

American Dietetic Association Revised 2008 Standards of Practice for Registered Dietitians in Nutrition Care; Standards of Professional Performance for Registered Dietitians; Standards of Practice for Dietetic Technicians, Registered, in Nutrition Care; and Standards of Professional Performance for Dietetic Technicians, Registered

*The American Dietetic Association Quality Management Committee**

As the most highly and specifically trained and qualified providers of food and nutrition services, registered dietitians (RDs) and dietetic technicians, registered (DTRs) are accountable and responsible for their practice and service. The American Dietetic Association (ADA) leads the profession of dietetics by developing standards against which the quality of practice

and performance of RDs and DTRs can be evaluated. As part of ADA's Scope of Dietetics Practice Framework (1), the 2008 Standards of Practice (SOP) in Nutrition Care and Standards of Professional Performance (SOPP) for RDs and DTRs, along with ADA's Code of Ethics (2), guide the practice and performance of RDs and DTRs in all settings.

These standards and indicators reflect the minimum competent level of dietetics practice and professional performance for RDs and for DTRs. The SOP in Nutrition Care is composed of four standards representing the four steps of the Nutrition Care Process (NCP) (3). The SOPP for RDs and DTRs consists of six standards representing six domains of professionalism.

This article represents the 2008 ADA SOP in Nutrition Care and SOPP for RDs and DTRs (see the Web site exclusive Appendix at www.adajournal.org).

HOW DOES THE ADA SCOPE OF DIETETICS PRACTICE FRAMEWORK AND CODE OF ETHICS GUIDE THE PRACTICE AND PERFORMANCE OF RDS AND DTRS IN ALL SETTINGS?

Scope of practice is a fluid concept (4). It changes as knowledge, the health care environment, and technology expand. Food and nutrition professionals must possess the knowledge, skills, and competencies to perform their duties;

therefore, scope of practice comes down to the competency of individual practitioners and their particular practice settings. The decision tree and decision analysis tool of the Scope of Dietetics Practice Framework assist RDs and DTRs by providing tools for examining one's own practice (1). The code of ethics and SOPP are resources that support RDs' and DTRs' ability to provide specified nutrition services.

WHY WERE THE STANDARDS REVISED?

This update was initiated in response to a November 2006 ADA Board of Directors' motion that "Directs appropriate ADA units to formulate a clear and precise definition of the term 'supervision' as it applies to the Scope of Dietetics Practice Framework's SOP for the RD and for the DTR, and to revise these documents for accuracy and consistency with federal regulations and national standards."

HOW WERE THE STANDARDS REVISED?

The 2008 Standards are the result of a review and update of the 2005 ADA SOP in Nutrition Care and Updated SOPP (5). ADA's process for revising and updating the 2005 standards included a review by ADA Regulatory Affairs of the Centers for Medicare and Medicaid Services' Interpretive Guidelines; Centers for Medicare and Medic-

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aid Services Conditions of Participation and Conditions for Coverage for hospitals, critical access hospitals, end-stage renal disease, hospice, and home health agencies; and the US Department of Agriculture regulations for the Special Supplemental Nutrition Program for Women, Infants, and Children. ADA Regulatory Affairs also reviewed state regulations for hospitals, critical access hospitals, end-stage renal facilities, assisted living facilities, hospices, and home health agencies. A review of a draft revision of the SOP for DTRs in Nutrition Care was completed by ADA members, including ADA's 2006-2007 Scope of Dietetics Practice Framework Sub-Committee of the Quality Management Committee and non-ADA member RDs and DTRs via the Internet and electronic surveys. Survey results and comments were reviewed by ADA's 2006-2007 and 2007-2008 Quality Management Committees. Feedback regarding this draft was received from the 2006-2007 Executive Committee of the Dietetic Technicians in Practice Dietetic Practice Group of ADA during four conference calls.

The rationales and indicators for the 2008 standards were updated using information from ADA Regulatory Affairs' review of regulations, electronic survey feedback, and through the consensus of the members of the 2006-2007 and 2007-2008 Quality Management Committees. Consensus is group opinion based on expert knowledge and experience. The Quality Management Committee members represent diverse practice and geographic perspectives.

WHAT ARE THE SOP IN NUTRITION CARE?

The SOP in nutrition care:

- address activities related to patient/client care during the NCP;
- apply to RDs and DTRs who have direct contact with individual patient/client care in acute and long-term care, as well as in public health, community, extended care, and ambulatory care settings;
- are formatted according to the four steps of the NCP (ie, nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation); and
- reflect the individual levels (RD and DTR) of training, responsibility, and accountability.

WHAT ARE THE SOPP?

The SOPP:

- address behaviors related to the professional role that are not in the NCP;
- apply to RDs and DTRs in all practice settings;
- are formatted according to six domains of professional behavior (ie, provision of services, application of research, communication and application of knowledge, use and management of resources, quality in practice, and competence and accountability); and
- reflect the individual levels (RD and DTR) of training, responsibility, and accountability.

HOW DO THE SOP IN NUTRITION CARE, THE SOPP, AND PRACTICE-SPECIFIC STANDARDS RELATE TO EACH OTHER?

The SOP and SOPP are companion documents. The SOP in Nutrition Care describe the minimum expectation for competent nutrition care practice. The SOPP describe the minimum expectation for competent behavior in the non-direct patient/client nutrition care aspect of the roles of RDs and DTRs. Together the two sets of standards comprehensively depict the minimum expectation for competent patient/client care and professional behavior for RDs and DTRs.

ADA's 2005 SOP and SOPP (5) were designed as blueprints for the development of practice-specific SOP and SOPP for RDs in specialty and advanced levels of practice. The 2008 standards will also serve as the blueprint for future practice-specific standards. As of October 2007 the following dietetic practice groups of ADA have published practice-specific standards: Diabetes Care and Education (6); Behavioral Health Nutrition (7); Oncology Nutrition (8); and Dietitians in Nutrition Support, a joint project with the American Society for Parenteral and Enteral Nutrition (9,10). Practice-specific standards are in the process of being developed by the following workgroups of ADA dietetic practice groups: Pediatric Nutrition Care, Nephrology Care, Management of Food and Nutrition Systems, Education of Dietetics Practitioners, and Sports Dietetics.

WHAT IS MEANT BY "UNDER THE SUPERVISION OF AN RD"?

The definition of supervision is contextual. It varies by setting, by profession, and by intent. For example, supervision may be categorized as to whether it is managerial, clinical, personal, or professional. Further, an individual's experience in a work setting with supervision may affect his or her understanding of who a supervisor is and what supervision entails. In formulating a clear and precise definition of the term supervision as it applies to the 2008 SOP for DTRs in Nutrition Care, both legal definitions and definitions used in similar practice circumstances were identified and analyzed.

For the purpose of the 2008 SOP for DTRs in Nutrition Care, ADA describe supervision as follows:

An RD is accountable for the nutrition care of patients in various health care settings (eg, hospitals, nursing homes, home health agencies, and end-stage renal facilities) and social services programs (eg, Special Supplemental Nutrition Program for Women, Infants, and Children), and nutrition services provided by the Older Americans Act (through provision of daily meals provided in congregate and home-delivered settings).

In many health care settings, a DTR and other staff may be available to assist the RD. An RD in these settings must answer to patients, employers, boards of dietetics licensure, and the legal system if care is compromised.

RDs do not delegate the nutrition care process, but may assign certain tasks for the purpose of attaining needed information (eg, screening, gathering, and organizing data and information) or communicating with and educating patients. An RD may assign to DTRs interventions within their scope of practice, such as patient education, provision of medical food supplements, and referral to community agencies and programs.

Whether the supervision is direct (RD is on premises and immediately available) or indirect (RD is immediately available by telephone or other electronic means) is determined by regulatory and facility policies and procedures.

Additional considerations include regulation; that is, state dietitian/nutritionist licensure statutes and rules may include definitions of supervision and scope of practice specifications for technical and other assistive staff. Fed-

eral and state rules and regulations for health care facilities and for social service programs specify the qualified dietitian.

Accreditation must also be considered. Standards verify compliance with federal and state regulatory requirements and may specify additional requirements for an RD.

This description of supervision as it relates to RD/DTR teams is not synonymous with managerial supervision or oversight, clinical supervision (eg, peer-to-peer), supervision of provisional licensees, and/or supervision of dietetic interns and students. Clinical supervision is used in medicine and the mental health fields for the purposes of case review and professional development.

WHY ARE THE STANDARDS IMPORTANT?

The standards are designed to promote:

- safe, effective, and efficient food and nutrition services;
- evidence-based practice;
- improved health care and food and nutrition service-related outcomes;
- continuous quality improvement;
- dietetics research, innovation, and practice development; and
- development of the individual RDs and DTRs.

The standards:

- describe minimum levels of practice and performance;
- provide common indicators for self-evaluation;
- promote consistency in practice and performance;
- describe activities for which RDs and DTRs are accountable;
- describe the role of dietetics and the unique services that RDs and DTRs provide within the health care team;
- illustrate that food and nutrition services are provided in a framework that encourages continuous quality improvement;
- provide a basis for researchers to investigate relationships between dietetics practice and outcomes;
- provide a framework for educators to set objectives for educational programs; and
- reflect applicable federal laws and regulations (11,12).

The standards emphasize:

- the RD/DTR team; and
- the role of DTRs as an extension of RDs; for example, often being the first staff members from the nutrition team that a patient or client meets, serving as a conduit of nutrition care information at meetings and care conferences, and contributing to the continuum of care by facilitating communication between staff providing nutrition care and nursing care.

HOW ARE MEDICAL NUTRITION THERAPY (MNT) AND THE NCP RELATED?

ADA first defined MNT in the mid-1990s to promote the benefits of managing or treating a disease with nutrition (3). Its components included an assessment of nutritional status of patients and the provision of either diet modification, counseling, or specialized nutrition therapies. MNT became a broadly used term to describe a wide variety of food and nutrition care services.

However, in 2001, as part of the Medicare MNT benefit legislation, MNT received a new meaning. MNT services are now defined as the “nutritional diagnostic, therapy, and counseling services for the purpose of disease management, which are furnished by a registered dietitian or nutrition professional” (13).

In this context, RD or nutrition professional refers specifically to an individual who holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized by the Secretary of Health and Human Services for this purpose; has completed at least 900 hours of supervised dietetics practice under the supervision of an RD or nutrition professional; and is licensed or certified as an RD or nutrition professional by the state in which the services are performed; or in the case of an individual in a state that does not provide for such licensure or certification, meets such other criteria as the Secretary of Health and Human Services establishes (13).

As a result of this benefit legislation,

MNT is one specific type of nutrition care. NCP is a problem-solving method used in the application of MNT. The NCP is used to guide nutrition education and other preventative nutrition care services. The NCP articulates the consistent and specific steps exercised when delivering MNT. One of the key distinguishing characteristics between MNT and the other nutrition services using NCP is that MNT always involves in-depth, comprehensive assessment and individualized care (3).

HOW ARE THE STANDARDS STRUCTURED?

The standards are outcome focused with primarily process-type indicators. Each standard is equal in relevance and importance. Content for descriptions of standards, rationales, and indicators for standards of practice are adapted from ADA's *International Dietetics and Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process* (14). The standards are structured so that each has a standard (a brief description of the competent level of dietetics practice), a rationale (a description of the intent, purpose, and importance of the standard), indicators (action statements that illustrate how each standard may be applied in practice), and examples of outcomes (measurable results of applying the indicators to practice).

HOW CAN I USE THE STANDARDS TO EVALUATE MY PRACTICE AND PERFORMANCE?

The standards can be used as part of the Commission on Dietetic Registration Professional Development Portfolio process (15) to develop goals and focus continuing education efforts. The Professional Development Portfolio allows RDs and DTRs to engage in reflection, self-assessment, and goal setting, which are the critical components of Professional Development Portfolio recertification. The Figure shows a tool for reflecting on practice using the 2008 SOP in Nutrition Care and the SOPP. This assessment can lead to identification of individual learning needs.

HOW DO THE STANDARDS RELATE TO MY EVERYDAY PRACTICE?

The 2008 SOP in Nutrition Care and the SOPP provide a common under-

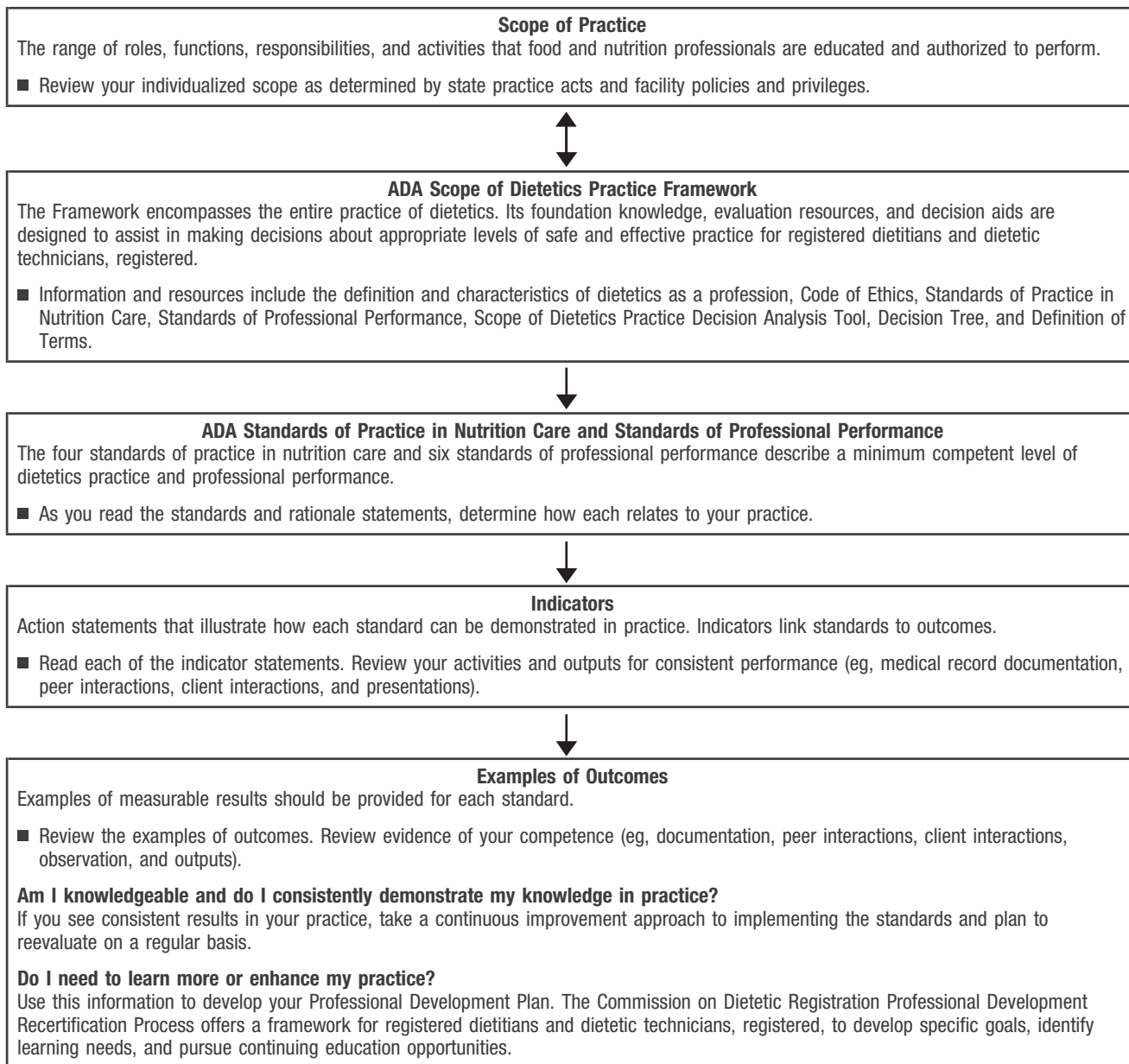


Figure. Flow chart for implementing the Standards of Practice and Standards of Professional Performance. Adapted from references 1 and 5; the American Dietetic Association: Standards of Professional Practice for Dietetics Professionals. *J Am Diet Assoc.* 1998;98:83-87; and the Evidence-Based Nutrition Practice Guidelines for Diabetes and Scope and Standards of Practice. *J Am Diet Assoc.* 2008;108(suppl 1):S52-S58.

standing of the role of RDs and DTRs in patient/client care and in nonpatient care roles, respectively. The standards also provide a common understanding about the profession's minimum expectations for practice and performance. Together the two sets of standards form a basis for self-evaluation and improvement and they establish an expectation about dietetic care and service delivery. Professional standards serve as a teaching tool and a guide for

both new and experienced RDs and DTRs (16,17).

The indicators and examples of outcomes are provided to elaborate on the standard. RDs and DTRs may not apply every indicator and achieve every outcome all at once, RDs and DTRs are not limited to the indicators and examples of outcomes provided, and all indicators may not be applicable to all RDs and DTRs.

The standards are written in broad

terms to allow for individual practitioners' handling of nonroutine situations. They are geared toward typical situations and toward practitioners with the RD or DTR credential, not those with credentials or degrees beyond that which is required for RD or DTR certification, and they are not intended to supersede the individual needs of a patient/client at any given time. RDs and DTRs face complex situations every day. Understanding the unique needs

of each situation and the latitude in applying standards is important to providing effective care and service. Strictly adhering to standards does not in and of itself constitute best care and service. It is the responsibility of individual practitioners to recognize and interpret situations, and to know what standards apply and in what ways they apply (18). Practitioners must understand the federal, state, and local laws and regulations affecting their practice as well as organizational policies and guidelines (1,19,20). Professional standards do not supersede laws and policies; however, they can serve as a resource for the development or modification of laws, policies, and guidelines.

The standards have been formulated to be used for individual self-evaluation and the development of practice guidelines, but not for institutional credentialing or for adverse or exclusionary decisions regarding privileging, employment opportunities or benefits, disciplinary actions, or determinations of negligence or misconduct. These standards do not constitute medical or other professional advice, and should not be taken as such. The information presented in these standards is not a substitute for the exercise of professional judgment by a health care professional. The use of the standards for any other purpose than that for which they were formulated must be undertaken with the sole authority and discretion of the user.

SUMMARY

The 2008 ADA SOP in Nutrition Care and SOPP for RDs and DTRs, practice-specific SOP/SOPP, and the ADA Code of Ethics are used collectively to gauge and guide a competent level of dietetics practice and performance. These resources continue to be reviewed and updated as new trends in the profession of dietetics and external influences emerge.

All RDs and DTRs should have in their personal libraries the most recent copies of the resources that compose the ADA Scope of Dietetics Practice Framework. To ensure that ADA members always have access to the most up to date materials, each resource is maintained on the Practice tab of ADA's Web site (www.eatright.org).

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Appendix. American Dietetic Association 2008 Standards of Practice for Registered Dietitians in Nutrition Care

Standard 1: Nutrition Assessment

Registered dietitians (RDs) use accurate and relevant data and information to identify nutrition-related problems.

Rationale: Nutrition assessment is the first of four steps of the Nutrition Care Process. Nutrition assessment is a systematic process of obtaining, verifying, and interpreting data to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals or groups for nutrition risk factors. Nutrition assessment is an ongoing, dynamic process that involves not only initial data collection, but also reassessment and analysis of client or community needs. It provides the foundation for nutrition diagnosis, the second step of the Nutrition Care Process.

Indicators for Standard 1: Nutrition Assessment

1. *Each RD:*

- 1.1 Evaluates dietary intake for factors that affect health and conditions including nutrition risk
 - 1.1A Adequacy and appropriateness of food, beverage and nutrient intake (eg, macro- and micro-nutrients, meal patterns, and food allergies)
 - 1.1B Adequacy and appropriateness of current diet prescription
- 1.2 Evaluates health and disease condition(s) for nutrition-related consequences
 - 1.2A Medical and family history and comorbidities
 - 1.2B Physical findings (eg, physical or clinical exam)
 - 1.2B1 Anthropometric measurements
 - 1.2C Medication management (eg, prescription, over-the-counter, and herbal medications; medication allergies; medication/food interaction; and adherence)
 - 1.2D Complications and risks
 - 1.2E Diagnostic tests, procedures, evaluations

- 1.2F Physical activity, habits, and restrictions
- 1.2G Population-based surveys
- 1.3 Evaluates psychosocial, socioeconomic, functional, and behavioral factors related to food access, selection, preparation, and understanding of health condition
 - 1.3A Uses validated tools to assess developmental, functional, and mental status, and cultural, ethnic, and lifestyle factors
- 1.4 Evaluates client(s) knowledge, readiness to learn, and potential for behavior changes
 - 1.4A History of previous nutrition care services/medical nutrition therapy
- 1.5 Identifies standards by which data will be compared
- 1.6 Identifies possible problem areas for determining nutrition diagnoses
- 1.7 Documents and communicates:
 - 1.7A Date and time of assessment
 - 1.7B Pertinent data and comparison to standards
 - 1.7C Client's perceptions, values, and motivation related to presenting problems
 - 1.7D Changes in clients' perceptions, values, and motivation related to presenting problems
 - 1.7E Reason for discharge/discontinuation or referral if appropriate

Examples of Outcomes for Standard 1: Nutrition Assessment

- Appropriate assessment tools and procedures (matching the assessment method to the situation) are implemented
- Assessment tools are applied in valid and reliable ways
- Appropriate data are collected
- Data are validated
- Data are collected, organized, and categorized in a meaningful framework that relates to nutrition problems
- Effective interviewing methods are used
- Problems that require consultation with or referral to another provider are recognized
- Documentation and communication of assessment are complete, relevant, accurate, and timely

Standard 2: Nutrition Diagnosis

RDs identify and label specific nutrition problem(s) that the RD is responsible for treating.

Rationale: Nutrition diagnosis is the second of four steps of the Nutrition Care Process. At the end of the nutrition assessment step, data are clustered, analyzed and synthesized. This will reveal a nutrition diagnosis category from which to formulate a specific nutrition diagnosis statement. There is a difference between a nutrition diagnosis and a medical diagnosis. A nutrition diagnosis changes as the client response changes, whereas a medical diagnosis does not change as long as the disease or condition exists. The nutrition diagnosis(es) demonstrates a link to determining goals for outcomes, selecting appropriate interventions, and tracking progress in attaining expected outcomes.

Indicators for Standard 2: Nutrition Diagnosis

2. *Each RD:*

- 2.1 Derives the nutrition diagnosis(es) from the assessment data
 - 2.1A Identifies and labels the problem
 - 2.1B Determines etiology (cause/contributing risk factors)
 - 2.1C Clusters signs and symptoms (defining characteristics)
- 2.2 Ranks (classifies) the nutrition diagnosis(es)
- 2.3 Validates the nutrition diagnosis(es) with clients/community, family members, or other health care professionals when possible and appropriate
- 2.4 Documents the nutrition diagnosis(es) using standardized language and written statement(s) that include problem (p), etiology (e), and signs and symptoms (s)
- 2.5 Re-evaluates and revises nutrition diagnosis(es) when additional assessment data become available

Examples of Outcomes for Standard 2: Nutrition Diagnosis

- Nutrition diagnostic statements that are:
 - Clear and concise

- Specific—client- or community-centered
- Accurate—relates to the etiology
- Based on reliable and accurate assessment data
- Includes date and time
- Documentation of nutrition diagnosis(es) is relevant, accurate, and timely
- Documentation of nutrition diagnosis(es) is revised and updated as additional assessment data become available

Standard 3: Nutrition Intervention

RDs identify and implement appropriate, purposefully planned actions designed with the intent of changing a nutrition-related behavior, risk factor, environmental condition, or aspect of health status for an individual, target group, or the community at large.

Rationale: Nutrition intervention is the third of four steps of the Nutrition Care Process. It consists of two inter-related components—planning and implementation. Planning involves prioritizing the nutrition diagnoses, conferring with the patient/client and/or others, reviewing practice guides and policies, and setting goals and defining the specific nutrition intervention strategy. Implementation of the nutrition intervention is the action phase that includes carrying out and communicating the plan of care, continuing data collection, and revising the nutrition intervention strategy, as warranted, based on the patient/client response. An RD performs the interventions or assigns the nutrition care that others provide in accordance with federal, state, and local laws and regulations.

Indicators for Standard 3: Nutrition Intervention

3. Each RD:

Plans the Nutrition Intervention:

- 3.1 Prioritizes the nutrition diagnosis based on problem severity, safety, patient/client needs, likelihood that nutrition intervention will influence problem, and patient/client perception of importance
- 3.2 Bases intervention plan on best available evidence (eg, national

guidelines, published research, evidence-based libraries, and databases)

- 3.3 Refers to policies and program standards
- 3.4 Confers with patient/client and caregivers
- 3.5 Determines patient/client-focused goals and expected outcomes
- 3.6 Details the nutrition prescription
- 3.7 Defines time and frequency of care
- 3.8 Utilizes standardized language for describing interventions
- 3.9 Identifies resources and/or referrals needed

Implements the Nutrition Intervention:

- 3.10 Collaborates with colleagues
- 3.11 Communicates the plan of care
- 3.12 Initiates the plan of care
- 3.13 Continues data collection
- 3.14 Individualizes nutrition intervention
- 3.15 Follows up and verifies that nutrition intervention is occurring
- 3.16 Adjusts intervention strategies, if needed, as response occurs
- 3.17 Documents:
 - 3.17A Date and time
 - 3.17B Specific treatment goals and expected outcomes
 - 3.17C Recommended interventions
 - 3.17D Adjustments to the plan and justification
 - 3.17E Client/community receptivity
 - 3.17F Referrals made and resources used
 - 3.17G Other information relevant to providing care and monitoring progress over time
 - 3.17H Plans for follow up and frequency of care
 - 3.17I Rationale for discharge if applicable

Examples of Outcomes for Standard 3: Nutrition Intervention

- Appropriate prioritizing and setting of goals/expected outcomes
- Appropriate nutrition plan or prescription is developed
- Interdisciplinary connections are established
- Nutrition interventions are delivered and actions are carried out
- Documentation of nutrition intervention is:

- Comprehensive
- Specific
- Accurate
- Relevant
- Timely
- Dated and timed
- Documentation of nutrition intervention is revised and updated

Standard 4: Nutrition Monitoring and Evaluation

RDs monitor and evaluate indicators and outcomes data directly related to the nutrition diagnosis, goals, and intervention strategies to determine the progress made in achieving desired outcomes of nutrition care and whether planned interventions should be continued or revised.

Rationale: Nutrition monitoring and evaluation is the fourth step in the Nutrition Care Process. Through monitoring and evaluation, an RD identifies important measures of change or patient/client outcomes relevant to the nutrition diagnosis and nutrition intervention and describes how best to measure these outcomes. The aim is to promote uniformity within the profession in evaluating the efficacy of nutrition interventions. In addition, an outcomes management system might be implemented.

Indicators for Standard 4: Nutrition Monitoring and Evaluation

4. Each RD:

- 4.1 Monitors progress:
 - 4.1A Checks patient/client understanding and compliance with nutrition intervention
 - 4.1B Determines whether the intervention is being implemented as prescribed
 - 4.1C Provides evidence that the nutrition intervention is or is not changing the patient/client behavior or status
 - 4.1D Identifies positive or negative outcomes
 - 4.1E Gathers information to indicate progress or reasons for lack of progress
 - 4.1F Supports conclusions with evidence
- 4.2 Measures outcomes:
 - 4.2A Selects the nutrition care outcome indicator(s) to measure
 - 4.2B Uses standardized nutrition care outcome indicator(s)

- 4.3 Evaluates outcomes:
 - 4.3A Compares monitoring data with nutrition prescription/goals or reference standard
 - 4.3B Evaluates effect of the sum of all interventions on overall patient/client health outcomes
- 4.4 Documents:
 - 4.4A Date and time
 - 4.4B Indicators measured, results, and the method for obtaining measurement
 - 4.4C Criteria to which the indicator is compared (eg, nutrition prescription/goal or a reference standard)
 - 4.4D Factors facilitating or hampering progress
 - 4.4E Other positive or negative outcomes
 - 4.4F Future plans for nutrition care, nutrition monitoring, and follow up or discharge

Examples of Outcomes for Standard 4: Nutrition Monitoring and Evaluation

- The client/community outcome(s) directly relate to the nutrition diagnosis and the goals established in the intervention plan. Examples include but are not limited to:
 - Nutrition outcomes (eg, change in knowledge, behavior, food or nutrient intake)
 - Clinical and health status outcomes (eg, change in laboratory values, body weight, blood pressure, risk factors, signs and symptoms, clinical status, infections, and complications)
 - Client-centered outcomes (eg, quality of life, satisfaction, self-efficacy, self-management, and functional ability)
 - Health care utilization and cost-effectiveness outcomes (eg, change in medication, special procedures, planned/unplanned clinic visits, preventable hospital admissions, length of hospitalizations, and prevented or delayed nursing home admissions)
- Documentation of nutrition monitoring and evaluation is:
 - Comprehensive
 - Specific
 - Accurate
 - Relevant
 - Timely
 - Dated and timed

AMERICAN DIETETIC ASSOCIATION 2008 STANDARDS OF PROFESSIONAL PERFORMANCE FOR REGISTERED DIETITIANS

Standard 1: Provision of Services

Registered dietitians (RDs) provide quality service based on customer expectations and needs.

Rationale: Quality service is provided, facilitated, and promoted based on an RD's knowledge, experience, and understanding of patient/client needs and expectations.

Indicators for Standard 1: Provision of Services

1. *Each RD:*
 - 1.1 Provides input and is active in the development of nutrition screening parameters
 - 1.2 Audits nutrition screening processes for efficiency and effectiveness
 - 1.3 Contributes to and designs referral process and systems to facilitate public access to food and nutrition professionals
 - 1.4 Collaborates with patient/client to assess needs, background, and resources and to set priorities, establish goals, and create individualized action plans
 - 1.5 Informs and involves patients/clients and their families in decision making
 - 1.6 Recognizes patient/client concepts of illness and their cultural beliefs
 - 1.7 Applies knowledge and principles of disease prevention and behavior change appropriate for diverse populations
 - 1.8 Collaborates and coordinates with colleagues
 - 1.9 Applies knowledge and skills to determine appropriate action plans
 - 1.10 Develops policies and procedures that reflect best evidence and applicable laws and regulations
 - 1.11 Advocates for the provision of food and nutrition services as part of public policy
 - 1.12 Maintains records of services provided
 - 1.13 Develops nutrition protocols and policies for target populations
 - 1.14 Implements food/formulary de-

livery systems in terms of the nutrition status, health, and well-being of target populations

Examples of Outcomes for Standard 1: Provision of Services

- Patients/clients participate in establishing goals
- Patients/clients needs are met
- Patients/clients are satisfied with services and products
- Evaluations reflect expected outcomes
- Effective screening and referral services are established
- Patients/clients have access to food assistance
- Patients/clients have access to nutrition services

Standard 2: Application of Research

RDs apply, participate in, or generate research to enhance practice.

Rationale: Application, participation, and generation of research promotes improved safety and quality of dietetic practice and services.

Indicators for Standard 2: Application of Research

2. *Each RD:*
 - 2.1 Accesses and reviews best available research findings for application to dietetics practice
 - 2.2 Bases practice on significant scientific principles and best evidence
 - 2.3 Integrates best evidence with clinical and managerial expertise and client values
 - 2.4 Promotes research through alliances and collaboration with food and nutrition and other professionals and organizations
 - 2.5 Contributes to the development of new knowledge and research in dietetics
 - 2.6 Collects measurable data and documents outcomes within practice setting
 - 2.7 Communicates research data and activities through publications and presentations

Examples of Outcomes for Standard 2: Application of Research

- Patient/client receives appropriate services based on the effective application of best evidence

- A foundation for performance measurement and improvement is established
- Best evidence is used for the development and revision of resources used in practice
- Benchmarking and knowledge of best practices is used to evaluate and improve performance

Standard 3: Communication and Application of Knowledge

RDs effectively apply knowledge and communicate with others.

Rationale: RDs work with and through others to achieve common goals by effective sharing and application of their unique knowledge and skills in food, human nutrition, and management services.

Indicators for Standard 3: Communication and Application of Knowledge

3. Each RD:

- 3.1 Exhibits knowledge related to a particular aspect of the profession of dietetics
- 3.2 Communicates and applies scientific principles, research, and theory
- 3.3 Selects appropriate information and best method or format for presenting in writing or verbally when communicating information
- 3.4 Integrates knowledge of food and human nutrition with knowledge of health, social sciences, communication, and management
- 3.5 Shares knowledge and information with patients/clients, colleagues, and the public
- 3.6 Guides students, interns, and patients/clients in the application of knowledge and skills
- 3.7 Seeks current and relevant information related to practice
- 3.8 Contributes to the development of new knowledge
- 3.9 Uses information technology to communicate, manage knowledge, and support decision making
- 3.10 Contributes to the multidisciplinary approach by promoting food and nutrition strategies that influence health and quality of life outcomes of target populations

- 3.11 Establishes credibility as a resource within the multidisciplinary health care and management team

Examples of Outcomes for Standard 3: Communication and Application of Knowledge

- Expertise in food, nutrition, and management is shared
- Individuals and groups:
 - Receive current and appropriate information
 - Understand information received
 - Know how to obtain additional guidance

Standard 4: Utilization and Management of Resources

RDs use resources effectively and efficiently.

Rationale: Mindful management of time, money, facilities, staff, and other resources demonstrates organizational citizenship.

Indicators for Standard 4: Utilization and Management of Resources

4. Each RD:

- 4.1 Uses a systematic approach to maintain and manage resources
- 4.2 Quantifies management of resources in the provision of dietetic services
- 4.3 Evaluates safety, effectiveness, and value while planning and delivering services and products
- 4.4 Participates in continuous quality improvement and documents outcomes relative to resource management
- 4.5 Assists individuals and groups to identify and secure appropriate and available resources and services

Examples of Outcomes for Standard 4: Utilization and Management of Resources

- Documentation of resource use is consistent with plan
- Data are used to promote and validate services
- Desired outcomes are achieved and documented

- Resources are effectively and efficiently managed

Standard 5: Quality in Practice

RDs systematically evaluate the quality of services and improve practice-based on evaluation results.

Rationale: Quality practice requires regular performance evaluation and continuous improvement.

Indicators for Standard 5: Quality in Practice

5. Each RD:

- 5.1 Knows, understands, and complies with federal, state, and local laws and regulations
- 5.2 Understands pertinent national quality and safety initiatives (eg, The Institute of Medicine, The National Quality Forum, The Institute for Healthcare Improvement)
- 5.3 Implements an Outcomes Management System to evaluate the effectiveness and efficiency of practice
- 5.4 Understands and continuously measures quality of dietetic services in terms of process and outcomes
- 5.5 Identifies performance improvement criteria to monitor effectiveness of services
- 5.6 Designs and tests interventions to improve processes and services
- 5.7 Identifies and addresses errors and hazards in dietetic services
- 5.8 Identifies expected outcomes
- 5.9 Documents outcomes
- 5.10 Compares actual performance to expected outcomes
- 5.11 Documents actions taken when discrepancies exist between actual performance and expected outcomes
- 5.12 Continuously evaluates and refines services based on measured outcomes

Examples of Outcomes for Standard 5: Quality in Practice

- Performance indicators are measured and evaluated
- Aggregate outcomes results meet pre-established criteria (goals/objectives)

- Results of quality improvement activities direct refinement of practice

Standard 6: Competency and Accountability

RDs engage in lifelong learning.

Rationale: Competent and accountable practice includes continuous acquisition of knowledge and skill development.

Indicators for Standard 6: Competence and Accountability

6. *Each RD:*

- 6.1 Conducts self-assessment of strengths and weakness at regular intervals
- 6.2 Identifies needs for development from a variety of sources
- 6.3 Participates in peer review
- 6.4 Mentors others
- 6.5 Develops and implements a plan for professional growth
- 6.6 Documents development activities
- 6.7 Adheres to the ADA Code of Ethics
- 6.8 Assumes responsibility for actions and behaviors
- 6.9 Integrates the ADA Standards of Practice and Standards of Professional Performance into self-assessment and development plans
- 6.10 Applies research findings and best available evidence into practice
- 6.11 Obtains occupational certifications in accordance with federal, state, and local laws and regulations
- 6.12 Seeks leadership opportunities

Examples of Outcomes for Standard 6: Competence and Accountability

- Self assessments are completed
- Development needs are identified
- Directed learning is demonstrated
- Practice reflects the ADA Code of Ethics
- Practice reflects the ADA Standards of Practice and Standards of Professional Performance
- Practice reflects best available evidence
- Relevant certifications are obtained
- Commission on Dietetic Registration

tion recertification requirements are met

AMERICAN DIETETIC ASSOCIATION 2008 STANDARDS OF PRACTICE FOR DIETETIC TECHNICIANS, REGISTERED IN NUTRITION CARE

The term *supervision* is used in the following Standards of Practice for dietetic technicians, registered (DTRs), in nutrition care.

For the purpose of this document ADA describes supervision as follows:

A registered dietitian (RD) is accountable for the nutrition care of patients in various health care settings (eg, hospitals, nursing homes, home health agencies, end-stage renal facilities, and other) and social services programs (eg, the Special Supplemental Nutrition Program for Women, Infants, and Children; Older Americans; and other). In many health care settings, a DTR and other staff may be available to assist an RD. In these settings RDs must answer to patients, employers, boards of dietetics licensure, and the legal system if care is compromised.

RDs do not delegate the nutrition care process, but may assign certain tasks for the purpose of providing RDs with needed information (eg, screens and gathering of data and other information) or communicating with and educating patients. RDs may assign to DTRs interventions within the DTR's scope of practice, such as provision of meals and snacks that meet the Dietary Guidelines for Americans.

Whether the supervision is direct (RD is on premises and immediately available) or indirect (RD is immediately available by telephone or other electronic means) is determined by regulatory and facility policies and procedures.

Additional considerations related to this description include:

Regulation: State licensure statutes and rules may include definitions of supervision and scope of practice specifications for technical and other assistive staff. Federal and state rules and regulations for health care facilities and for social service programs specify the qualified food and nutrition professional.

Accreditation: Standards verify compliance with federal and state regulatory requirements and may specify additional requirements for an RD.

Other forms of supervision not

covered by this definition: This description of supervision as it relates to the RD/DTR team is not synonymous with managerial supervision or oversight, clinical supervision, (eg, peer-to-peer), supervision of provisional licensees, and/or supervision of dietetic interns and students. Clinical supervision is used in medicine and the mental health fields for the purposes of case review and professional development.

Standard 1: Participates in Nutrition Screening and Provides Support to Nutrition Assessment

DTRs participate in the nutrition screening of individuals and/or populations and obtains and verifies relevant data and information in a timely manner for support of nutrition assessment under the supervision of an RD.

Rationale: Nutrition screening is the preliminary step that precedes the first step of the Nutrition Care Process—nutrition assessment. Although nutrition assessment is the responsibility of RDs, DTRs take an active role in obtaining and verifying relevant data and information for the RD to complete the assessment.

Indicators for Standard 1: Participates in Nutrition Screening and Provides Support to Nutrition Assessment

1. *DTRs assist RDs by obtaining and documenting verifiable, relevant data and information for individuals and/or populations by the following:*
 - 1.1 Conducts nutrition screening according to pre-established criteria
 - 1.2 Conducts dietary intakes:
 - 1.2A Collects dietary/nutrient intake information
 - 1.2B Records dietary/nutrient intake data
 - 1.2C Calculates dietary/nutrient intake
 - 1.2D Compares calculated intake to standards that have been identified by the RD
 - 1.2E Summarizes dietary intake information
 - 1.3 Conducts interviews and/or reviews records for:
 - 1.3A Medical and family history and co-morbidities
 - 1.3B Physical observations

- 1.3B1 Anthropometric measurements
- 1.3C Medication data (eg, prescription, over-the-counter, and herbal medications; medication allergies; potential for medication/food interaction; and adherence)
- 1.3D Potential nutrition-related complications and risks
- 1.3E Diagnostic tests, procedures, evaluations, and population-based surveys
- 1.3F Physical activity habits and restrictions
- 1.3G Psychosocial, socioeconomic, functional, and behavior factors related to food access, selection, preparation, and understanding of health condition
- 1.4 Documents and communicates:
 - 1.4A Date and time of interviews
 - 1.4B Date and time of records and data review
 - 1.4C Pertinent data and comparisons to standards
 - 1.4D Patient/client perceptions, interest, and motivation related to nutrition care
 - 1.4E Patient/client level of understanding, reported food-related behaviors, and other pertinent information

Examples of Outcomes for Standard 1: Participates in Nutrition Screening and Provides Support to Nutrition Assessment

- Effective interviewing methods are utilized
- Appropriate data are recorded
- Data can be verified
- Data are organized and categorized in a meaningful framework that relates to nutrition problems
- Documentation is:
 - Comprehensive
 - Specific
 - Accurate
 - Relevant
 - Timely
 - Dated and Timed
- Corrections to recorded data are made by approved methods

Standard 2: Provides Support to Nutrition Diagnosis

DTRs obtain, verify, and document relevant data and information to support RDs in identifying nutrition diagnoses of individuals or nutrition problems for populations. DTRs ob-

serve and communicate signs, symptoms, and other relevant information in a timely and accurate manner.

Rationale: The nutrition diagnosis is the second step in the Nutrition Care Process. DTRs contribute to nutrition diagnosis by obtaining and verifying relevant data and information about signs and symptoms for an RD to effectively cluster, analyze, and synthesize information to determine a nutrition diagnostic category(ies). Timely/appropriate nutrition diagnosis by an RD leads to timely/appropriate nutrition intervention.

Indicators for Standard 2: Provide Support to Nutrition Diagnosis

- 2. *DTRs assist RDs by obtaining and documenting accurate, relevant data, and information about signs and symptoms for individuals and/or populations by the following:*
 - 2.1 Observes and obtains signs and symptoms (defining characteristics)
 - 2.2 Verifies signs and symptoms with clients/community, family members, or other health care professionals when possible and appropriate
 - 2.3 Documents signs and symptoms/defining characteristics
 - 2.4 Communicates information about signs and symptoms/defining characteristics to an RD

Examples of Outcomes for Standard 2: Provide Support to Nutrition Diagnosis

- Documentation of signs and symptoms is:
 - Comprehensive
 - Specific
 - Accurate
 - Relevant
 - Timely
 - Dated and Timed
- Documentation of signs and symptoms is updated as additional data and information become available

Standard 3: Provides Support to Nutrition Intervention as Directed by an RD

DTRs assist RDs with nutrition interventions related to the nutrition diagnosis by implementing appropriate, purposefully planned intervention de-

signed with the intent of changing a nutrition-related behavior, risk factor, environmental condition, or aspect of health status for individuals and/or populations.

Rationale: Nutrition intervention is the third step of the Nutrition Care Process. Nutrition intervention is purposefully planned actions designed with the intent of changing nutrition-related behaviors, risk factors, environmental conditions, or aspect of health status for an individual, target group or community-at-large. DTRs contribute to the nutrition intervention by performing certain interventions such as nutrition classes and patient education with the goal of positively influencing the nutrition diagnosis/problem.

Indicators for Standard 3: Provide Support to Nutrition Intervention as Directed by an RD

- 3. *DTRs assist RDs by performing certain nutrition interventions for individuals and/or populations by the following:*
 - 3.1 Provides interventions as planned and directed by an RD and in accordance with
 - 3.1A Federal, state, and local statutes and regulations
 - 3.1B Health care facility or program policies and procedures
 - 3.2 Responds to patient/client inquiries regarding interventions that are within the established plan of care and consistent with a DTR's demonstrated competencies
 - 3.3 Communicates and clarifies the nutrition care plan, as developed by an RD, with patients/clients and interdisciplinary health care team members
 - 3.4 Documents intervention activities
 - 3.5 Verifies that nutrition interventions are occurring and patient/client needs are being met

Examples of Outcomes for Standard 3: Provide Support to Nutrition Intervention as Directed by an RD

- Nutrition prescription is implemented
- Documentation of intervention is
 - Comprehensive

- Specific
- Accurate
- Relevant
- Timely
- Dated and timed
- Patient/client menus reflect nutrition prescription
- DTRs report to RDs observed changes in the patient/client status that might influence the planned intervention
- Interdisciplinary connections are established

Standard 4: Provides Nutrition Monitoring and Supports Nutrition Evaluation

DTRs participate in the nutrition monitoring of individuals and/or populations under the supervision of RDs. DTRs use selected indicators as established by or in communication with RDs that are relevant to the patient's/client's defined needs, nutrition diagnosis/problem, nutrition goals, and health status.

Rationale: Nutrition monitoring and evaluation is the fourth step in the Nutrition Care Process. By obtaining nutrition data and information at scheduled (preplanned) follow-up points, DTRs assist RDs in nutrition monitoring and supports nutrition evaluation by an RD.

Indicators for Standard 4: Provides Nutrition Monitoring and Supports Nutrition Evaluation

4. *DTRs provide nutrition monitoring as support to nutrition evaluation of individuals and/or populations by the following:*
 - 4.1 Checks client understanding and adherence with plan for care
 - 4.2 Determines whether the intervention is being implemented as prescribed
 - 4.3 Identifies data and information impacting the effectiveness of the intervention strategy
 - 4.4 Communicates with RDs regarding monitoring activities and findings
 - 4.5 Participates in discharge planning for individuals and/or populations
 - 4.6 Tracks and documents:
 - 4.6A Progress toward goals
 - 4.6B Factors affecting progress
 - 4.6C Changes in patient/client level

- of understanding and food-related behaviors
- 4.6D Change in clinical data, health, or functional status
- 4.6E Outcomes of intervention

Examples of Outcomes for Standard 4: Provides Nutrition Monitoring and Supports Nutrition Evaluation

- Documentation of monitoring may include:
 - Knowledge or understanding
 - Behavior
 - Intake
 - Laboratory values
 - Body weight
 - Blood pressure
 - Complications
 - Activities of daily living
 - Medication/diet prescription changes
 - Satisfaction measurement
 - Communications with RDs
 - Participation in discharge planning
- Observed deviations in implementation of nutrition care plan are reported to RDs
- Documentation of monitoring is:
 - Comprehensive
 - Specific
 - Accurate
 - Relevant
 - Timely
 - Dated and timed

AMERICAN DIETETIC ASSOCIATION 2008 STANDARDS OF PROFESSIONAL PERFORMANCE FOR DIETETIC TECHNICIANS, REGISTERED

Standard 1: Provision of Services

Dietetic technicians, registered (DTRs) provide quality service based on customer expectations and needs.

Rationale: Quality service is provided, facilitated, and promoted based on a DTR's knowledge, experience, and understanding of patient/client needs and expectations.

Indicators for Standard 1: Provision of Services

1. *Each DTR:*
 - 1.1 Implements established screening systems
 - 1.2 Implements established referral systems
 - 1.3 Informs and involves patients/

- clients and their families in decision making
- 1.4 Recognizes patient/client concepts of illness and their cultural beliefs
- 1.5 Applies knowledge and principles of disease prevention and behavior change appropriate for diverse populations
- 1.6 Collaborates and coordinates with other practitioners as appropriate
- 1.7 Applies knowledge and skills to participate in determining the most appropriate action plan
- 1.8 Delivers services according to policies and procedures that reflect best evidence and applicable laws and regulations
- 1.9 Advocates for the provision of food and nutrition services as part of public policy
- 1.10 Maintains records of services provided

Examples of Outcomes for Standard 1: Provision of Services

- Patients/clients needs are met
- Patients/clients are satisfied with services and products
- Screening and referral services are implemented as designed
- Patients/clients have access to food assistance
- Patients/clients have access to nutrition services

Standard 2: Application of Research

DTRs participate in research to enhance practice.

Rationale: Participation in dietetics research leads to improved safe and quality practice and services.

Indicators for Standard 2: Application of Research

2. *Each DTR in collaboration with RDs and other health care professionals:*
 - 2.1 Reviews best available research findings for application to dietetics practice
 - 2.2 Bases practice on significant scientific principles and best evidence
 - 2.3 Integrates best evidence with clinical and managerial expertise and client values

- 2.4 Collects measurable data and documents outcomes within practice setting
- 2.5 Contributes ideas and assists in activities of the research team

Examples of Outcomes for Standard 2: Application of Research

- Patient/client receives appropriate services based on the effective application of best evidence
- A foundation for performance measurement and improvement is established
- Best evidence is used for the development and revision of resources used in practice
- Benchmarking and knowledge of best practices is used to evaluate and improve performance

Standard 3: Communication and Application of Knowledge

DTRs effectively apply knowledge and communicate with others.

Rationale: DTRs work with and through others to achieve common goals by effective sharing and application of their unique knowledge and skills in food, human nutrition, and management services.

Indicators for Standard 3: Communication and Application of Knowledge

3. *Each DTR:*

- 3.1 Exhibits knowledge related to a specific area(s) of dietetic service
- 3.2 Integrates knowledge of food and human nutrition with knowledge of health, social sciences, communication, and management
- 3.3 Selects appropriate information and best method or format for presenting in writing or verbally when communicating information
- 3.4 Shares knowledge and information with patients/clients, colleagues, and the public
- 3.5 Guides students, interns, and patients/clients in the application of knowledge and skills
- 3.6 Seeks current and relevant information related to practice
- 3.7 Contributes to the development of new knowledge
- 3.8 Uses information technology to

communicate, manage knowledge, and support decision making

- 3.9 Establishes credibility as a resource within the multidisciplinary health care or management team

Examples of Outcomes for Standard 3: Communication and Application of Knowledge

- Expertise in food, nutrition, and management is shared
- Individuals and groups:
 - Receive current and appropriate information
 - Understand information received
 - Know how to obtain additional guidance

Standard 4: Utilization and Management of Resources

DTRs use resources effectively and efficiently.

Rationale: Mindful management of time, money, facilities, staff, and other resources demonstrates organizational leadership.

Indicators for Standard 4: Utilization and Management of Resources

4. *Each DTR:*

- 4.1 Uses a systematic approach to maintain and manage resources
- 4.2 Quantifies management of resources in the provision of dietetic services
- 4.3 Participates in evaluations of safety, effectiveness, and value while planning and delivering services and products
- 4.4 Participates in continuous quality improvement and documents outcomes relative to resource management
- 4.5 Assists individuals and groups to identify and secure appropriate and available resources and services

Examples of Outcomes for Standard 4: Utilization and Management of Resources

- Documentation of resource use is consistent with plan
- Data are used to promote and validate services

- Desired outcomes are achieved and documented
- Resources are effectively and efficiently managed

Standard 5: Quality in Practice

DTRs participate in systematic evaluations of the quality of services and improve practice-based evaluation results.

Rationale: Quality practice requires regular performance evaluation and continuous improvement.

Indicators for Standard 5: Quality in Practice

5. *Each DTR:*

- 5.1 Knows, understands, and complies with federal, state, and local laws and regulations
- 5.2 Understands pertinent national quality and safety initiatives (eg, The Institute of Medicine, The National Quality Forum, and The Institute for Healthcare Improvement)
- 5.3 Participates in an Outcomes Management System to evaluate the effectiveness and efficiency of dietetic practice
- 5.4 Participates in the collection of measures of the quality of dietetic services in terms of process and outcomes
- 5.5 Collects performance improvement criteria designed to monitor the effectiveness of services
- 5.6 Helps to design and test interventions to improve processes and services
- 5.7 Identifies and communicates errors and hazards in dietetic services
- 5.8 Documents outcomes
- 5.9 Compares actual performance to expected outcomes
- 5.10 Documents actions taken when discrepancies exist between actual performance and expected outcomes
- 5.11 Continuously evaluates and refines services based on measured outcomes

Examples of Outcomes for Standard 5: Quality in Practice

- Performance improvement criteria are measured

- Performance measurement data are collected
- Aggregate outcomes meet pre-established criteria (goals/objectives)
- Results of quality improvement activities direct refinement of practice
- Commission on Dietetic Registration recertification requirements are met

Standard 6: Competence and Accountability

DTRs engage in lifelong learning.

Rationale: Competent and accountable practice includes continuous acquisition of knowledge and skill development.

Indicators for Standard 6: Competence and Accountability

6. *Each DTR:*

- 6.1 Conducts self-assessment of strengths and weakness at regular intervals
- 6.2 Identifies needs for development from a variety of sources
- 6.3 Participates in peer review and mentors others
- 6.4 Develops and implements a plan for professional growth
- 6.5 Documents development activities
- 6.6 Adheres to the ADA Code of Ethics
- 6.7 Assumes responsibility for actions and behaviors
- 6.8 Integrates the ADA Standards of Practice and Standards of Professional Performance into self-assessment and development plans
- 6.9 Applies research findings and best available evidence into practice
- 6.10 Seeks leadership opportunities

Examples of Outcomes for Standard 6: Competence and Accountability

- Self assessments are completed
- Development needs are identified
- Directed learning is demonstrated
- Practice reflects the ADA Code of Ethics
- Practice reflects the ADA Standards of Practice and Standards of Professional Performance
- Practice reflects best available evidence
- Relevant certifications are obtained