into a single concurrent engagement. The scale of such a multi-programme engagement would exceed that of a single programme engagement but certain benefits are likely to accrue. These benefits include the potential for bodies to set out their 'hub and spoke' arrangements and indicating which documents, policies and protocols are common to all programmes, and which are programme-specific.

Raising concerns

31. Bodies shall have an opportunity, through a formal, internal process, to raise an appeal or concern with the Dental Council before an accreditation report is finalised. The following provides confirmation of the stages of approval of an accreditation report, and the stage of consideration at which a body may make a submission setting out its concerns to Council: -

Report of Accreditation Team
(Narrative, conclusions, sources of evidence relied upon etc.)

Dental School
(School invited to comment on factual accuracy only)

Education & Training Committee
(Receives report, factually amended as appropriate, cannot change findings/content of report, can recommend to Council that the categorisation of report findings be adjusted e.g. a condition to become a recommendation)

School provided with update from E&T Committee
(And details of any recommendations being made to Council in relation to the report), and advised of date on which Council will be considering report. ***School invited to make a submission to Council if necessary***

Dental Council
Council considers report and any relevant recommendations from E&T Committee, considers any submission received, makes final decision

32. The parameters within which such a submission can be raised are not defined and bodies retain a significant degree of flexibility in this regard. Similarly, on receipt of an accreditation report, and any corresponding submissions, the Dental Council maintains a degree of flexibility and discretion to ultimately support Council's obligations to protect the public interest, to maintain the integrity of the dental registers, and to drive a strong quality agenda in relation to dental education and training. The options available to Council may include accepting a report in total, querying an element of a report, or referring a matter back to the committee stage for further consideration or clarification.

Report generation

33. It is intended to generate accreditation reports as contemporaneously as possible, with the majority of content written with the accreditation team present on site at the conclusion of accreditation visits. Site visit timetables will provide for this activity, and this time commitment will be made clear to accreditation team members. Final editing of reports will be undertaken by the Chair of the accreditation team and the Head of Education.

34. Draft reports will be made available to the school no later than 14 days after the conclusion of the site visit for factual accuracy only. The report, and feedback regarding factual accuracy, will be presented at the next available Education and Training Committee meeting.

Publication of Reports

35. It shall be Dental Council policy to publish accreditation reports with redactions as necessary, and as would be the case in the management of a Freedom of Information (FOI) request. The editorial style of reports will support the privacy of individuals to the greatest extent possible. Material received from bodies as part of the accreditation process will not be routinely published although it is acknowledged that FOI requests can nonetheless be received for such material which will be managed in accordance with the FOI legislation. It shall also be policy to publish school responses to accreditation reports as a means of increasing transparency, and of providing balanced access to this important dialogue.

Collaboration

36. The Dental Council is acutely aware of the cumulative burden of regulatory, accreditation and other quality assurance activities on bodies. Council is committed to playing its role in reducing any unnecessary burden arising from its own engagement with bodies and programmes and is actively involved in the ongoing conversation between stakeholders to consider what further measures could be considered.

37. Council holds a statutory remit to evaluate the quality of dental education and training in Ireland and as such must be mindful to not become overly dependent on the processes of other bodies holding similar remits. Notwithstanding this point, it is entirely a matter for Council to determine the specific means by which it could be satisfied that particular requirements are being met e.g. through direct engagement or through reliance on other processes or proxy arrangements. This could take the form of accepting material for the purposes of accreditation that was prepared for a separate process entirely.

Dental Council
An Comhairle Fiaclóireachta

Re: Memo to accompany the Dental Council's requirements for undergraduate dentistry

1. The Dental Council's requirements for undergraduate dentistry comprise three key elements – '*Accreditation Standards'*, '*Domains, Competences and Associated Learning Outcomes*', and '*Annotations and Suggested Evidence*'. Each of these elements is introduced below, as too is their interrelationship.

Accreditation standards

2. The nine thematic headings are based on the most recent standards published by the World Federation for Medical Education (WFME). Where necessary, the language has been adapted to reflect the dental context. These headings are an update to the headings that have been used by the Dental Council for many years. The narrative accompanying each standard provides additional detail and "unpacks" each standard into a number of separate requirements.

Domains, competences and associated learning outcomes

3. This document extracts the key content adapted from the 2017 *Association for Dental Education in Europe* framework into a set of learning outcomes which are related to areas of competence and grouped thematically under four domains. The learning outcomes are those which must be supported by undergraduate dental programmes, and the linkage with the '*Accreditation Standards*' is primarily through *2. Educational Programme* and the standards housed therein. This linkage is expanded upon in the '*Annotation and Suggested Evidence*'.

Annotations and suggested evidence

4. This document is intended to act as a guide to institutions who are due to undergo an accreditation visit. It is intended to support engagement between parties by clarifying the context and intentions of the Dental Council's requirements, and by suggesting some sources of documentary evidence that could be presented by institutions to demonstrate their adherence to requirements.

   This document is presented in two sections – Section One relates to the accreditation standards introduced above under 6(a) and Section Two relates to the domains, competences and learning outcomes introduced under 6(b) above.

Dental Council
An Comhairle Fiaclóireachta

Dental Council Accreditation Standards (Approved Sept 2020)

1. MISSION AND OUTCOMES

1.1 MISSION

The Educational Institution **must: -**

• state its mission.
• make itself known to its constituency and the health sector it serves.
• outline the aims and the educational strategy resulting in a dental professional being
- competent at a basic level.
- capable of undertaking the roles of dental professionals as defined by the health sector.
- committed to life-long learning.
• consider that the mission encompasses the health needs of the community, the needs of the health care delivery system and other aspects of social accountability.

1.2. INSTITUTIONAL AUTONOMY

The Educational Institution **must** have institutional autonomy to: -

• formulate and implement policies for which its faculty/academic staff and administration are responsible, especially regarding
- design of the curriculum.
- use of the allocated resources necessary for implementation of the curriculum.

1.3. EDUCATIONAL OUTCOMES

The Educational Institution **must: -**

• define the intended educational outcomes that students should exhibit upon graduation in relation to
- their achievements at a level regarding knowledge, skills, and attitudes.
- their future role in the health sector.
- their commitment to and skills in life-long learning and an appreciation of, and commitment to, evidence-based practice
- the health needs of the community and the needs of the health care delivery system.
• ensure appropriate student conduct with respect to fellow students, faculty members, other health care personnel, patients, and their relatives.
• make the intended educational outcomes publicly known.

1.4. PARTICIPATION IN FORMULATION OF MISSION AND OUTCOMES

The Educational Institution **must: -**

• ensure that its principal stakeholders participate in formulating the mission and intended educational outcomes.

• endeavour to ensure that the formulation of its mission and intended educational outcomes is based also on input from other stakeholders.

2. EDUCATIONAL PROGRAMME

2.1. FRAMEWORK OF THE PROGRAMME

The Educational Institution **must: -**

• define the overall curriculum.
• use a curriculum and instructional/learning methods that stimulate, prepare and support students to take responsibility for their learning process.
• ensure that the curriculum is delivered in accordance with principles of equality.
• ensure that the curriculum prepares the students for life-long learning.

2.2. SCIENTIFIC METHOD

The Educational Institution **must: -**

• throughout the curriculum teach
- the principles of scientific method, including analytical and critical thinking.
- research methods.
- evidence-based practice.

2.3. BASIC BIOMEDICAL SCIENCES

The Educational Institution **must: -**

• in the curriculum identify and incorporate the contributions of the basic biomedical sciences to create understanding of
- scientific knowledge fundamental to acquiring and applying clinical science.
- concepts and methods fundamental to acquiring and applying clinical science.

2.4. BEHAVIOURAL AND SOCIAL SCIENCES, DENTAL ETHICS, REGULATION

The Educational Institution **must: -**

• in the curriculum identify and incorporate the contributions of:
- behavioural sciences.
- social sciences.
- dental ethics.
- regulation.

2.5. CLINICAL SCIENCES AND SKILLS

The Educational Institution **must: -**

• in the curriculum identify and incorporate the contributions of the clinical sciences to ensure that students
- acquire sufficient knowledge and clinical and professional skills to assume appropriate responsibility at the point of graduation.
- spend a reasonable part of the programme in planned contact with patients in relevant clinical settings.
- experience health promotion and preventive practice.
• specify the amount of time spent in training in major clinical disciplines and other key areas.

• organise clinical training with appropriate attention to patient safety.
• ensure that every student has early patient contact gradually including participation in patient care.
• structure the different components of clinical skills training according to the stage of the programme.

2.6. PROGRAMME STRUCTURE, COMPOSITION AND DURATION

The Educational Institution **must: -**

• describe the content, extent and sequencing of courses and other curricular elements to ensure appropriate coordination between basic biomedical, biological, and behavioural sciences, and the clinical and technical aspects of dentistry.
• describe the horizontal and vertical integration of associated sciences, disciplines, and subjects throughout the programme.

2.7. PROGRAMME MANAGEMENT

The Educational Institution **must: -**

• have a curriculum committee, which under the governance of the academic leadership has the responsibility and authority for planning and implementing the curriculum to secure its intended educational outcomes.
• ensure representation of staff and students in its curriculum committee.
• consider the merits of also including representatives of other external stakeholders.

2.8. LINKAGE WITH THE DENTAL PROFESSION AND THE HEALTH SECTOR

The Educational Institution **must: -**

• maximise the operational linkage between the educational programme, the requirements of the dental profession and the requirements of the community and society, recognising the social determinants of health
• ensure that there is a mechanism for the curriculum committee to seek and receive input to its activities from the environment in which graduates will be expected to work.

3. ASSESSMENT OF STUDENTS

3.1. ASSESSMENT METHODS

The Educational Institution **must: -**

• define, state, and publish the principles, methods and practices used for assessment of its students, including the criteria for setting pass marks, grade boundaries and number of allowed retakes.
• ensure that assessments cover knowledge, skills, and attitudes.
• use a wide range of assessment methods and formats according to their “assessment utility”.
• ensure that methods and results of assessments avoid conflicts of interest.
• ensure that assessments are open to scrutiny by external expertise.
• use a system of appeal of assessment results.
• evaluate and document the reliability and validity of assessment methods.
• incorporate new assessment methods where appropriate.
• enable effective engagement of external examiners to maintain and enhance academic quality and standards

3.2. RELATION BETWEEN ASSESSMENT AND LEARNING

The Educational Institution **must: -**

• use assessment principles, methods, and practices that
- are clearly compatible with intended educational outcomes and instructional methods.
- ensure that the intended educational outcomes are met by the students.
- promote student learning.
- provide an appropriate balance of formative and summative assessment to guide both learning and decisions about academic progress.
• ensure timely, specific, constructive, and fair feedback to students on basis of assessment results.

4. STUDENTS

4.1. ADMISSION POLICY AND SELECTION

The Educational Institution **must: -**

• formulate and implement an admission policy based on principles of objectivity, including a clear statement on the process of selection of students.
• have a policy and implement a practice for admission of disabled students.
• have a policy and implement a practice for transfer of students from other national or international programmes and institutions.

4.2. STUDENT INTAKE

The Educational Institution **must: -**

• define the size of student intake and relate it to its capacity at all stages of the programme.
• periodically review the size and nature of student intake in consultation with other stakeholders in the context of the health needs of the community and society.

4.3. STUDENT COUNSELLING AND SUPPORT

The Educational Institution and/or the Parent Institution **must: -**

• have a system for academic counselling of its student population.
• offer a programme of student support, addressing social, financial, and personal needs.
• allocate resources for student support.
• ensure confidentiality in relation to counselling and support.

4.4. STUDENT REPRESENTATION

The Educational Institution **must: -**

• formulate and implement a policy on student representation and appropriate participation in
- mission statement.
- design of the programme.
- management of the programme.
- evaluation of the programme.

5. ACADEMIC STAFF/FACULTY

5.1. RECRUITMENT AND SELECTION POLICY

The Educational Institution **must: -**

• formulate and implement a staff recruitment and selection policy which
- outlines the type, responsibilities, and balance of the academic staff/faculty of the basic biomedical sciences, the behavioural and social sciences and the clinical sciences required to deliver the curriculum, including the balance between dental and non-dental academic staff, the balance between full-time and part-time academic staff, and the balance between academic and non-academic staff.
- addresses criteria for scientific, educational, and clinical merit, including the balance between teaching, research, and service functions.
- specify and monitor the responsibilities of its academic staff/faculty of the basic biomedical sciences, the behavioural and social sciences, and the clinical sciences.

5.2. STAFF ACTIVITY AND STAFF DEVELOPMENT

The Educational Institution **must: -**

• formulate and implement a staff activity and development policy which
- allows a balance of capacity between teaching, research, and service functions.
- ensures recognition of meritorious academic activities, with appropriate emphasis on teaching, research and service qualifications.
- ensures that clinical service functions and research are used in teaching and learning.
- ensures sufficient knowledge by individual staff members of the total curriculum.
- includes teacher training, development, support, and appraisal.

6. EDUCATIONAL RESOURCES

6.1. PHYSICAL FACILITIES

The Educational Institution **must: -**

• have sufficient physical facilities for staff and students to ensure that the curriculum can be delivered adequately.
• ensure a learning environment, which is safe for staff, students, and patients.
• monitor the ongoing adequacy of its physical resources

6.2. CLINICAL TRAINING RESOURCES

The Educational Institution **must: -**

• ensure necessary resources for giving the students adequate clinical experience, to meet programme requirements, including sufficient
- number and categories of patients.
- clinical training facilities.
- supervision of their clinical practice with appropriate staff : student ratios

6.3. INFORMATION TECHNOLOGY

The Educational Institution **must: -**

• formulate and implement a policy which addresses effective and ethical use and evaluation of appropriate information and communication technology.
• ensure access to web-based or other electronic media.

6.4. RESEARCH AND SCHOLARSHIP

The Educational Institution **must: -**

• use dental research and scholarship as a basis for the educational curriculum.
• foster the relationship between research and education.
• describe the research facilities and priorities at the institution.
• ensure that interaction between research and education
- influences current teaching.
- encourages and prepares students to engage in dental research and development.

6.5. EDUCATIONAL EXPERTISE

The Educational Institution **must: -**

• have access to educational expertise where required.
• formulate and implement a policy on the use of educational expertise in
- curriculum development.
- development of teaching and assessment methods.
• demonstrate evidence of the use of in-house or external educational expertise in staff development.
• allow staff to pursue educational research interest.

6.6. EDUCATIONAL EXCHANGES

The Educational Institution **must: -**

• formulate and implement a policy for
- national and international collaboration with other educational institutions, including staff and student mobility.
- transfer of educational credits.

7. PROGRAMME EVALUATION

7.1. MECHANISMS FOR PROGRAMME MONITORING AND EVALUATION

The Educational Institution **must: -**

• have a programme of routine curriculum monitoring of processes and outcomes.
• establish and apply a mechanism for programme evaluation that
- addresses the curriculum and its main components.
- addresses student progress.
- identifies and addresses concerns.
• ensure that relevant results of evaluation influence the curriculum.

7.2. TEACHER AND STUDENT FEEDBACK

The Educational Institution **must: -**

• systematically seek, analyse, and respond to teacher and student feedback.
• consider feedback results as part of programme development.

7.3. PERFORMANCE OF STUDENTS AND GRADUATES

The Educational Institution **must: -**

• analyse performance of cohorts of students and graduates in relation to
- mission and intended educational outcomes.
- curriculum.
- provision of resources.
• analyse performance of cohorts of students and graduates in relation to student
- background and conditions.
- entrance qualifications.
• use the analysis of student performance to provide feedback to the committees responsible for
- student selection.
- curriculum planning.
- student counselling.

7.4. INVOLVEMENT OF STAKEHOLDERS

The Educational Institution **must: -**

• involve its principal stakeholders in its programme monitoring and evaluation activities.

8. GOVERNANCE AND ADMINISTRATION

8.1. GOVERNANCE

The Educational Institution **must: -**

• define its governance structures and functions including their relationships within the Parent Institution.
• set out the committee structure in its governance structures, and indicate representation from
- principal stakeholders.
- other stakeholders.
• ensure transparency of the work of governance and its decisions.

8.2. ACADEMIC LEADERSHIP

The Educational Institution **must: -**

• describe the responsibilities of its academic leadership for definition and management of the dental educational programme.

8.3. EDUCATIONAL BUDGET AND RESOURCE ALLOCATION

The Educational Institution **must: -**

• have a clear line of responsibility and authority for resourcing the curriculum, including a dedicated educational budget.
• allocate the resources necessary for the implementation of the curriculum and distribute the educational resources in relation to educational needs.
• have autonomy to direct resources, including teaching staff remuneration, in an appropriate manner in order to achieve its intended educational outcomes.

8.4. ADMINISTRATION AND MANAGEMENT

The Educational Institution **must: -**

• have an administrative and professional staff that is appropriate to
- support implementation of its educational programme and related activities.
- ensure good management and resource deployment.

8.5. INTERACTION WITH HEALTH AND EDUCATION SECTORS

The Educational Institution **must: -**

• have constructive interaction with the health and health-related sectors of society and government.
• have constructive interaction with the education sectors of society and government.
• have constructive interaction with similar institutions in other jurisdictions for bench-marking purposes

9. CONTINUOUS RENEWAL

The Educational Institution **must** as a dynamic and socially accountable institution: -

• initiate procedures for regularly reviewing and updating the process, structure, content, outcomes/competencies, assessment and learning environment of the programme.
• rectify documented deficiencies.
• allocate resources for continuous renewal.

Dental Council
An Comhairle Fiaclóireachta

Dental Council draft domains, competences and associated learning outcomes for undergraduate dentistry

DOMAIN 1: PROFESSIONALISM

AREA OF COMPETENCE: 1.1 ETHICS

Learning outcomes:
A graduating Dentist must be able to:

1.1.1	Apply core ethical principles to patient care and healthcare research
1.1.2	Differentiate between ethical or unethical situations and act on them appropriately
1.1.3	Apply ethical principles to the business aspects of dentistry
1.1.4	Demonstrate dignity and respect for others, without prejudice in respect of protected characteristics and social perceptions such as age, culture, diversity of background and opportunity, disability, gender, language, religion and sexual orientation
1.1.5	Demonstrate and ensure respect for patient confidentiality at all times, including situations outside the healthcare setting
1.1.6	Demonstrate respect for patient autonomy, patient choices and informed consent
1.1.7	Demonstrate candour and act without delay if they, or a colleague, or the environment in which they are providing care is putting someone at risk
1.1.8	Demonstrate digital professionalism by protecting patient data, and the appropriate use of social media and digital communication, mindful of how these activities may force them into ethically challenging situations and/or damage the reputation of the wider profession (bring it into disrepute).

AREA OF COMPETENCE: 1.2 REGULATION

Learning Outcomes:
A graduating Dentist must be able to:

1.2.1	Describe the regulation of the practice of dentistry, the local legal framework (of the country or organisation) and the various codes of practice related to dentistry, including the requirement to be registered with an appropriate regulatory body
1.2.2	Apply the law and guidelines relating to consent to all patients, including children and adults unable to consent for themselves
1.2.3	Describe, and ensure adherence to, the scope of practice of all members of the dental team
1.2.4	Adhere to the code or accepted standards of practice on advertising in all media
1.2.5	Discuss the implications of, and be able to comply with, general legislation or regulation in areas such as health and safety legislation, infection prevention and control procedures, data protection and the use of ionising radiation

AREA OF COMPETENCE: 1.3 PROFESSIONAL BEHAVIOUR

Learning outcomes:
A graduating Dentist must be able to:

1.3.1	Communicate effectively with patients (including parents and carers), colleagues in the dental team, other healthcare professionals, stakeholders and the public in general
1.3.2	Demonstrate a holistic approach to the provision of high-quality patient care at all times
1.3.3	Respect social concepts of health care, being conscious that it is a privilege to be entrusted with the health care of members of society and that with this privilege come responsibilities
1.3.4	Demonstrate patient-centred care, ensuring that patients' interests come first and acting to protect them at all times
1.3.5	Encourage and promote good general health in their patients
1.3.6	Demonstrate self-awareness and identify their own limitations through self-reflection, critical appraisal and peer review
1.3.7	Demonstrate conceptual reasoning skills to think through problems and know when to seek support or advice.
1.3.8	Select and prioritise treatment options that are sensitive to each patient's individual needs, goals and values, compatible with contemporary therapy and congruent with human rights, a comprehensive oral health care philosophy and healthcare economics
1.3.9	Demonstrate skills in reflection on their own decisions, actions and performance and be able to apply this to the process of continuing professional development
1.3.10	Demonstrate accountability and the need to explain their actions and decisions with openness and transparency
1.3.11	Describe the procedures involved in audit, clinical governance and peer review

DOMAIN 2: SAFE AND EFFECTIVE CLINICAL PRACTICE

AREA OF COMPETENCE: 2.1 EVIDENCE-BASED PRACTICE

Learning outcomes:
A graduating Dentist must be able to:

2.1.1	Demonstrate successful engagement with the scientific basis of dentistry, including the relevant biomedical sciences, the mechanisms of knowledge acquisition, scientific method and evaluation of evidence
2.1.2	Apply contemporaneous knowledge of basic biological, medical and clinical sciences to all clinical situations
2.1.3	Evaluate the validity of claims made by industry, primarily in relation to the risk, clinical benefit and cost of products and techniques
2.1.4	Evaluate published clinical, scientific and public health-related research and integrate this information to improve the oral health of the patient
2.1.5	Emphasise current concepts of oral health promotion, behaviour change, risk assessment and treatment of oral disease

AREA OF COMPETENCE: 2.2 MANAGEMENT AND LEADERSHIP

Learning outcomes:

A graduating Dentist must be able to:

2.2.1	Establish, manage and maintain a safe working environment
2.2.2	Effectively manage their own time and resources
2.2.3	Effectively integrate other members of the dental team with regard to risk management, for example: working posture, visual perception, the use of equipment, dealing with stress and burn-out, cross-infection control, working with hazardous chemicals and ionising radiation
2.2.4	Effectively raise concerns in an appropriate manner, at various levels, recognising that those who raise concerns are protected from discrimination
2.2.5	Manage adverse events in the short and longer term
2.2.6	Consider implementing changes within the team and the wider practise environment that will significantly improve efficiency and sustainability of resources

AREA OF COMPETENCE: 2.3 TEAM-WORKING AND COMMUNICATION

Learning outcomes:

A graduating Dentist must be able to:

2.3.1	Effectively lead all members of the dental team
2.3.2	Describe the role of all members of the dental team, and how they can contribute to a patient-centred approach to the delivery of safe and effective care
2.3.3	Request and share information and professional knowledge effectively, using verbal, written and electronic methods
2.3.4	Initiate appropriate referrals to effectively manage care including concerns regarding abuse and neglect
2.3.5	Request and correctly report on clinical laboratory and other diagnostic procedures and tests
2.3.6	Effectively engage with the wider healthcare team, as required, during routine and emergency care
2.3.7	Obtain informed consent by effectively explaining and discussing aspects of treatment planning to patients including risks, benefits and likely longevity of treatment interventions
2.3.8	Effectively explain to patients the properties of commonly used dental materials, their risks and intended benefits
2.3.9	Educate patients at all stages in their life, emphasising current concepts of oral health, prevention, risk assessment and treatment of oral disease
2.3.10	Assess and take account of the intellectual, socio-emotional and language development of patients
2.3.11	Effectively manage patients whose needs, desires and requirements may influence the planning and delivery of routine dental care
2.3.12	Increase the patient's awareness of their own role in the prevention of oral disease, creating personalised methods and approaches for each patient where possible
2.3.13	Explain and discuss the need for advanced procedures and know the appropriate and proper method of timely referral for interprofessional care
2.3.14	Evaluate the results of treatment and establish an effective monitoring and maintenance programme for patients, in cooperation with the wider dental team where appropriate

2.3.15	Manage acute oral conditions, including appropriate communication for patient referral and prescription of drugs
2.3.16	Counsel patients regarding the nature and severity of their diseases and disorders, providing the patient with realistic options, expectations of how these are managed, and likely prognoses
2.3.17	Communicate effectively with a laboratory technician to design and prescribe appropriate restorations and appliances
2.3.18	Conduct effective quality control of prostheses (fixed and removable) and appliances, including dental implants and their associated components
2.3.19	Train allied dental and medical healthcare workers in basic skills of oral health promotion
2.3.20	Display appropriate professional behaviour towards all members of the dental team and in their dealings with other allied healthcare workers

AREA OF COMPETENCE: 2.4 AUDIT AND RISK MANAGEMENT

Learning outcomes:

A graduating Dentist must be able to:

2.4.1	Produce and maintain an accurate, contemporaneous and secure patient record, in accordance with any legal requirements
2.4.2	Interpret, grade and audit radiographic and other diagnostic images
2.4.3	Effectively communicate and manage the hazards within the clinical environment including infection prevention and control, use of hazardous materials and working with ionising radiation
2.4.4	Conduct quality control of customised prostheses
2.4.5	Check and implement maintenance of, dental equipment in a timely manner
2.4.6	Evaluate the satisfaction/dissatisfaction of those directly involved with patient-centred care, including relatives and carers
2.4.7	Interpret, implement and disseminate aspects of audit and clinical governance

AREA OF COMPETENCE: 2.5 PROFESSIONAL EDUCATION AND TRAINING

Learning outcomes:

A graduating Dentist must be able to:

2.5.1	Use contemporary information technology for documentation, continuing education, communication, management of information and applications related to health care
2.5.2	Review the knowledge and skills base (their own, and that of the wider team) and seek additional information/training to correct any perceived limitations
2.5.3	Effectively appraise performance (their own, and that of the wider team) and seek additional training/support to correct any perceived deficiencies
2.5.4	Demonstrate a “record of clinical achievement,” ideally through the use of a contemporaneous portfolio of clinical activity and reflection; something to use with pride and to be of value as a learning tool that impacts positively on their future and continuing clinical and professional practise.

DOMAIN 3: PATIENT-CENTRED CARE

AREA OF COMPETENCE: 3.1: APPLYING THE SCIENTIFIC BASIS OF ORAL HEALTH CARE

Learning outcomes:
A graduating Dentist must be able to apply the scientific knowledge base relating to:

3.1.1	The aetiology, pathology, diagnosis and management of oral diseases and disorders including (but not exclusively): i) caries, ii) tooth surface loss, iii) gingival, periodontal and peri-implant diseases, iv) apical periodontitis, v) temporomandibular joint dysfunction and occlusal disharmony, vi) mucosal conditions and salivary pathology, vii) odontogenic cysts and tumours, viii) craniofacial disorders, dental and maxillofacial trauma and orofacial pain.
3.1.2	Normal craniofacial growth and development from birth through to adolescence
3.1.3	Normal and abnormal tooth development, tooth eruption and occlusal development of the primary, transitional and adolescent permanent dentition
3.1.4	Age-related changes in oral tissues and their associated functions
3.1.5	Social and behavioural sciences, including factors that facilitate the delivery of oral health care
3.1.6	Communication and language development, specifically of children and adolescents and those with special needs
3.1.7	Sterilisation, disinfection and decontamination, and the core principles of infection prevention and control
3.1.8	The hazards of ionising radiation and the regulations relating to its use
3.1.9	Disease processes relating to acute and chronic orofacial conditions, and how inflammation, disorders of the immune system, degeneration, neoplasia, metabolic disturbances and genetic disorders can impact on these
3.1.10	The aetiology and pathological features of common disorders of the major organ systems and their relationship with oral health
3.1.11	Pharmacology and therapeutics relevant to clinical practice
3.1.12	The science of dental materials, their risks, benefits and limitations including environmental/political issues relevant to their use
3.1.13	The potential limitations, risks and benefits of dental technological procedures
3.1.14	Methods of imaging relevant to Dentistry, including the principles that underpin dental radiographic and relevant imaging techniques
3.1.15	Clinical laboratory and other diagnostic procedures and tests
3.1.16	The impact of oral health on the quality of life
3.1.17	Behaviour change, in relation to oral and general health
3.1.18	Medical emergencies and their immediate management
3.1.19	The role of and indications for the use of sedation, particularly in the management of anxious or uncooperative patients, including those with systemic disease
3.1.20	The effects of tobacco, alcohol and substance abuse on general and oral health, and appropriate methods of intervention and referral
3.1.21	Abuse, neglect and non-accidental injury, and the safeguarding of individuals at risk of harm, including appropriate referral mechanisms

AREA OF COMPETENCE: 3.2: CLINICAL INFORMATION GATHERING AND DIAGNOSES

Learning outcomes:

A graduating Dentist must be able to effectively gather, record and interpret information relating to:

3.2.1	Patient presenting complaints, including a comprehensive history
3.2.2	Concerns, ideas and expectations of the patients or their carers
3.2.3	Medical, family, social and dental history
3.2.4	Extra-oral and intra-oral examination of the soft and hard tissues of the orofacial region, including radiographic imaging
3.2.5	i) caries, ii) tooth surface loss, iii) gingival, periodontal and peri-implant diseases, iv) apical periodontitis, v) temporomandibular joint dysfunction and occlusal disharmony, vi) mucosal conditions and salivary pathology, vii) odontogenic cysts and tumours, viii) craniofacial disorders, dental and maxillofacial trauma and orofacial pain—and the individual risk factors for each presenting condition
3.2.6	Dietary and behavioural analysis (particularly relating to oral hygiene practice and the use of tobacco and alcohol), identifying risk factors for oral health
3.2.7	Appropriate special investigations and diagnostic tests
3.2.8	Fixed and removable prostheses and dental implants
3.2.9	*A graduating Dentist must be able to utilise the information obtained in order to reach an appropriate diagnosis*

AREA OF COMPETENCE: 3.3: TREATMENT PLANNING

Learning outcomes:

A graduating Dentist must be able to:

3.3.1	Select and prioritise treatment options that are sensitive to each patient's individual needs, goals and values, compatible with contemporaneous methods of treatment
3.3.2	Identify relevant psychological and social factors that may complicate treatment planning, the delivery of care and appropriate maintenance/follow-up
3.3.3	Consider patient expectations, desires and attitudes when considering treatment planning and during treatment
3.3.4	Use behaviour and lifestyle analysis, identifying individual risk factors for oral health to develop a comprehensive prevention programme to maintain good oral health
3.3.5	Consider the implications of systemic disease and polypharmacy
3.3.6	Consider the specific needs of the very young or anxious patient, the older patient or any other patient with special needs, including the need for domiciliary care
3.3.7	Appropriately prescribe direct, fixed and removable restorations, implants and removable prostheses
3.3.8	Evaluate the results of various therapies, and establishing a monitoring and maintenance programme, involving the wider dental team where appropriate
3.3.9	Participate in the prompt and proper referral and coordination of patients with life-threatening conditions (such as oral cancer) and in situations where their own knowledge and

	skills are not appropriate enough to provide adequate treatment (e.g. in relation to orthodontics, oral medicine, implant therapy or in relation to general anaesthesia)

AREA OF COMPETENCE: 3.4: ESTABLISHING AND MAINTAINING ORAL HEALTH

Learning outcomes:
A graduating Dentist must be able to:

3.4.1	Develop strategies to predict, prevent and correct deficiencies in a patient's oral hygiene regime, work with the patient supportively to optimise their oral hygiene regime and provide patients with strategies to control habits that impact negatively on their oral health
3.4.2	Prescribe and apply fluoride, provide dietary advice and carry out minimally invasive restorative procedures that prevent hard tissue disease
3.4.3	Provide preventive advice and carry out operative interventions to promote periodontal and soft tissue health
3.4.4	Manage the deterioration and failure of restorations in clinical practice
3.4.5	Select and prescribe drugs for the management of pain and anxiety, whilst acting as a responsible antibiotic guardian
3.4.6	Administer infiltration and block local anaesthesia in the oral cavity for restorative and surgical procedures, and manage potential complications
3.4.7	Perform periodontal therapy (including prophylaxis, stain removal, biofilm removal, supragingival and subgingival root surface debridement) using both powered and manual instrumentation
3.4.8	Perform procedures to preserve the vitality of all or part of the pulp and to promote repair mechanisms in the dentine-pulp complex
3.4.9	Perform procedures designed to alter the colour of teeth
3.4.10	Perform nonsurgical root canal treatment of uncomplicated single rooted and multirooted teeth
3.4.11	Manage dental emergencies of the primary and permanent dentition including those of pulpal, periodontal or traumatic origin
3.4.12	Provide direct restorations, indirect fixed restorations, removable prostheses and occlusal splints
3.4.13	Design appliances and prescribe laboratory procedures, being able to make appropriate chair-side adjustments.
3.4.14	Engage with the planning of dental implants, with a view to being able to place and restore straightforward implants following suitable postgraduate training
3.4.15	Perform extractions of erupted teeth including surgery for the straightforward removal of fractured or retained roots and partially erupted teeth
3.4.16	Design, insert and adjust space maintainers and active removable appliances to manage simple malocclusions
3.4.17	Manage failing dentitions using techniques that are sympathetic to the patient's needs and the healthcare setting
3.4.18	Develop a programme to monitor and maintain interventions, most notably in relation to periodontal health, direct restorations and the fitting of fixed and removable prostheses
3.4.19	Manage medical emergencies that may occur in the course of dental practice

DOMAIN 4: DENTISTRY IN SOCIETY

AREA OF COMPETENCE: 4.1: DENTAL PUBLIC HEALTH

Learning outcomes:
A graduating Dentist must be able to:

4.1.1.	Define Dental Public Health and discuss its implications for dental practice
4.1.2.	Describe effective public health strategies
4.1.3.	Discuss oral and systemic diseases, and their associated risk factors, which are recognised public health problems
4.1.4.	Advocate for oral and general health with patients and the community including policy leaders

AREA OF COMPETENCE: 4.2: HEALTH AND DISEASE PREVENTION

Learning outcomes:
A graduating Dentist must be able to:

4.2.1.	Describe concepts and definitions of general and oral health
4.2.2.	Discuss the social determinants of health (and health inequalities)
4.2.3.	Appraise the importance of context, when applying the evidence base for health promotion
4.2.4.	Evaluate the importance and limitations of behaviour change at population level
4.2.5.	Appraise the importance of professional advocacy for population health in achieving change
4.2.6.	Describe and implement interprofessional approaches to disease prevention and promotion, including the training of nondental health care providers
4.2.7.	Discuss and advocate for a common risk factor approach in promoting health
4.2.8.	Discuss approaches to health promotion and disease prevention which address inequalities in health

AREA OF COMPETENCE: 4.3: POPULATION DEMOGRAPHY, HEALTH AND DISEASE

Learning outcomes:
A graduating Dentist must be able to:

4.3.1.	Describe demographic trends and discuss their implications
4.3.2.	Describe the process of assessing population oral health needs including the use of epidemiological tools and indicators
4.3.3.	Discuss the trends of oral diseases
4.3.4.	Discuss national and global oral health trends and their implications
4.3.5.	Discuss political, social and economic trends and their implications for health
4.3.6.	Describe inequalities in health and oral health
4.3.7.	Discuss and promote the association of oral health with general health and quality of life, including common risk factors for disease

AREA OF COMPETENCE: 4.4: HEALTHCARE SYSTEMS

Learning outcomes:

A graduating Dentist must be able to:

4.4.1.	Debate the organisation and delivery of oral health care in relation to equity (public and private) of access, quality and outcomes
4.4.2.	Discuss evidence-based population healthcare interventions
4.4.3.	Describe known oral health, and wider health, policies
4.4.4.	Describe the general mechanisms of delivering health care
4.4.5.	Describe various remuneration and payment systems and debate their merits
4.4.6.	Discuss examples of changes in health services at local and national levels in support of health
4.4.7.	Describe available career choices and training opportunities

AREA OF COMPETENCE: 4.5: PLANNING FOR HEALTH AND ORAL HEALTH

Learning outcomes:

A graduating Dentist must be able to:

4.5.1.	Provide examples of effective public health interventions
4.5.2.	Discuss strategies to best use dental (and wider health care) teams for oral health
4.5.3.	Discuss future research needed to inform oral health promotion, disease prevention and the delivery of dental care
4.5.4.	Discuss principles of coproduction of care with local communities

Dental Council
An Comhairle Fiaclóireachta

Draft annotations and suggested evidence to support engagement with the Dental Council's accreditation process (January 2022)

Introduction

The following material is intended to support programmes and institutions in their engagement with the Dental Council's accreditation process. It is intended to clarify the context and intention behind the Dental Council's requirements, and to suggest non-exhaustive sources of documentary evidence that could be considered by institutions to demonstrate adherence to requirements. It is also intended to support programmes and institutions to prepare their students for practice in an Irish healthcare setting. It is intended to also complement the requirements by providing specific references where such specific references are deemed appropriate.

It is intended that this document will be updated on a regular basis as national policy develops, as additional relevant benchmarks are identified, and as the Dental Council identifies new priorities which should be supported by programmes.

The document is presented in two sections – Section One relates to the annotations and suggested evidence relevant to the accreditation standards. Section Two relates to the Dental Council domains, competences and associated earning outcomes for undergraduate dentistry.

Section One – Accreditation Standards

1.1. MISSION

Annotations:

• *Mission* provides the overarching frame to which all other aspects of the educational institution and its programme have to be related. Mission statement would include general and specific issues relevant to institutional, national, regional and global policy and needs. Mission in this document includes the institutions' vision.

• *Educational Institution* in this document is the educational organisation providing a programme in dentistry or an auxiliary dental profession.

• *Constituency* would include the leadership, staff and students of the Educational Institution as well as other stakeholders.

• *Life-long learning* is the professional responsibility to keep up to date in knowledge and skills through appraisal, audit, reflection or continuing professional development (CPD) activities.

• *Encompassing the health needs of the community* would imply interaction with the local community, especially the health and health related sectors, and adjustment of the curriculum to demonstrate attention to and knowledge about health problems of the community.

• *Social accountability* would include willingness and ability to respond to the needs of society, of patients and the health and health related sectors.

Suggested evidence:

✓ Confirmation of the mission statement which addresses each aspect of the standard.

1.2. INSTITUTIONAL AUTONOMY

Annotations:

• *Institutional autonomy* would include appropriate independence to be able to make decisions about key areas such as design of curriculum, assessments, student admission, staff recruitment / selection and employment conditions, research and resource allocation.

Suggested evidence:

✓ Confirmatory statement confirming that the standard is being met.

✓ Confirmation from Parent Institution that such autonomy is supported.

✓ Governance documentation which confirms how and where key decisions are made.

✓ Terms of Reference of committees with responsibility for key decision-making and policy formulation.

1.3. EDUCATIONAL OUTCOMES

Annotations:

• *Educational outcomes* or learning outcomes/competencies refer to statements of knowledge, skills and attitude that students demonstrate at the end of a period of learning. The educational outcomes must align with the associated competencies, learning outcomes and scopes of practice approved by the Dental Council for each member of the dental team.

• *Appropriate student conduct* would presuppose a written code of conduct.

Suggested evidence:

✓ A detailed mapping document which relates the programme to the associated competencies, learning outcomes and scope of practice. It is likely that the same detailed mapping document could suffice at evidence towards meeting a number of standards.

✓ A copy of the student code conduct document and details of the extent to which this document is brought to the attention of students.

✓Details of any formal or informal mechanisms through which student conduct is monitored and encouraged or addressed as necessary.

1.4. PARTICIPATION IN FORMULATION OF MISSION AND OUTCOMES

Annotations:

• *Principal stakeholders* would include as appropriate the dean, the faculty board/council, the curriculum committee, programme leads, representatives of staff and students, the parent institution leadership and administration, relevant governmental authorities and regulatory bodies.

• *Other stakeholders* would include representatives of other health professions, patients, the community and public (e.g. users of the health care delivery systems, including patient organisations). Other stakeholders would also include other representatives of academic and administrative staff, education and health care authorities, professional organisations, scientific societies and postgraduate medical educators.

Suggested evidence:

✓ Description of the mechanisms through which such inputs are sought and considered.

✓ Details of the range of stakeholders whose contributions are formally sought, and the frequency of such engagements.

✓ Specific examples of stakeholder contributions leading to enhanced mission and/or outcomes.

2. Educational Programme

2.1. FRAMEWORK OF THE PROGRAMME

Annotations:

• *Overall curriculum* in this document refers to the specification of the educational programme, including a statement of the intended educational outcomes, the content/syllabus, learning experiences and processes of the programme. The curriculum should set out what knowledge, skills, and attitudes the student will achieve. Also, the curriculum would include a description of the planned instructional and learning methods and assessment methods. Curriculum description would sometimes include models based on disciplines, clinical problems/tasks or disease patterns as well as models based on modular or spiral design. The curriculum would be based on contemporary learning principles.

• Sound scientific knowledge is critical for healthcare professionals to rationalise their treatment choices and offer patient-centred integrated oral health care. The scientific basis of Dentistry is vast, and it is recommended that educators refer to specialist societies and the curricula/guidelines, that

they have published, in order to detail specific learning outcomes that map contemporaneously to individual areas of specialist practice.

• *Instructional/ learning methods* would encompass lectures, small-group teaching, problem-based or case-based learning, peer-assisted learning, practicals, supervised patient care, laboratory exercises, clinical demonstrations, clinical skills laboratory training, field exercises in the community and web--based instruction.

• *Principles of equality* mean equal treatment of staff and students irrespective of gender, ethnicity, religion, sexual orientation, socio--economic status, and taking into account physical capabilities.

Suggested evidence:

✓ Copy of programme material that is made available to staff and students.

✓ Copy syllabus and curriculum.

✓ Module descriptions and content.

✓ A comprehensive document (or series of documents) to provide the following: -

> Demonstration that the Dental Council competences and learning outcomes are embedded in the programme
> Demonstration that the relevant Dental Council scope of practice is embedded in the programme
> Duration of the programme and confirmation of ECTS credits
> Confirmation of how the minimum requirements of Professional Qualifications Directive are being met

2.2. SCIENTIFIC METHOD

Annotations:

• To *teach the principles of scientific method, research methods and evidence-based practice* requires scientific competencies of teachers. This training would be a compulsory part of the curriculum and would include that students conduct or participate in minor research projects.

• *Evidence-based practice* means practice founded on documentation, trials and accepted scientific results.

Suggested evidence:

✓ Description of the prominence of the scientific method throughout the curriculum.

✓Reference to the relevant modules in any curriculum documents furnished to Dental Council.

2.3. BASIC BIOMEDICAL SCIENCES

Annotations:

• *The basic biomedical sciences* would -- depending on local needs, interests and traditions -- include anatomy, biochemistry, biophysics, cell biology, genetics, immunology, microbiology molecular biology, pathology, pharmacology and physiology.

• Some students entering dentistry may not have completed Chemistry or Physics at Leaving Certificate level, or equivalent. An understanding of these subjects is essential for the understanding of many facets of oral health and treatments. While this is likely to be reflected in the minimum entry requirements for programmes, there may be an opportunity to actively establish whether students are at a similar starting point and/or to consider signposting additional resources for those students who feel they may benefit from same.

Suggested evidence:

✓ Description of the prominence of the basic biomedical sciences throughout the curriculum.

✓ Reference to the relevant modules in any curriculum documents furnished to Dental Council.

2.4. BEHAVIOURAL AND SOCIAL SCIENCES, DENTAL ETHICS, REGULATION

Annotations:

• *Behavioural and social sciences* would -- depending on local needs, interests and traditions -- include biostatistics, community medicine, epidemiology, global health, hygiene, psychology, sociology, public health.

• *Dental ethics* deals with moral issues in dental practice such as values, rights and responsibilities related to practitioner behaviour and decision making.

• *Regulation* includes laws and other regulations of the health care delivery system which are applicable to the practice of dentistry.

• These areas provide the knowledge, concepts, methods, skills and attitudes necessary for understanding socio-economic, demographic and cultural determinants of causes, distribution and consequences of health problems as well as knowledge about the national health care system and patients' rights. This would enable analysis of health needs of the community and society, effective communication, clinical decision making and ethical practices. The Dental Council anticipates that these matters would be fully addressed by programmes.

Suggested evidence:

✓ Description of the prominence of behavioural and social sciences throughout the curriculum.

✓ Description of the prominence of ethical practice and regulation throughout the curriculum.

✓ Reference to the relevant modules in any curriculum documents furnished to Dental Council.

2.5. CLINICAL SCIENCES AND SKILLS

Annotations:

• *Clinical skills* include history taking, physical examination, communication skills, procedures and investigations, and prescription and treatment practices.

• *Professional skills* would include patient management skills, team-work/team leadership skills and inter-professional training.

• *Appropriate clinical responsibility* would include activities related to health promotion, disease prevention and patient care.

• *Planned contact with patients* would imply consideration of purpose and frequency sufficient to put their learning into context.

• *Patient safety* would require supervision of clinical activities conducted by students.

• *Participation in patient care* would include responsibility under supervision for parts of investigations and/or treatment to patients, which could take place in relevant community settings.

Suggested evidence:

✓ Description of the prominence of clinical sciences and skills throughout the curriculum.

✓ Reference to the relevant modules in any curriculum documents furnished to Dental Council.

✓ Description of the sequencing and oversight of student/patient contact in the programme.

✓ Description of the opportunities provided to work within a dental team, and the opportunities to learn and provide patient care alongside colleagues from allied health professions.

2.6. PROGRAMME STRUCTURE, COMPOSITION AND DURATION

Suggested evidence:

✓ Description (and potentially an accompanying mapping document) of how this standard is being met and how the relevant co-ordination and integration is being met.

✓ Year and term timetables.

2.7. PROGRAMME MANAGEMENT

Annotations:

• *The authority of the curriculum committee* would include authority over specific departmental and subject interests, and the control of the curriculum within existing rules and regulations as defined by the governance structure of the institution and governmental authorities. The curriculum

committee would allocate the granted resources for planning and implementing methods of teaching and learning, assessment of students and course evaluation.

Suggested evidence:

✓ Terms of Reference and membership details of the relevant committee.

2.8. LINKAGE WITH THE DENTAL PROFESSION AND THE HEALTH SECTOR

Annotations:

• The *operational linkage* implies identifying dental health problems and defining required educational outcomes. This requires clear definition and description of the elements of the educational programmes and their interrelations in the various stages of training and practice, paying attention to the local, national, regional and global context. It would include mutual feedback to and from the health sector and participation of teachers and students in activities of the health team. Operational linkage also implies constructive dialogue with potential employers of the graduates as basis for career guidance.

Suggested evidence:

✓ Description of engagement with Government, Department of Health, national oral health policy, overarching general health strategy, dental representative bodies and unions, patient groups, professional bodies, specialist societies.

✓ Description of the opportunities afforded to external stakeholders to contribute to the Institution's activities. Details of the extent to which these opportunities are taken up by stakeholders.

3. Assessment of Students

3.1. ASSESSMENT METHODS

Annotations:

• *Assessment methods* used would include consideration of the balance between formative and summative assessment, the number of examinations and other tests, the balance between different types of examinations (written and oral), the use of normative and criterion--referenced judgements, and the use of personal portfolio and log--books and special types of examinations, e.g. objective structured clinical examinations (OSCE). It would also include systems to detect and prevent plagiarism.

• It is increasingly common for schools to employ an electronic portfolio combining clinical activity, performance and reflective practise in order to longitudinally track student progress and this approach is recommended.

• *"Assessment utility"* is a term combining validity, reliability, educational impact, acceptability and efficiency of the assessment methods and formats.

• *Evaluate and document the reliability and validity of assessment methods* would require an appropriate quality assurance process of assessment practices.

• *Use of external examiners* will increase fairness, quality and transparency of assessments.

• Educators are referred to the Association for Dental Education in Europe (ADEE) 2017 paper *The Graduating European Dentist: Contemporaneous methods of Teaching, Learning and Assessment in Dental Undergraduate Education*. The Dental Council considers this to be a valuable resource for educators and aligns well with the domains, competences and learning outcomes which the Dental Council has adapted from the ADEE's publications in this area.

• The validation of school educational processes is very important, particularly those surrounding assessment. As well as considering the opinions and experiences of staff and students internally, external review is valuable to an institution because it allows programmes and student cohorts to be compared with the wider educational community. External review can also provide reassurance for students about the fairness of assessment processes. Involving students in the quality assurance of assessment is becoming increasingly common. At the same time, staff involved in examining need to be trained and calibrated appropriately—this also extends to staff who are assessing formatively as part of a more longitudinal process, such as the recording of portfolio grades. Patient feedback is a potentially valuable source of information for individual students, although as yet there are limited data showing any correlation with the development of professional attitudes and behaviours. Nonetheless, it is important that strategies are in place to record comments and inform students of positive and negative feedback. These data can be held by the student and used as part of the reflective process and held by the institution and used as to facilitate progression, or fitness to proceed processes.

• The Dental Council anticipates that the above will be fully reflected by programmes.

Suggested evidence:

✓ Description and breakdown of the range of assessment methods employed.

✓ Detailed confirmation of how each component of the standard is being met.

✓ External examiner reports

3.2. RELATION BETWEEN ASSESSMENT AND LEARNING

Annotations:

• *Assessment principles, methods and practices* refer to assessment of student achievement and would include assessment in all domains: knowledge, skills and attitudes.

• *Decisions about academic progress* would require rules of progression and their relationship to the assessment process.

• *Adjustment of number and nature of examinations* would include consideration of avoiding negative effects on learning. This would also imply avoiding the need for students to learn and recall excessive amounts of information and curriculum overload.

• *Encouragement of integrated learning* would include consideration of using integrated assessment, while ensuring reasonable tests of knowledge of individual disciplines or subject areas.

• It is the role of dental educators to produce clinicians who are patient-centred, who will act as advocates for high-quality patient care, and who will be resilient enough to maintain professional standards in challenging circumstances. The challenge is to identify students who (despite passing written, practical and clinical assessments) fail to engage in professional behaviour over a longitudinal period. A fair and robust process, with a range of possible interventions and sanctions, is required to manage these students. The Dental Council anticipates that this issue would be proactively addressed by programmes while respecting the overarching processes of the parent organisation.

Suggested evidence:

✓ Description of the relationship between assessment and learning.

✓ Description of the process by which the Institution identifies the most appropriate assessment principles, methods and practices which achieve the requirements of this standard.

✓ Describe the range of opportunities that exist, formal and informal, to provide feedback to students.

✓ Description of the process used to manage students who fail to engage in professional behaviour and who may not be suited to a career in dentistry.

4. Students

4.1. ADMISSION POLICY AND SELECTION

Annotations:

• *Admission policy* would imply adherence to possible national regulation as well as adjustments to local circumstances. If the Educational Institution does not control admission policy, it would demonstrate responsibility by explaining relationships and drawing attention to consequences, e.g. imbalance between intake and teaching capacity.

• The *statement on process of selection of students* would include both rationale and methods of selection such as secondary school results, other relevant academic or educational experiences, entrance examinations and interviews, including evaluation of motivation to become dentists. Selection would also take into account the need for variations related to diversity of medical practice.

• It is accepted that many aspects of the admission policy and entry criteria will be determined at university level and subject to broader national requirements. There is an opportunity for dental educational institutions to confirm the extent of their input in this area, and to confirm if mechanisms exist through which institutions can provide feedback on the appropriateness of entry criteria.

• *Policy and practice for admission of disabled students* will have to be in accordance with national law and regulations.

• *Transfer of students* would include dental students from other Educational Institutions and potentially students from other programmes.

Suggested evidence:

✓ Copy of the admissions policy and other supporting documentation in this area.

4.2. STUDENT INTAKE

Annotations:

• Decisions on *student intake* would imply necessary adjustment to national requirements for dental workforce. If the Educational Institution does not control student intake, it would demonstrate responsibility by explaining relationships and drawing attention to consequences, e.g. imbalance between intake and teaching capacity.

• *The health needs of the community and society* would include consideration of intake according to gender, ethnicity and other social requirements including the potential need of a special recruitment, admission and induction policy for underprivileged students and minorities.

Suggested evidence:

✓ Confirmation of the size of the student intake and the student cohort as a whole.

✓ Confirmation of the factors, internal and external, which define the size of the student intake.

✓ Confirmation of the process by which changes to the size of the student intake are considered.

4.3. STUDENT COUNSELLING AND SUPPORT

Annotations:

• *Academic counselling* would include questions related to choosing electives, preparing for clinical/patient contact and career guidance. Organisation of the counselling would include appointing academic mentors for individual students or small groups of students.

• *Addressing social, financial and personal needs* would mean professional support in relation to social and personal problems and events, health problems and financial matters, and would include signposting the access to health clinics, and financial advice and/or assistance.

Suggested evidence:

✓ Description of the range of resources available to students.

✓ Confirmation of whether such resources are specific in-house, shared.

✓ Description of the means by which these resources are brought to the students' attention, and subsequently signposted.

✓ An indication of the scale of engagement with these resources by the student population.

✓ The results of any surveys conducted amongst students to establish knowledge of, and satisfaction with, student support services.

✓ Documentation outlining student disciplinary processes including management of unprofessional behaviour.

4.4. STUDENT REPRESENTATION

Annotations:

• *Student representation* would include student self-governance and representation on the curriculum committee, other educational committees, scientific and other relevant bodies as well as social activities and local health care projects.

Suggested evidence:

✓ Details on the policy in place to provide for student representation.

✓ Details of the opportunities available for students to contribute to programme design, committee membership etc.

✓ Details of how such opportunities are brought to the attention of students.

✓ Details of the extent to which such opportunities are availed of by students.

5. Academic Staff/Faculty

5.1. RECRUITMENT AND SELECTION POLICY

Annotations:

• The *staff recruitment and selection policy* would include ensuring a sufficient number of highly qualified basic biomedical scientists, behavioural and social scientists and clinicians to deliver the curriculum and a sufficient number of experienced researchers in relevant disciplines or subjects.

• *Balance of academic staff/faculty* would include staff with joint responsibilities in the basic biomedical, the behavioural and social and clinical sciences in the Parent Institution and health care facilities, and teachers with dual appointments.

• *Balance between dental and non-dental staff* would imply consideration of sufficient dental orientation of the qualifications of non-dentally educated staff.

• *Merit* would be measured by formal qualifications, professional experience, research output, teaching awards and peer recognition.

• *Service functions* would include clinical duties in the health care delivery system, as well as participation in governance and management.

• *Significant local issues* would include gender, ethnicity, religion, language and other items of relevance to the school and the curriculum.

Suggested evidence:

✓ Details of the staff recruitment and selection policy to address each aspect of the Standard.

✓ Details of staffing numbers and profile to address each aspect of the Standard.

5.2. STAFF ACTIVITY AND STAFF DEVELOPMENT

Annotations:

• The *balance of capacity between teaching, research and service functions* would include provision of protected time for each function, taking into account the needs of the Educational Institution and professional qualifications of the teachers.

• *Recognition of meritorious academic activities* would be through rewards, promotion and/or remuneration.

• *Sufficient knowledge of the total curriculum* would include knowledge about instructional/learning methods and overall curriculum content in other disciplines and subject areas with the purpose of fostering cooperation and integration.

• *Teacher training, development, support and appraisal* would involve all teachers, not only new teachers, and would include part-time teachers.

• The example demonstrated by staff is hugely influential in forming students' attitudes to professionalism. Teaching staff may be unaware of their potential impact in this respect. Structured and regular staff training provides a useful method to ensure all staff are providing the same level of teaching and are familiar with the curriculum. It is expected that a dental teaching institution will ensure that all policies, procedures and protocols are updated and aligned to a contemporaneous evidence base—and that teaching staff adopt a professional attitude in adhering to these requirements, and undertake appropriate training and development in terms of their professional, scientific, and pedagogic expertise. Academic staff may find it useful to align their professional activities to existing standards for dental educators.

Suggested evidence:

✓ Details of any overarching policy which draws together the components of this standard.

✓ Documentation which protects teaching time, requires minimum research output or establishes minimum service commitments.

✓ Details of staff development opportunities to full and part-time staff.

✓ Details of the extent to which these opportunities are availed of, including whether engagement with such opportunities are mandatory or otherwise.

6. Educational Resources

6.1. PHYSICAL FACILITIES

Annotations:

• *Physical facilities* would include lecture halls, class, group and tutorial rooms, teaching and research laboratories, clinical skills laboratories, offices, libraries, information technology facilities and student amenities such as adequate study space, lounges, transportation facilities, catering, student housing, personal storage lockers, sports and recreational facilities.

• *A safe learning environment* would include provision of necessary information and protection from harmful substances, specimens and organisms, laboratory safety regulations and safety equipment.

Suggested evidence:

✓ Description of the physical facilities available for staff and students.

✓ Details of any process which monitors the ongoing adequacy of such resources.

✓ Benchmarks or comparators which supports the Institution's consideration of such matters.

✓ Description of the range of safety measures, protocols and processes which collectively operate to protect staff, students and patients.

6.2. CLINICAL TRAINING RESOURCES

Annotations:

• *Patients* may include validated simulation using standardised patients or other techniques, where appropriate, to complement, but not substitute clinical training.

• *Clinical training facilities* would include hospitals, primary health care settings, health care centres and other community health care settings as well as skills laboratories, allowing clinical training to be organised using an appropriate range of clinical settings.

Suggested evidence:

✓ Description of the range of clinical resources made available to students.

✓ Confirmation of the timing and frequency of patient contact through training.

✓ Description of the mechanism which supports students having access to an appropriate case-mix.

✓ Description of the process through which deficits in the case-mix are addressed.

✓ Description of nature and scale of the supervisory arrangements in place to protect students and patients.

6.3. INFORMATION TECHNOLOGY

Annotations:

• *Effective and ethical use of information and communication technology* would include use of computers, mobile telephones, internal and external networks and other means as well as coordination with library services. The policy would include common access to all educational items through a learning management system. Information and communication technology would be useful for preparing students for evidence-based practice and life-long learning through continuing professional development (CPD).

• *Ethical use* refers to the challenges for both practitioner and patient privacy and confidentiality following the advancement of technology in dental education and health care. Appropriate safeguards would be included in relevant policy to promote the safety of practitioners and patients while empowering them to use new tools.

Suggested evidence:

✓ Copy of any policies which set out the appropriate use and method of engagement with such technology.

✓ Details of engagement with students to confirm the personal and professional boundaries which must be respected when using such technology.

✓ Details of facilities made available to students to support their access to online or network resources.

6.4. RESEARCH AND SCHOLARSHIP

Annotations:

• *Dental research and scholarship* encompasses scientific research in basic biomedical, clinical, behavioural and social sciences.

Suggested evidence:

✓ Confirmation of the role of research in the Institution, and any policies or processes which link research capacity and output to the programme.

✓ Confirmation of teaching of research methodologies.

✓ Details of research output of the Institution.

6.5. EDUCATIONAL EXPERTISE

Annotations:

• *Educational expertise* would deal with processes, practice and problems of dental education and would include dental professionals with research experience in dental education, educational psychologists and sociologists. It can be provided by an education development unit or a team of interested and experienced teachers at the institution or be acquired from another national or international institution.

Suggested evidence:

✓ Details of the full range of educational expertise available within the Institution, and additional expertise made available to the Institution by the Parent Institution.

✓ Description of the processes by which such expertise is drawn upon.

✓ Description of the supports available to staff to pursue research interests.

6.6. EDUCATIONAL EXCHANGES

Annotations:

• *Other educational institutions* would include other Educational Institutions as well as other faculties and institutions for health education.

• A *policy for transfer of educational credits* would imply consideration of limits to the proportion of the study programme which can be transferred from other institutions. Transfer of educational credits would be facilitated by establishing agreements on mutual recognition of educational elements and through active programme coordination between Educational Institutions. It would also be facilitated by use of a transparent system of credit units and by flexible interpretation of course requirements.

• *Staff* would include academic, administrative and technical staff.

Suggested evidence:

✓ Details of policies which drive collaboration with peer organisations within and outside the jurisdiction, including with allied healthcare education institutions.

✓ Examples of noteworthy collaborations.

7. Programme Evaluation

7.1. MECHANISMS FOR PROGRAMME MONITORING AND EVALUATION

Annotations:

• *Programme monitoring* would imply the routine collection of data about key aspects of the curriculum for the purpose of ensuring that the educational process is on track and for identifying any areas in need of intervention. The collection of data is often part of the administrative procedures in connection with admission of students, assessment and graduation.

• *Programme evaluation* is the process of systematic gathering of information to judge the effectiveness and adequacy of the institution and its programme. It would imply the use of reliable and valid methods of data collection and analysis for the purpose of demonstrating the qualities of the educational programme or core aspects of the programme in relation to the mission and the curriculum, including the intended educational outcomes. Involvement of external reviewers from other institutions and experts in dental education would further broaden the base of experience for quality improvement of dental education at the institution.

• *Main components of the curriculum* would include the curriculum model, curriculum structure, composition and duration.

• *Identified concerns* would include insufficient fulfilment of intended educational outcomes. It would use measures of and information about educational outcomes, including identified weaknesses and problems, as feedback for interventions and plans for corrective action, programme development and curricular improvements; this requires safe and supporting environment for feedback by teachers and students.

Suggested evidence:

✓ Details of the mechanisms as set out in the Standard. These details should include the processes and frequency of such activity.

✓ Details of the full range of contributors to such activity whether internal, from Parent Institution or outside agencies / stakeholders, and the corresponding reports & outcomes of such activities.

✓ Examples of some identified concerns and confirmation of how these concerns were remedied.

7.2. TEACHER AND STUDENT FEEDBACK

Annotations:

• *Feedback* would include students' and teachers' reports and other information about the processes and products of the educational programmes.

Suggested evidence:

✓ Description of the processes by which such feedback is sought, analysed and acted upon as necessary.

7.3. PERFORMANCE OF STUDENTS AND GRADUATES

Annotations:

• Measures and analysis of *performance of cohorts of students* would include information about actual study duration, examination scores, pass and failure rates, success and dropout rates and reasons, student reports about conditions in their courses. It would also include interviews of students frequently repeating courses and exit interviews with students who leave the programme.

• Measures of *performance of cohorts of graduates* would include information on career choice and further professional development.

• *Student background and conditions* would include social, economic and cultural circumstances.

Suggested evidence:

✓ Details of the processes by which the performance of students and graduates are analysed.

✓ Sample analyses of student performance, corresponding feedback to and from committees.

✓ Details of engagement with graduates to establish employment status, location, career aspirations, further professional development.

7.4. INVOLVEMENT OF STAKEHOLDERS

Suggested evidence:

✓ Details of the process by which such stakeholder inputs are sought and supported.

✓ Details of the range of stakeholders who routinely contribute in this area.

8. Governance and Administration

8.1. GOVERNANCE

Annotations:

• *Governance* means the act and/or the structure of governing the Educational Institution. Governance is primarily concerned with policy making, the processes of establishing general institutional and programme policies and also with control of the implementation of the policies.

The institutional and programme policies would normally encompass decisions on the mission of the institution, the curriculum, admission policy, staff recruitment and selection policy and decisions on interaction and linkage with dental practice and the health sector as well as other external relations.

• *Relationships within the Parent Institution* of its governance structures would be specified, for example if the Educational Institution is part of or affiliated to a university.

• *The committee structure*, which includes a curriculum committee, would define lines of responsibility.

• *Transparency* would be obtained by newsletters, web--information or disclosure of minutes.

Suggested evidence:

✓ Description and accompanying diagram of the governance structure.

✓ Terms of reference for key committees to include extent of decision-making powers.

✓ Membership lists of key committees confirming each member's route to the committee e.g. representative, nominated, elected, other.

8.2. ACADEMIC LEADERSHIP

Annotations:

• *Academic leadership* refers to the positions and persons within the governance and management structures being responsible for decisions on academic matters in teaching, research and service and would include dean, deputy dean, vice deans, provost, heads of departments, programme leads, course leaders, directors of research institutes and centres as well as chairs of standing committees (e.g. for student selection, curriculum planning and student counselling).

Suggested evidence:

✓ Description of responsibilities of senior staff.

✓ Confirmation of associated line-management / reporting arrangements.

8.3. EDUCATIONAL BUDGET AND RESOURCE ALLOCATION

Annotations:

• *The educational budget* would depend on the budgetary practice in each institution and on national policy and practice. It would be linked to a transparent budgetary plan for the Educational Institution.

• *Resource allocation* presupposes institutional autonomy.

Suggested evidence:

✓ Description of how the programme is resourced and how resources are allocated.

✓ Description of how budgeting or resourcing deficits are managed.

✓ Confirmation of the extent to which the Institution has autonomy in this area from Parent Institution.

8.4. ADMINISTRATION AND MANAGEMENT

Annotations:

• *Management* means the act and/or the structure concerned primarily with the implementation of the institutional and programme policies including the economic and organisational implications i.e. the actual allocation and use of resources within the Educational Institution. Implementation of the institutional and programme policies would involve carrying into effect the policies and plans regarding mission, the curriculum, admission, staff recruitment and external relations.

• *Administrative and professional staff* in this document refers to the positions and persons within the governance and management structures being responsible for the administrative support to policy making and implementation of policies and plans and would -- depending on the organisational structure of the administration -- include head and staff in the dean's office or secretariat, heads of financial administration, staff of the budget and accounting offices, officers and staff in the admissions office and heads and staff of the departments for planning, personnel and IT.

• *Appropriateness of the administrative staff* means size and composition according to qualifications.

Suggested evidence:

✓ Overall staffing profile of administrative and management colleagues confirming range of professional expertise and supports available to the programme and to the Institution generally.

✓ Description of process by which deficits in such expertise are identified and remedied.

8.5. INTERACTION WITH HEALTH AND EDUCATION SECTORS

Annotations:

• *Constructive interaction* would imply exchange of information, collaboration, and organisational initiatives. This would facilitate provision of dental professionals with the qualifications needed by society.

• *The health sector* would include the health care delivery system, whether public or private.

• *The health--related sector* would -- depending on issues and local organisation -- include

institutions and regulating bodies with implications for health promotion and disease prevention (e.g. with environmental, nutritional and social responsibilities).

• The *education sector* would include bodies and institutions with responsibility for establishing and monitoring national educational policy and strategy, for monitoring compliance with European and international educational policies and strategies where appropriate, and for national education funding.

Suggested evidence:

✓ Details of engagement with peer organisations, representative bodies, professional associations, Department of Health, Department of Education, Higher Education Authority, the Dental Council, national funding bodies, national qualifications and quality agencies.

✓ Examples of the positive impact of such engagements whether for the Institution, students, staff, patients, the profession, society generally.

9. CONTINUOUS RENEWAL

Suggested evidence:

✓ Details of the full range of ongoing and scheduled processes and procedures in this area.

✓ Examples of deficiencies that were identified and subsequently addressed through such processes and procedures.

✓ Description of the committee with responsibility for activities in this area, including frequency of meetings and the staffing and other resources available.

Section Two – Domains, Competences and Associated Learning Outcomes

DOMAIN 1: PROFESSIONALISM

Professionalism is a commitment to a set of values, behaviours and relationships, which underpin the trust that the public hold in dental care professionals. Shortcomings within this area are often responsible for patient dissatisfaction, concern and complaint—and emphasis is placed on the importance of embedding these values from an early stage within the curriculum.

Professionalism must permeate all aspects of good dental practice. It is a complex, multidimensional construct, which has individual, interpersonal and societal dimensions. These are context dependent and encompass competences within areas relating to: ethics, regulation and professional behaviour.

Knowledge of the ethical, legal/regulatory and professional basis of dentistry is essential to clinical practice. The undergraduate curriculum should reflect this and integrate student learning about professionalism throughout the curriculum to facilitate the development of high standards of professional practice.

Dentists must make the care of patients their primary concern. They must be reflective, clinically competent and keep their knowledge and skills up to date by engaging in continuing professional development. They must establish and maintain good relationships with patients and colleagues, communicate effectively and treat each person as an individual. They should work in partnership with patients, respecting patient choice and each patient's right to privacy and dignity.

It is expected that Dentists are committed to high personal and professional standards, being responsible, accountable and acting within the law. They must seek to protect and improve the oral health of their community and work to maintain the trust the public has in the profession,
by raising concerns where necessary.

AREA OF COMPETENCE: 1.1 ETHICS *incorporating* Learning Outcomes: 1.1.1 to 1.1.8

Annotations:

• Ethics provides the foundation for professionalism. The graduate Dentist must understand the ethical principles of health care and be competent to apply them in every aspect of Dentistry. In common with other branches of health care, the core ethical principles are: - the primacy of patient welfare, respect for patient autonomy, and commitment to social justice.

• The key document relating to ethical dental practice in Ireland is the Dental Council's *Code of Practice regarding Professional Behaviour and Ethical Conduct*.

• Key information relating to anti-discrimination legislation is available on central government websites including the Department of Justice and Equality and on official Citizens Information websites.

AREA OF COMPETENCE: 1.2 REGULATION *incorporating* Learning Outcomes: 1.2.1 to 1.2.5

Annotations:

• The graduate Dentist must have comprehensive knowledge of, and the skills to comply with, the regulatory system of the country in which they trained. This will necessarily include legislation, and codes of practice applicable to all aspects of the practice of dentistry.

• A key source of information is the Dental Council's website which sets out in detail the full range of the Dental Council's responsibilities as dental regulator. The Dental Council provides information and guidance to the dental team and to patients. This information includes the Dental Council's role in education and training, registration of dental professionals, scopes of practice for the full dental team, and fitness to practice issues.

• The Dental Council has developed a suite of documents (Codes of Practice) to further promote good practice and patient safety.

• Other pertinent sources of information include the Health Information and Quality Authority, Department of Health, Health Services Executive and the Data Protection Commission.

AREA OF COMPETENCE: 1.3 PROFESSIONAL BEHAVIOUR *incorporating* Learning outcomes: 1.3.1 to 1.3.11

Annotations:

• Professional behaviour can be understood as the manner in which one reflects on and reconciles different aspects of professional practice, demonstrating acceptance of professional responsibility and accountability. It is an overarching competence which must permeate all aspects of good dental practice and is manifested in the manner in which high-quality oral healthcare is provided.

• The Dental Council is strongly supportive of Interprofessional Education and Learning. The WHO definition has been adopted by the Dental Council and the other health and social care regulators in Ireland in order to support future collaboration and policy development in this area. The WHO definition is as follows: - *"Interprofessional education occurs when students, or members from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes and services."*

• Of particular relevance within dentistry is the concept of the dental team working together in the best interests of patients. Dentistry is somewhat unique amongst health professions in this regard and it is important that members of the dental team integrate and collaborate during their education and training in way that prepares them for patient-centred care upon graduation.

DOMAIN 2: SAFE AND EFFECTIVE CLINICAL PRACTICE

Dentists are required to ensure that they are capable of providing appropriate care for their patients, whilst also effectively managing and leading the wider clinical team. The patient-centred care that is provided should align to a contemporaneous evidence base wherever possible, and the quality of care and the management systems that underpin it should be regularly audited and improved.

Dental educators are challenged with the task of ensuring that students are competent in basic operative procedures and are safe to begin treating patients. This should exist as a robust process, acting as a "gatekeeper" for access to patient care. Effective monitoring systems should also be in place that follows the student's educational journey, longitudinally, throughout the remainder of the programme.

It is increasingly common for schools to employ an electronic portfolio combining clinical activity, performance and reflective practise in order to longitudinally track student progress and this approach is recommended.

Once access to the clinical environment has been granted, it is expected that the vast majority of student clinical experience will involve preventive and operative care provided to actual patients.

AREA OF COMPETENCE: 2.1 EVIDENCE-BASED PRACTICE *incorporating* Learning outcomes: 2.1.1 to 2.1.5

Annotations:

• Whilst it is important for Dentists to be familiar with the scientific principles that underpin their practise, it is equally important to ensure that they are working to a robust and contemporaneous evidence base. This requires a motivated and interested professional who is willing to seek out new information, rationalise its source and credibility, and apply it suitably to the clinical environment.

AREA OF COMPETENCE: 2.2 MANAGEMENT AND LEADERSHIP *incorporating* Learning outcomes: 2.2.1 to 2.2.6

Annotations:

• Effective clinical leadership is increasingly being shown to result in higher-quality care. Leadership involves setting a vision for the team, and inspiring and setting organisational values and strategic goals. Effective management involves the direction of resources to effectively achieve those goals. As the leader of a wider-healthcare team, the Dentist is responsible for implementing a systematic approach to the delivery of safe, high-quality patient-centred, clinical services. This necessarily involves managing people and resources with openness and integrity. On a very basic level, this means ensuring that leaders/managers and the team are adhering to all local policies and procedures. However, upon qualification, it is expected that Dentists will also be able to deal with minor performance issues, effectively audit local performance and mediate necessary changes.

AREA OF COMPETENCE: 2.3 TEAM-WORKING AND COMMUNICATION *incorporating* Learning outcomes: 2.3.1 to 2.3.20

Annotations:

• As an autonomous healthcare professional, a graduating Dentist is responsible for communicating effectively with their patients, the local healthcare team and allied professionals who are involved with patient-centred care. Being able to communicate and integrate effectively within a team requires a degree of emotional competence. It is expected that new graduates will be ready and able to manage their own patients within a primary care environment. This involves the integration of

both verbal and written methods of communication, judgements relating to timekeeping and awareness of their own personal and professional boundaries.

• Some of the most commonly reported problems with new graduates relate to their inability to know when to seek help, and poor time management. It is therefore important, on a longitudinal basis, to expose undergraduates to these important elements throughout the delivery of carefully planned and realistic clinical duties. The need to communicate effectively may also extend to wider regulatory and professional organisations, healthcare system providers and insurance companies.

• The Dental Council is strongly supportive of Interprofessional Education and Learning. The WHO definition has been adopted by the Dental Council and the other health and social care regulators in Ireland in order to support future collaboration and policy development in this area. The WHO definition is as follows: - *"Interprofessional education occurs when students, or members from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes and services."*

• Of particular relevance within dentistry is the concept of the dental team working together in the best interests of patients. Dentistry is somewhat unique amongst health professions in this regard and it is important that members of the dental team integrate and collaborate during their education and training in way that prepares them for patient-centred care upon graduation.

AREA OF COMPETENCE: 2.4 AUDIT AND RISK MANAGEMENT *incorporating* Learning outcomes: 2.4.1 to 2.4.7

Annotations:

• Risks to patient care can be minimised through effective risk management. This necessarily includes Dentists being able to identify when things are going wrong, why they have happened, and what to do in order to prevent adverse events from happening again. Clinical audit is a process of measuring and monitoring the quality of care that is provided against a set standard, or previous performance and this is an essential first step in identifying systematic risks to safe and effective patient-centred care.

• The Dental Council has published a Code of Practice relating to Infection Prevention and Control (IPC) in Dentistry. The principles and procedures of IPC should be introduced at an early stage in the curriculum.

• The Health Information and Quality Authority and the Environmental Protection Agency each have specific responsibilities in relation to the oversight and regulation of the use of ionising radiation in dentistry.

AREA OF COMPETENCE: 2.5 PROFESSIONAL EDUCATION AND TRAINING *incorporating* Learning outcomes: 2.5.1 to 2.5.4

Annotations:

• It is essential that graduating dentists are familiar with the process of continuing professional development (CPD), appraisal and professional development planning. Graduation is considered to be a "springboard" leading to a period of lifelong learning, underpinned by this professional and

academic development, achieved through the acquisition of quality CPD. Graduates should therefore be in the habit of continually assessing and updating their knowledge and skills to keep up to date with the latest developments and evidence-based practise. It is also important that Dentists are motivated and interested to learn and develop new skills for themselves and to facilitate this process for the wider dental team.

DOMAIN 3: PATIENT-CENTRED CARE

Patient-centred care is becoming increasingly prominent within the literature and within policy documents and is defined by the Institute of Medicine (2011) as "Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."

Whilst working to an evidence base is critical, dentists must also be aware of the scientific basis that underpins the treatment they provide. The evaluation process, which supports treatment planning, also requires dentists to be able to listen, collate, and record pertinent information effectively.

The degree to which a dentist can assess and discriminate patient emotion will undoubtedly affect the quality and accuracy of history taking. The ability to read and manage emotions is therefore considered to be an important skill for any healthcare professional. In addition, the ability to account for a patient's social, cultural and linguistic needs will result in a practitioner who is able to treatment plan for patient-centred care. This often results in patients being more satisfied and more likely to actively participate in their treatment.

AREA OF COMPETENCE: 3.1: APPLYING THE SCIENTIFIC BASIS OF ORAL HEALTH CARE *incorporating* Learning outcomes: 3.1.1 to 3.1.21

Annotations:

• Sound scientific knowledge is critical for healthcare professionals to rationalise their treatment choices and offer patient-centred integrated oral health care. The scientific basis of Dentistry is vast, and within this Domain the recommendation is made that educators refer to specialist societies and the curricula/guidelines, that they have published, in order to detail specific learning outcomes that map contemporaneously to individual areas of specialist practice.

Notwithstanding the specific learning outcomes below, it is expected that curricula will cover:

> The scientific basis of oral and related biosciences, including the relevant physical and Biomedical sciences, the mechanisms of knowledge acquisition, scientific method and evaluation of evidence

> The biological processes in the body to a sufficient depth to be able to exploit new emerging biological technologies in clinical practice, especially in regenerative medicine

> Mechanisms of behaviour change in order to effectively lead clinical teams, implement tailored oral healthcare regimes for patients and manage patient behaviours which are potentially harmful to general and oral health

> The complex interactions between oral health, nutrition, general health, medications, ageing and disease

• The Health Information and Quality Authority and the Environmental Protection Agency each have specific responsibilities in relation to the oversight and regulation of the use of ionising radiation in dentistry.

• The Dental Council has produced a Code of Practice relating to the administration of general anaesthesia and sedation and on resuscitation in dentistry.

AREA OF COMPETENCE: 3.2: CLINICAL INFORMATION GATHERING AND DIAGNOSES *incorporating* Learning outcomes: 3.2.1 to 3.2.9

Annotations:

• It is common for educators to deliver the scientific knowledge base using a "disease" framework (pathophysiology, signs, symptoms and investigations). Often, however, students then become preoccupied with recording their findings and being efficient in making a diagnosis. Students should also appreciate the "illness" framework, as perceived by the patient (ideas, concerns, expectations and feelings). Information should be gathered and recorded comprehensively and contemporaneously, but at the same time appreciating that the patient requires information that they can understand, freedom of choice, respect and adequate time for discussion. Information gathering is about a dynamic exchange of information and should result in shared decision-making between the dentist and their patient. In order to facilitate recording the patient's presenting condition and reaching a diagnosis, educators are encouraged to refer to indices and screening tools championed by specialist societies.

AREA OF COMPETENCE: 3.3: TREATMENT PLANNING *incorporating* Learning outcomes: 3.3.1 to 3.3.9

Annotations:

• After successfully diagnosing the patient's condition, a graduating Dentist should be capable of writing a comprehensive treatment plan that systematically addresses the patient's oral healthcare needs. It is important to account for any relevant biological, psychosocial or temporal factors that may impact on the timely delivery of safe and effective patient-centred care.

AREA OF COMPETENCE: 3.4: ESTABLISHING AND MAINTAINING ORAL HEALTH *incorporating* Learning outcomes: 3.4.1 to 3.4.19

Annotations:

• In order to establish the highest standard of oral health, graduating Dentists must be competent to operatively manage dental trauma and disease and to develop appropriate behaviour change with patients. This means communicating effectively with patients at all stages of their lives, including children, adolescents, adults and the ageing population. Current concepts of prevention, risk assessment and treatment should be implemented using materials and techniques that maintain pulp vitality and soft tissue health, and restore tooth form, function and appearance in a way that is

acceptable to the patient. For discipline-specific learning outcomes, educators are encouraged to make reference to existing agreed curricula, published by specialist societies.

DOMAIN 4: DENTISTRY IN SOCIETY

In addition to treating individual patients, a Dentist must be able to focus on promoting health, monitoring interventions and implementing effective strategies of care at community and population levels. This necessarily involves understanding population demography and health trends, engaging with health policy and promoting health. A Dentist must also understand population demography and health trends, in the context of the healthcare system, or systems, within which they work.

Recognising that most of dentistry is provided in a primary dental care setting, where Dentists practise as members of teams in healthcare systems, it is vitally important that Dentists:

> take account of the wider context within which they practise
> integrate effectively with society
> advocate for general and oral health, and system change

The undergraduate curriculum should reflect the importance of these principles and provide students with the opportunity to engage outside of dental settings. To understand populations and their health, new graduates must understand demographic changes and trends in oral/general health and society, which have major implications for their future patient base and care provision. Additionally, it is important to be aware of wider contextual influences: social, political, economic and environmental and their influence on populations and the health workforce. Dentists must be capable of promoting the general and oral health of their community, and that of the wider population.

This population health aspect of the dental undergraduate curriculum is often labelled “Dental Public Health”. This will typically be delivered by specialists in Dental Public Health and could be further supported by a range of specialties such as Restorative Dentistry, Special Care Dentistry, Periodontics, Endodontics, Prosthodontics, Gerodontology, Paediatric Dentistry, Oral Medicine, Oral Surgery and Orthodontics.

Dental Public Health should be introduced into the curriculum as early as possible in order to enhance student appreciation and understanding of the broader role and impact of dentistry.

AREA OF COMPETENCE: 4.1: DENTAL PUBLIC HEALTH *incorporating* Learning outcomes: 4.1.1 to 4.1.4

Annotations:

• Dental public health is concerned with the strategic aspects of dentistry at individual, community and population levels. It has been defined as “the science and art of preventing oral disease, promoting oral health and the quality of life through the organised efforts and informed choices of society; organisations, public and private; communities and individuals” (Gallagher 2005).

AREA OF COMPETENCE: 4.2: HEALTH PROMOTION AND DISEASE PREVENTION *incorporating* Learning outcomes: 4.2.1 to 4.2.8

Annotations:

• Health promotion not only addresses diseases and behaviours which take a common risk factor approach but also seeks to take into consideration the wider social determinants of health and, in doing so, uncovers the fundamental causes. This recognises that health follows a social gradient, and better health often arises as a result of increased socio-economic position. Dental professionals should therefore be conscious that promoting oral health means identifying the contexts in which people live their lives, taking into account the health promotion action areas recommended by the World Health Organisation (WHO 1997). Addressing social inequalities in health means that interventions should be appropriate to reduce the gradient. The opportunity for students to participate in community oral health projects, either during their formal programme or as part of an elective study period, is therefore highly recommended.

AREA OF COMPETENCE: 4.3: POPULATION DEMOGRAPHY, HEALTH AND DISEASE *incorporating* Learning outcomes: 4.3.1 to 4.3.7

Annotations:

• The graduate Dentist must have knowledge of the global burden of oral disease, population demographic, social, health, and oral health trends; and consider the implications for oral diseases and conditions and the practice of dentistry. Wider European and global perspectives will be important given Dentist and patient movement. The tools for assessing and monitoring oral health needs should be understood and the implications of findings.

AREA OF COMPETENCE: 4.4: HEALTHCARE SYSTEMS *incorporating* Learning outcomes: 4.4.1 to 4.4.7

Annotations:

• Graduating Dentists should possess a working knowledge of healthcare systems, including human resources for health, most notably dentistry and the oral health workforce. It is important to gain insight into public and private healthcare systems, the policies governing systems at national and European levels and how healthcare systems serve the population, particularly vulnerable groups.

• Knowledge of national policies and those advocated by the World Health Organisation and the United Nations will be particularly important resources, including concepts of universal health coverage (World Health Organisation 2013, World Health Organisation 2016), human resources for health (World Health Organisation 2016) and the integration of oral health with wider general health assessment, to meet sustainable development goals.

• Additionally, it will be important to explore how health systems are orientating towards prevention and managing risk, as well as defined disease, and examining patient experience and outcomes with an emerging emphasis on “value-based healthcare”; this considers how treatments are distributed across a population, how effectively treatments meet the needs of the population, and individual patients.

• *Slaintecare* is the ten-year programme in Ireland intended to transform the health and social care services. It was published in May 2017.

• *Smile agus Slainte* is the national oral health policy in Ireland and was published in April 2019.

AREA OF COMPETENCE: 4.5: PLANNING FOR HEALTH AND ORAL HEALTH *incorporating*
Learning outcomes: 4.5.1 to 4.5.4

Annotations:

• Just as Dentists plan care for individual patients, students should have the chance to explore strategic planning for the health of populations. This should draw on theory and the evidence base for community and population interventions. They should have the opportunity to consider different populations and the needs of different patient groups.