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Welcome to this www.4everlearning.com article, which if you follow the instructions can provide 1 hour of verifiable CPD certification for GDC registered Dental Professionals. This informative article is also useful to those involved in UK Dentistry administratively or as part of the wider Dental Team/Dental Trade.

The main areas this article covers are:

Reading Efficiency and Comprehension;
Additional permissible duties for DCPs;
Understanding Competency.

Aims and Objectives:
To explore the issues involved with reading, learning, comprehension, competency and additional duties in dentistry, to better deliver/refer for patient care.

Educational Outcomes:
To have improved understanding about professional learning and any limitations, so one can demonstrate true Competency and plan future Learning goals.

Feedback is welcome on the feedback form at the end. Thankyou.

Section 1

Reading Efficiency and Comprehension -

Much of our Dental CPD and Theoretical learning is done via the medium of reading, so if we are to achieve the optimal learning result getting the right balance between reading efficiency and comprehension is essential. This article, for example, is designed to be equivalent to 1 hour’s “verifiable CPD time” as if spent attending a lecture. So from an educational creditors point of view, aspects like Rates of Reading measured in words per minute, are an important part of that time equivalence determination.

In the literature, rates of reading include reading for memorisation (fewer than 100 words per minute(wpm); reading for learning (100–200 wpm); reading for comprehension (200–400 wpm); and skimming (400–700 wpm). Reading for comprehension is the essence of the daily reading of most people. Skimming is for superficially processing large quantities of text at a low level of comprehension (below 50%). Reading for Learning is what CPD is aimed at. If you find you are reading much quicker than than say 150 wpm, then it is unlikely you are Learning – you are either so familiar with the subject there is nothing new to learn OR you are skimming and not retaining much if any knowledge, so either way it is not valid Continuing Professional Development (CPD), so shouldn’t be counted.
<table>
<thead>
<tr>
<th>Reading Rate</th>
<th>Description in literature</th>
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<tbody>
<tr>
<td>1 – 100 wpm</td>
<td>Reading for Memorisation task OR by a very young child</td>
</tr>
<tr>
<td>100 – 200 wpm</td>
<td>Reading for Learning task OR rate of a 6-12 yr old child</td>
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<tr>
<td>200 - 400 wpm</td>
<td>Reading for general Comprehension or by regular reader</td>
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<tr>
<td>400-700+ wpm</td>
<td>Skimming or Speed reading – not suitable for CPD use</td>
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Educational advice for choosing the appropriate reading-rate includes reading flexibly, slowing when concepts are closely presented or when the material is new, and increasing when the material is familiar and of thin concept. Speed reading courses and books often encourage the reader to continually accelerate; comprehension tests on superficial or factually thin reading materials may mis-lead the reader to believe his or her comprehension is continually improving; yet, competence-in-reading requires knowing that skimming is dangerous, as a default habit.

Some authors encourage Speed reading by focussing in blocks of words rather than vocalising each word in one’s head, but studies have shown when we focus on one area we see a max. of 4-5 letters clearly and other words/letters in diminishing clarity, never mind diminishing comprehension and understanding (see diagram below). So by all means practice reading faster, but NOT at the expense of understanding and reflecting upon the content when you are reading an article of Learning, otherwise you may not learn much quicker, hardly a worthwhile process, is it?

![Diagram](image)

Around the fixation point only four to five letters are seen with 100% acuity. Indeed you will need to score higher than 50% correct answers in the questionnaire at the end of this article, if you wish to be credited with 1 hour of verifiable CPD, thus attempting to Speed Read and skim through this article superficially will NOT benefit you, because you will not have spent enough time to absorb new facts, ideas, applications or limitations of the information presented!

We have based this article using the scientific principles of the Nelson-Denny Reading Test, which scores readers both on the speed with which they can read a passage, and also their ability to accurately answer questions about that passage. Thus for 1 hour of verifiable CPD activity, at the rate of 100 wpm, 60 minutes is 6000 words – an easy rule of thumb to assess whether ANY claims that written educational materials are equivalent to 1 hour of CPD activity, recognised by the GDC, are actually proper and valid claims!
You may be interested to know that the Nelson-Denny Reading Test was created in 1929 by M.S. Nelson and E.C. Denny, both of whom were on the faculty of Iowa State Teacher's College. The original purpose of the test was to measure reading ability among high school and college students. The test has been revised and updated several times under the direction of James I. Brown of the University of Minnesota. The most recent revision was published in 1993.

Reference:


The primary uses of the Nelson-Denny Test are now as a screening test for reading problems, as a predictor of academic success and as a measure of progress resulting from educational interventions. These functions obviously overlap to some degree. It is not appropriate for the clinical evaluation of reading disorders. However, it may be used to identify students in need of remedial reading instruction, so don’t take too long to read this article either!

Ultimately the test has been found to be a reliable measure of reading comprehension ability of the populations it is designed for over the decades of reading research using this test, which is why www.4everlearning.com use this educationally valid tool for converting reading material into CPD time credits, by combining established wpm reading rates with sufficient questions to test comprehension, in a scientifically valid way.

Of course learning to read and assimilate information so one “learns and understands” doesn’t just improve one’s intellect/abilities, it is also strongly correlated with earnings and career success too!

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The data for the graph below and the table on the top right are from the 1992 National Adult Literacy Survey, or NALS. You can see the source data at the National Center for Education Statistics, or NCES. The 2003 National Assessment of Adult Literacy (NAAL) has not yet released data showing literacy level and earnings, but overall results from the 2003 NAAL were not significantly different from the 1992 NALS.
The above earning trends have stayed constant through the years in the USA since 1992 to the present day, so reading and comprehension are key life-skills in of themselves and an important part of our continued professional development and education too!

**Section 2**

**Additional Duties for DCPs and Dentists –**

Are you aware of the recent changes affecting your duties and those of your fellow professionals, as described in the GDC’s Scope of Practice document?

These are many and are detailed below, so you can be sure of what you can (or can’t) safely do, delegate or need to refer to another appropriate dental professional!

1. **Dental Nurses:**

Dental nurses are registered dental professionals who provide clinical and other support to other registrants and patients. Current duties that Dental Nurses are deemed to already be trained, tested and competent to do (but may still decide they further training/revision for if not done in some time) are:

- Prepare and maintain the clinical environment, including the equipment
- Carry out infection-control procedures to prevent physical, chemical and microbiological contamination in the surgery or laboratory
• Record dental charting carried out by other appropriate registrants
• Prepare, mix and handle dental materials
• Provide chairside support to the operator during treatment
• Keep full and accurate patient records
• Prepare equipment, materials and patients for dental radiography
• Process dental radiographs
• Monitor, support and reassure patients
• Give appropriate advice to patients
• Support the patient and their colleagues if there is a medical emergency
• Make appropriate referrals to other health professionals

Thus the Additional skills dental nurses could develop during their careers include those below in addition to the above:

• further skills in oral health education and oral health promotion
• assisting in the treatment of patients who are under conscious sedation
• further skills in assisting in the treatment of patients with special needs
• intra-oral photography
• shade taking
• placing rubber dam
• measuring and recording plaque indices
• pouring, casting and trimming study models
• removing sutures after the wound has been checked by a dentist
• applying fluoride varnish as part of a programme which is overseen by a consultant in dental public health or a registered specialist in dental public health
• constructing occlusal registration rims and special trays
• repairing the acrylic component of removable appliances
• tracing cephalographs (x-rays of side of skull)

Additional skills on prescription a dental nurse can also do when competent:

• taking radiographs to the prescription of a dentist
• applying topical anaesthetic to the prescription of a dentist
• constructing mouthguards and bleaching trays to the prescription of a dentist
• constructing vacuum formed retainers to the prescription of a dentist
• taking impressions to the prescription of a dentist or a CDT (where appropriate)

Importantly Dental Nurses do not Diagnose Disease or Treatment Plan
All other skills are reserved to one or more of the other registrant groups.
2. Dental Technicians:

Dental technicians are registered dental professionals who make dental devices including dentures, crowns and bridges to a prescription from a dentist or clinical dental technician. They also repair dentures direct for members of the public. Current duties that Dental Technicians are deemed to already be trained, tested and competent to do (but may still decide they further training/revision for if not done in some time) are:

- review cases coming into the laboratory to decide how they should be progressed
- work with the dentist or clinical dental technician on treatment planning and outline design
- design, plan and make a range of custom-made dental devices according to a prescription
- repair and modify dental devices
- carry out shade taking
- carry out infection control procedures to prevent physical, chemical and microbiological contamination in the laboratory
- keep full and accurate laboratory records
- verify and take responsibility for the quality and safety of devices leaving a laboratory
- make appropriate referrals to other healthcare professionals

Thus the Additional skills dental technicians could develop during their careers include those below in addition to the above:

a) Working with a dentist in the clinic assisting with treatment by:
• taking impressions
• recording facebows
• carrying out intra-oral and extra-oral tracing
• carrying out implant frame assessments
• recording occlusal registrations
• carrying out intra-oral scanning for CAD/CAM
• helping dentists to fit attachments at chair side

b) Working with a clinical dental technician in the clinic assisting with treatment by:

• taking impressions
• recording facebows
• carrying out intra-oral and extra-oral tracing
• recording occlusal registrations
• tracing cephalographs
• taking intra-oral photographs

Dental technicians do not:

• work independently in the clinic
• perform clinical procedures related to providing removable dental appliances
• carry out independent clinical examinations
• identify abnormal oral mucosa and related underlying structures
• fit removable appliances

Dental technicians do not provide treatment for or give advice to patients in the ways that are described under the sections for hygienists, therapists, orthodontic therapists or dentists.

3. Dental Clinical Technicians:

Clinical dental technicians are registered dental professionals who provide complete dentures direct to patients and other dental devices on prescription from a dentist. They are also qualified dental technicians.

Patients with natural teeth or implants must see a dentist before the CDT can begin treatment.

CDTs refer patients to a dentist if they need a treatment plan or if the CDT is concerned about the patient’s oral health.

Clinical dental technology builds on dental technology.

CDTs are also deemed to already be trained, tested and competent (but may still decide they further training/revision for if not done in some time) to:

• take detailed dental history and relevant medical history
• perform technical and clinical procedures related to providing removable dental appliances
• carry out clinical examinations
• take and process radiographs and other images related to providing removable dental appliances
• distinguish between normal and abnormal consequences of ageing
• recognise abnormal oral mucosa and related underlying structures and refer patients to other healthcare professionals if necessary
• fit removable appliances
• give appropriate advice to patients

Additional skills which CDTs could develop during their career include:

• oral health education
• providing sports mouth guards
• re-cementing crowns with temporary cement
• providing anti-snoring devices on prescription of a dentist
• removing sutures after the wound has been checked by a dentist

CDTs do not provide treatment for patients as described under the sections for hygienists, therapists, orthodontic therapists or dentists, as the skills set out are reserved to the relevant groups.

4. Dental Hygienists:

Dental hygienists are registered dental professionals who help patients maintain their oral health by preventing and treating gum disease and promoting good oral health practice.

They carry out treatment under prescription from a dentist. Current duties that Dental Hygienists are deemed to already be trained, tested and competent to do (but may still decide they further training/revision for if not done in some time) are:

• provide dental hygiene care to a wide range of patients
• plan the delivery of care for patients to improve and maintain their periodontal health
• obtain a detailed dental history from patients and evaluate their medical history
• complete periodontal examination and charting and use indices to screen and monitor periodontal disease
• provide preventive oral care to patients and liaise with dentists over the treatment of caries, periodontal disease and tooth wear
• undertake supragingival and subgingival scaling and root debridement using manual and powered instruments
• use appropriate anti-microbial therapy to manage plaque related diseases
• adjust restored surfaces in relation to periodontal treatment
• apply topical treatments and fissure sealants
• give patients advice on how to stop smoking
• take, process and interpret various film views used in general dental practice
• give infiltration and inferior dental block analgesia
• place temporary dressings and re-cement crowns with temporary cement
• take impressions
• identify anatomical features, recognise abnormalities and interpret common pathology, and carry out oral cancer screening
• if necessary, refer patients to other healthcare professionals
• placing rubber dam

Thus the Additional skills Dental Hygienists could develop during their careers include those below in addition to the above:

• tooth whitening to the prescription of a dentist
• prescribing radiographs
• administering inhalational sedation
• removing sutures after the wound has been checked by a dentist

Dental hygienists do not
• diagnose disease
• restore teeth
• carry out pulp treatments
• adjust unrestored surfaces
• extract teeth

These skills are reserved to dental therapists and dentists. They do not undertake any of the skill areas described as being reserved to dental technicians, clinical dental technicians or dentists
5. Dental Therapists:

Dental therapists are registered dental professionals who carry out certain items of dental treatment under prescription from a dentist. Dental therapy covers the same areas as dental hygiene, but dental therapists are also deemed to already be trained, tested and competent (but may still decide they further training/revision for if not done in some time) to:

- carry out direct restorations on permanent and primary teeth
- carry out pulpotomies on primary teeth
- extract primary teeth
- place pre-formed crowns on primary teeth
- plan the delivery of a patient’s care

*Additional skills which dental therapists could develop during their careers include*

- administering inhalational sedation
- varying the detail of a prescription but not the direction of a prescription
- prescribing radiographs
- carrying out tooth whitening to the prescription of a dentist
- removing sutures after the wound has been checked by a dentist

Dental therapists do not carry out a patient’s initial diagnosis or take overall responsibility for planning a patient’s treatment.

They do not undertake any of the skill areas described as being within the roles of the dental technician, clinical dental technician or dentist.

6. Orthodontic Therapists:

Orthodontic therapists are registered dental professionals who carry out certain parts of orthodontic treatment under prescription from a dentist.

Orthodontic therapists are also deemed to be trained, tested and competent (but may still decide they further training/revision for if not done in some time) to:

- clean and prepare tooth surfaces ready for orthodontic treatment
- identify, select, use and maintain appropriate instruments
- insert passive removable orthodontic appliances
- insert active removable appliances adjusted by a dentist
- remove fixed appliances, orthodontic adhesives and cement
- take impressions
- pour, cast and trim study models
- make a patient’s orthodontic appliance safe in the absence of a dentist
- fit orthodontic headgear
- fit orthodontic facebows which have been adjusted by a dentist
- take occlusal records including orthognathic facebow readings
- place brackets and bands
- prepare, insert, adjust and remove archwires
- give advice on appliance care and oral health instruction
- fit tooth separator
- fit bonded retainers
- make appropriate referrals to other healthcare professionals

Additional skills which orthodontic therapists could develop during their career include:

- applying fluoride varnish to the prescription of a dentist
- repairing the acrylic component part of orthodontic appliances
- measuring and recording plaque indices and gingival indices
- removing sutures after the wound has been checked by a dentist

Orthodontic Therapists do not:
- remove sub-gingival deposits
- give local analgesia
- re-cement crowns
- place temporary dressings
- place active medicaments
- as these tasks are reserved to dental hygienists, dental therapists and dentists.

They do not carry out laboratory work other than that listed above as that is reserved to dental technicians and clinical dental technicians.
They cannot diagnose disease, treatment plan or activate orthodontic wires — only dentists can do this.
7. Dentists

Dentists are deemed to already be trained, tested and competent to do (but may still decide they further training/revision for if not done in some time) all of the treatments we have already mentioned in 1-6.DCP duties.

Dentists also:

• diagnose disease
• prepare comprehensive treatment plans (this is a ‘strategic’ role as a treatment plan can be taken to any appropriate DCP — dentists are not the only dental-health professionals to plan how to deliver care, but they have an overall long-term responsibility for the treatment)
• prescribe and provide endodontic treatment on adult teeth
• prescribe and provide fixed orthodontic treatment
• prescribe and provide fixed and removable prostheses
• carry out oral surgery
• carry out periodontal surgery
• extract permanent teeth
• prescribe and provide crowns and bridges
• carry out treatment on patients who are under general anaesthesia
• give inhalational and intravenous conscious sedation
• prescribe drugs as part of dental treatment
• prescribe and interpret radiographs

*Additional skills which a dentist could develop during their career*

provision of implants
Understanding Competency.

The Scope of Practice document published by the General Dental Council (November 2008) outlines the skills that each member of the dental team is expected to have by virtue of their initial training and the additional skills that may be acquired as a result of further training throughout a dental career. In essence it describes what each member of the dental team does and provides some clear fixed points within the team's skill mix.

So the Scope of Practice document issued by the GDC details these “existing” Competencies for different Dental Professionals and also the other possible “additional” duties DCPs and Dentists can do, following further training to be Competent in those additional skills.

BUT none of these documents state HOW one knows one has done enough to be deemed “Competent” in such additional duties before undertaking these upon patients.

So what is “enough” evidence to show the GDC if someone decides to accuse one of being “Incompetent” or “inadequately” trained in a procedure?

The next section will look in detail what it means, from a Healthcare Professional and Educational point of view, to be deemed “Competent in a procedure, whether currently taught/examined before qualification/registration or done later as an additional duty.

Can you prove your Competency?

Most people when asked think they know what is meant by Competency, mainly by considering that they may not be “incompetent” at something, but can you become Competent in something new, just by going on a theory lecture course or just watching a procedure yourself and then “having a go” to see how you do?

For the majority of skills or duties that are genuinely “new” to that dental registrant, then the short answer is NO, theory alone or just watching then doing isn’t enough – they may form part of the process at some stage of the “Competency” process, but being partly Competent is like saying you are partly Pregnant, you either are or aren’t!

So why is Competency important?

Well the GDC in its documents for registrants states quite clearly, for standard OR additional duties performed by any registrants, they should gain the patient’s consent AND be Competent to undertake that duty.

Of course things can go wrong that isn’t anyone’s fault, by chance or by biological variation in response, BUT, it is common for an accusation to be made by a patient or their representative that the Professional person caused or contributed to the alleged consequences by being negligent or incompetent in some way.
The UK is now more litigious per capita than the USA for medical and dental cases and complaints can come via the GDC, PCTs and/or No Win, No Fee Lawyers too. It is of course very easy to accuse, but the onus to refute those accusations is on the Registrant. In such circumstances, registrants need to prove they were first of all Competent to be even doing a procedure, then to show they weren’t negligent in not applying their previously tested skills properly. When duties are delegated to other Team members, it may mean that a shotgun approach is taken, where several members are accused of incompetence in their delegation/training/execution of those duties by a dis-satisfied patient or their representative.

So to avoid any misunderstandings, let’s define what we mean by “competency” first of all. Competence is a standardised requirement for an individual to properly perform a specific duty. It encompasses a combination of knowledge, skills and behaviour, utilised to improve performance. Thus it is SO MUCH MORE than just doing doing steps a+b+c to get d – a monkey on a production line can do that without ANY understanding!

In management, competency includes the traits of systems thinking and emotional intelligence, with skills in influence and negotiation. A person possesses a competence as long as the skills, abilities, and knowledge that constitute that competence are a part of them, enabling the person to perform effective action within a certain workplace environment, ewhich may be dynamic and changing too. Therefore, one might not lose knowledge, a skill, or an ability, but still lose a competence if what is needed to do a job well, changes often and we don’t adapt to remain competent in different circumstances.

Competence is also used to work with more general descriptions of the requirements of human beings in organizations and communities. An important detail of this approach is that all competences have to be action competences, which means you show in action, that you are competent. In the military the training systems for this kind of competence is called Artificial Experience, which is the basis for all simulators. Likewise, in one’s dental training already, one will have been taught theory and tested on that theory
(KNOWLEDGE), one will have then done “dry” practicals to apply that theory under supervision (SKILLS) by someone qualified to be able to assess your Behaviour (KNOWING LIMITATIONS), using a variety of Educationally valid tools, from Questionnaires to Direct Observation check-lists to Objective Structured Clinical Examinations (OSCEs), before one then treats patients to then get further experiences and continually adapt/learn/increase in competency.

**Can Competency really change/develop?**

Competence is shown in action in a situation in a context that might be different the next time you have to act. In emergency contexts, competent people will react to the situation following behaviors they have previously found to succeed, hopefully to good effect. To be competent you need to be able to interpret the situation in the context and to have a repertoire of possible actions to take and have trained in the possible actions in the repertoire, if this is relevant.

Thus Competence grows through experience and the extent of an individual to learn and adapt. What happens when one becomes highly competent – then you may be regarded as an Expert! Read on to discover how Competency can develop in any Professional person.

**The 4 Stages of COMPETENCY:**

The earliest origins of the conscious competence theory are not entirely known, although the US Gordon Training International Organisation has played a major role in defining it and promoting its use.

The four stages of competence is often compared to a Johari window (although Johari deals with self-awareness; while the four stages of competence deals with learning stages)

According to Linda Adams, president of Gordon Training International, the "Learning Stages (model) i.e., unconsciously unskilled, consciously unskilled, consciously skilled, unconsciously skilled ... was developed by one of our employees and course developers (Noel Burch) in the 1970's and first appeared in our Teacher Effectiveness Training Instructor Guide in the early 70's." GTI's has never added a fifth stage, and did not devise the matrix representation, the origins of which remain a mystery.

**The Four Stages**

1. **Unconscious incompetence** - The individual neither understands or knows how to do something, nor recognizes the deficit or has a desire to address it. See also: Dunning-Kruger effect in psychology. In short, They Don’t know that they Don’t know!
2. Conscious incompetence
   Though the individual does not understand or know how to do something, he or she does recognize the deficit, without yet addressing it. In short, They know they don’t know, but haven’t done anything about it!

3. Conscious competence
   The individual understands or knows how to do something. However, demonstrating the skill or knowledge requires a great deal of consciousness or concentration.
   In short, They are at full stretch just to cope adequately = stressful

4. Unconscious competence
   The individual has had so much practice with a skill that it becomes "second nature" and can be performed easily (often without concentrating too deeply). He or she may or may not be able teach it to others, depending upon how and when it was learned.
   In short, they know how to, but cannot always teach how to, well!

Natural language is an example of unconscious competence. Not every native speaker who can understand and be understood in a language is competent to teach it. Distinguishing between unconscious competence for performance-only, versus unconscious competence with the ability to teach, the term "kinesthetic competence" is sometimes used for the ability to perform but not to teach, while "theoretic competence" refers to the ability to do both.

Certain brain personality types favor certain skills (see the Benziger theory), and each individual possesses different natural strengths and preferences. Therefore, advancing from, say, stage 3 to 4 in one skill might be easier for one person than for another. Certain individuals will even resist progression to stage 2, because they refuse to acknowledge or accept the relevance and benefit of a particular skill or ability!

Maybe we can all think of an individual like that in Dentistry somewhere?
Individuals develop competence only after they recognize the relevance of their own incompetence in the skill concerned.

Possible 5th stage of Competence?

Many attempts have been made to add to this competence model. This addition would be a fifth stage, and there have been many different suggestions for what this fifth stage would be called. One suggestion is that it be called "Conscious competence of unconscious competence". This would describe a person's ability to recognize and develop unconscious competence in others.

Another suggestion for a 5th level of competency, by consultant David Baume:

As a fifth level, I like what I call 'reflective competence'. As a teacher, I thought "If unconscious competence is the top level, then how on earth can I teach things I'm unconsciously competent at?" I didn't want to regress to conscious competence - and I'm not sure if I could even if I wanted to! So, reflective competence - a step beyond unconscious competence. Conscious of my own unconscious competence, yes, as you suggest. But additionally looking at my unconscious competence from the outside, digging to find and understand the theories and models and beliefs that clearly, based on looking at what I do, now inform what I do and how I do it. These won't be the exact same theories and models and beliefs that I learned consciously and then became unconscious of. They'll include new ones, the ones that comprise my particular expertise. And when I've surfaced them, I can talk about them and test them. Nonaka is good on this.


General Competence Development

Another way of looking at “Competency” and developing this, is to look at what happens when someone has reached a state of “conscious competence” in a brand-new skill – perhaps you can remember the first time you assisted chairside, scaled teeth, mounted models, made a denture, gave an injection, took an impression, extracted a tooth etc. Remember what that was like – even with good training, theory and practice before hand, did your Competency begin well OR did you feel unprepared for the reality/difficulty encountered? Did you improve with experience?
WELL Dreyfus and Dreyfus in 1986 (since applied by Eraut and others 1994 to present) has introduced a language of the levels of competence in competence development. The causative reasoning of such a language of levels of competence may be seen in their paper on Calculative Rationality titled, “From Socrates to Expert Systems: The Limits and Dangers of Calculative Rationality”.

The five levels originally proposed by Dreyfus and Dreyfus were:

- Novice: Rule based behaviour, strongly limited and inflexible
- Experienced Beginner: Incorporates aspects of the situation
- Practitioner: Acting consciously from long term goals and plans
- Knowledgeable practitioner: Sees the situation as a whole and acts from personal conviction, now Proficient
- Expert: Has intuitive understanding of situation and central aspects

The process of competence development is a lifelong series of doing and reflecting. It requires a special environment, where the rules are necessary in order to introduce novices.

Thus after the initial Competency Training and Assessments, there needs to be strict guidance/protocols to follow, detailed dangers and limitations to look out for and recognise, with good close support available for those first 10 cases.

But people at a more advanced level of competence and Expertise will systematically break the rules if the situations requires it. This environment is synonymously described using terms such as learning organization, knowledge creation, self organizing and empowerment. Clearly breaking the rules or varying greatly too early in one’s experiences can quickly turn a competency into an incompetency, so avoiding over-confidence and knowing one’s limitations is critically important too.
An Example of the Competency Process we can All relate to – Driving a Car.

If we are going to be a passenger in a car, then we want to be sure the driver is safe and competent in what they are doing. If we are going to want to drive a car, then we want to be sure we are properly trained and assessed by someone society has confidence in, to certify us as safe and competent to drive, for passengers and pedestrians sake too!

So what are the processes involved with becoming Competent to Drive?

**Theory Test** – one has to learn the theory and be tested upon it before one can even take a driving test. Clearly it makes sense if one doesn’t know the highway code, danger signs and techniques to deal with difficulties, then one shouldn’t be driving at all!

Lessons by friends/parents and a qualified Instructor – These are quite different, aren’t they? It is always tempting to get lessons/be trained by a friend or family member who is already “competent” by virtue of holding a driving licence themselves, sometimes for many years. This can at least help to practice common tasks, but are they qualified to Teach – would you fail your driving (competency) test if all you had were lessons from well meaning friends? The answer is probably, yes, your abilities wouldn’t stand up to the scrutiny of a Driving (competency) test. Thus having at least some lessons by a qualified and competent Teacher and some again before your Competency test, would probably be the most efficient way to get Trained and Experienced sufficiently well.

**Passing a Driving Test** – So you’ve had the theory training and passed a Competency test, you’ve had lessons by someone qualified/competent to teach you and they have deemed you ready for your final part of the Competency to drive assessment, the driving test!

You will be tested on your application of knowledge, your actual ability to do certain tasks (reverse, drive progressively) and deal with problems (emergency stop) whilst knowing your limitations (speed limit), to then be certified as Competent overall by someone competent to test in the most up to date methods (Trained Tester).

**Starting out as a novice** – Now you can start driving as a novice, displaying a “P” plate which you can remove after a year. With experience your Competence and confidence
grows and you may venture into more complex areas cautiously, such as motorway driving and even driving abroad under different rules.

Transferable skills – once experienced after a year or two, you may wish to develop these existing skills further into other kinds of driving eg: HGV, Bus etc.

This will then entail further Competency assessments along similar lines to above (Theory tests, Taught Lessons, Another Driving Test) before becoming a competent Novice at a new level of driving safely.

Those principles for Driving Competency above are just as valid for Additional Skills in Dentistry too, so that you can confidently demonstrate your competency acquired at the right level, in the right way, tested and proved by someone qualified to test competency in others.

Indeed current Dental Education methods are based upon these sound principles for undergraduate and postgraduate Training in different areas of competency training and assessment.

Miller’s pyramid above shows how we have to build upon the Knowledge/Theory first and test this (Knows), then test that they Apply that knowledge appropriately to the Tasks in hand (Knows how) to the demonstrate this through a practical test that is Structured
(Shows how), which for clinical tests are OSCEs, Standardised patients, Direct Observational tests/reports etc. Just like the Driving Test process !!!

Then we have progress and audit of early experience recorded and assessed to assess how well a “competent novice” is performing in the real world, the top of the Pyramid.

The type of assessment used should often reflect the stage in professional training, thus Post-Graduate Dental Deans tend to recommend for Additional Duties for Dentists and DCPs, assessments should reach the higher levels of Miller’s pyramid wherever possible. Thus just Theory Lectures or Courses alone are rarely sufficient, from an Educationally valid point to reach recognised Competency, to deliver high-quality care in a safe, predictable way that has been appropriately tested/recorded for the individual, by someone who is also Competent to assess this using the Educational tools in Millar’s pyramid.

As the GDC document “Standards for Dental Professionals” states, we should ONLY provide Services/treatments to which the patient has Consented and which you are Competent to undertake.

If a friend who had a driving licence showed you how to drive a few times and you picked it up quite quickly, so started driving on public roads alone but then had an “accident” after a couple of weeks, could you prove you were competent?

Would your Insurance be valid? Would you get into a lot of trouble, regardless of the details of who did what in the accident? Would you dream of ever Driving a Car like this not going through the proper “Competency” stages of Driving Lessons by a qualified Instructor and a proper Driving test to prove your Competency to drive, in different conditions and knowing your limits?
Accidents and complications occur in Dentistry too, but should they happen to you, hopefully you will be able to assure easily anyone who asks the question, “Were you even Competent to be doing that?” Prove it!

Additional duties for DCPs and Dentists offer exciting possibilities to improve and expand the whole Dental team’s involvement in patient care long-term, more than ever before – but hopefully in the “rush” to provide these Additional duties to the public, we will all recognize that we must first make ourselves competent in a valid and recognized process that stands up to scrutiny, both to protect our Professional integrity AND deliver high-quality care safely to our patients in the future too, as a competent knowledgeable Practitioner, who is ever-learning and improving.

The clinical team at 4everlearning.com thanks you for your participation in this mini course and trusts you found this article from www.4everlearning.com valuable.

Please go to the Questionnaire page now in order to validate your 1 hour’s verifiable CPD certificate. (the link was sent to you by email)

Full instructions for answering the questions and for receiving your vCPD certification will be found in this section.