American Dietetic Association: Standards of Practice and Standards of Professional Performance for Registered Dietitians (Competent, Proficient and Expert) in Extended Care Settings

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Approved December 2010 by the Quality Management Committee of the American Dietetic Association (ADA) House of Delegates and the Executive Committee of Dietetics in Health Care Communities Dietetic Practice Group of the ADA. **Scheduled review date: April 2016.** Questions regarding the Standards of Practice and Standards of Professional Performance for registered dietitians in extended care settings may be addressed to ADA quality management staff—Sharon McCauley, MS, MBA, RD, LDN, FADA, director, Quality Management, or Cecily Byrne, MS, RD, LDN, manager, Quality Management at quality@eatright.org.

The Dietetics in Health Care Communities (DHCC) Dietetic Practice Group of the American Dietetic Association (ADA), under the guidance of the ADA Quality Management Committee and Scope of Dietetics Practice Framework Sub-Committee, has developed Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for registered dietitians (RDs) in extended care settings (ECS). These documents build on the ADA Revised 2008 SOP for RDs in Nutrition Care and SOPP for RDs (1). ADA's Code of Ethics (2) and the 2008 SOP in nutrition care and SOPP for RDs (1) are tools within the Scope of Dietetics Practice Framework (3) that guide the practice and performance of RDs in all settings. The concept of scope of practice is fluid (4), changing in response to the expansion of knowledge, the practice environment, and technology. An RD's legal scope of practice is defined by state legislation (eg, state licensure law) and differs from state to state. An RD may determine his or her own individual scope of practice using the Scope of Dietetics Practice Framework (3), which takes into account federal regulations; state laws; institutional policies and procedures; and individual competence, accountability, and responsibility for his or her own actions.

ADA's Revised 2008 SOP in nutrition care and SOPP (1) reflect the minimum competent level of dietetics practice and professional performance for RDs. ADA's SOP in nutrition care and SOPP (1) serve as blueprints for the development of focus area SOP and SOPP for RDs in competent, proficient, and expert levels of practice. The SOP in nutrition care address the four steps of the Nutrition Care Process (NCP) and activities related to an individual's care (5). They are designed to promote the provision of safe, effective, and efficient food and nutrition services; facilitate evidence-based practice; and serve as a professional evaluation resource. The SOPP are authoritative statements that describe a competent level of behavior in the professional role. Categorized behaviors that correlate with professional performance are divided into six separate standards.

The SOP and SOPP for RDs in ECS are a guide for self-evaluation and expanding practice, a means of identifying areas for professional development, and a tool for demonstrating competence in delivering nutrition care services. They are used by RDs to assess their current level of practice and to determine the education and training required to maintain currency in their

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focus area and for advancement to a higher level of practice. In addition, the standards may be used to assist RDs in transitioning their knowledge and skills to a new focus area. Like the Revised SOP in nutrition care and SOPP, the indicators (ie, measureable action statements that illustrate how each standard can be applied in practice) (see Figure 1, available online at www.adajournal.org) for the SOP and SOPP for RDs in ECS were developed with input and consensus of content experts representing diverse practice and geographic perspectives. The SOP and SOPP for RDs in ECS were reviewed and approved by the Executive Committee of the DHCC Dietetic Practice Group, the Scope of Dietetics Practice Framework Sub-Committee, and ADA's Quality Management Committee.

THREE LEVELS OF PRACTICE

Competent Practitioner

In dietetics, a competent practitioner is an individual who has just attained RD status, is starting in professional employment, and who acquires on-the-job skills as well as engages in tailored continuing education to enhance knowledge and skills. This beginner RD starts with technical training and interaction for advancement and breadth of competence. This RD's practice may include responsibilities across several areas of practice, including, but not limited to, more than one of the following: community, clinical, consultation and business, research, education, and food and nutrition management. A competent RD could be an entry-level RD just starting practice after registration or an experienced RD who has newly assumed responsibility to provide nutrition care in a new focus area. A focus area is defined as an area of dietetics practice that requires focused knowledge, skills, and experience.

Proficient Practitioner

A proficient practitioner is an RD who is ≥3 years beyond entry level into the profession, who has obtained operational job performance skills, and is successful in the chosen focus area of practice. This proficient practitioner demonstrates additional knowledge, skills, and experience in a focus area of dietetics practice. This RD may begin to acquire specialist credentials, if available, to demonstrate proficiency in a focus area of practice.

Expert Practitioner

An expert practitioner is an RD who is recognized within the profession and has mastered the highest degree of skill in or knowledge of a certain focus or generalized area of dietetics through additional knowledge, experience, or training. An expert practitioner exhibits a set of characteristics that include leadership and vision and demonstrates effectiveness in planning, evaluating, and communicating targeted outcomes. An expert practitioner may have expanded or specialist roles or both, and may possess an advanced credential in a focus area of practice, if available. Generally, the practice is more complex, and the practitioner has a high degree of professional autonomy and responsibility (6).

These standards, along with the ADA's Code of Ethics (2), answer the questions: Why is an RD uniquely qualified to provide nutrition services in the extended care setting? What knowledge, skills, and competencies does an RD need to demonstrate for the provision of safe, effective, and quality nutrition care in the ECS at the competent, proficient, and expert levels?

OVERVIEW

Seventy percent of people aged 65 years and older will require some form of long-term care services and/or assistance with activities of daily living during their lifetime, according to the US Department of Health and Human Services (7). Currently there are 9 million people living in the United States who are older than age 65 years and require long-term care. That number is expected to increase to 12 million by 2020 (8). It is estimated that individuals will spend at least 3 years in long-term care, of which 2 years will be spent at home taking advantage of community-based programs such as home health care, adult day care, home care, and senior centers (8). As an individual's activities of daily living decline he or she may transition into a health care community such as adult foster care, assisted living, continuing care retirement communities, board and care homes, or skilled nursing facilities.

Traditionally, a nursing home was one of the few options for extended care, but as the population ages, reimbursement for entitlement programs such as Medicare and Medicaid is broadening. In addition, there is a growing consensus that long-term care must be transformed from institution based and provider driven to person centered, consumer directed, and community based. The Money Follows the Person Rebalancing Demonstration Program was authorized by Congress in section 6071 of the Deficit Reduction Act of 2005 (9) and was designed to provide assistance to states to balance their long-term care systems and help Medicaid enrollees transition from institutions to the community.

The paradigm shift to person-centered care has been slowly integrated into skilled nursing facilities. Organizations such as the Pioneer Network are driving person-centered, resident-directed care with core values of dignity, respect, self-determination, and purposeful living (10). The Centers for Medicare & Medicaid Services (CMS) began this culture change in response to the 1987 Omnibus Budget Reconciliation Act by developing rules for Medicare/Medicaid program survey, certification, and enforcement of skilled nursing facilities that focus on improved quality of life and decision making by individuals and/or their surrogate decision makers (11). This has enhanced individual choice in all areas of care, including nutrition care.

Nutrition care in the ECS is broad and typically addresses needs of individuals with multiple complex comorbidities rather than just one ailment. RDs provide nutrition care for individuals living in the ECS. Residents aged 65 years and older commonly present with chronic kidney disease, diabetes mellitus, stroke, cancer, and heart disease (12). An RD may integrate disease-specific published SOP for diabetes, nephrology, and nutrition support (13-15) while including an individual's right to choose treatment modalities that are consistent with his or her beliefs and goals for health care and quality of life. In the ECS, end-of-life decisions significantly affect the development of nutrition care interventions for hydration and nourishment (16) perhaps more so than in other nutrition care settings.

The depth of RD involvement with an individual is dependent on his/her

How to Use the *Standards of Practice and Standards of Professional Performance for Registered Dietitians (Competent, Proficient and Expert) in Extended Care Settings* as part of the *Professional Development Portfolio* Process[a]	
1. Reflect	Assess your current level of practice and whether your goals are to expand your practice or maintain your current level of practice. Review the Standards of Practice and Standards of Professional Performance document to determine what you want your future practice to be, and assess your strengths and areas for improvement. These documents can help you set short- and long-term professional goals.
2. Conduct learning needs assessment	Once you have identified your future practice goals, you can review the Standards of Practice and Standards of Professional Performance document to assess your current knowledge, skills, behaviors, and define what continuing professional education is required to achieve the desired level of practice.
3. Develop learning plan	Based on your review of the Standards of Practice and Standards of Professional Performance, you can develop a plan to address your learning needs as they relate to your desired level of practice. Your learning plan may include a goal to obtain a specialist credential (eg, Board Certified Specialist in Gerontological Nutrition [CSG]).
4. Implement learning plan	As you implement your learning plan, keep reviewing the Standards of Practice and Standards of Professional Performance document to re-assess knowledge, skills, and behaviors and your desired level of practice.
5. Evaluate learning plan process	Once you achieve your goals and reach or maintain your desired level of practice, it is important to continue to review the Standards of Practice and Standards of Professional Performance document to re-assess knowledge, skills, and behaviors and your desired level of practice.

Figure 4. Application of the Commission on Dietetic Registration Professional Development Portfolio process. [a]The Commission on Dietetic Registration *Professional Development Portfolio* process is divided into five interdependent steps that build sequentially upon the previous step duringeach 5-year recertification cycle and succeeding cycles.

nutrition needs, the policies of the facility, and the desires and expectations of the individual and surrogate decision makers. The RD is responsible for overseeing the nutrition care of individuals in the ECS whether employed by or contracted with a health care organization. Consultant RDs rely heavily on members of the interdisciplinary team (IDT) for comprehensive overviews of individuals' health status, whereas RDs employed by a facility maintain a more hands-on relationship with individuals. IDT members who care for individuals are specific to the organization and may include the physician, nurse, Minimum Data Set (MDS) coordinator, social worker, therapists (eg, physical, occupational, recreational, and speech-language), pharmacist, dietitian, dietetic technician, chef, dietary manager and food production/safety/sanitation supervisor. Regardless of the practice scenario, RDs must meet regulatory compliance standards set forth by CMS or other regulatory agencies (17-19) for the particular health care setting while achieving nutrition outcomes consistent with professional standards, person-centered care, and individual wishes.

Individualizing to the least-restrictive diet possible preferred by and tolerated by an individual is the premise of nutrition care in the ECS (20). Individuals are encouraged to participate in their nutrition care by selecting foods according to their preferences and health care goals. Individuals with complications secondary to food selections may benefit from RD interventions. Understanding the risk/benefit of food choices, as explained by an RD, empowers individuals by giving them an increased feeling of control over their own care.

Screening is a key step in the identification of individuals at increased nutritional risk who require a referral to an RD for assessment. Dietetic technicians, registered (DTRs), competent support personnel, and other trained health care staff can complete a validated screening tool specific to the population served (21-23). If determined to be at nutritional risk, an individual is referred to an RD for an assessment that incorporates the principles of the NCP (24).

RDs coordinate the nutrition care of individuals in ECS utilizing the NCP, which includes four steps: nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation (24). A DTR may complete any step of the NCP after the DTR's demonstrated competencies to perform functions in that step have been documented by an RD. RDs are accountable and responsible for overall nutrition care and dining services provided in ECS. An RD must clearly identify the steps to be completed by a DTR in coordinating nutrition care. As part of RD/DTR teams, DTRs work under an RD's supervision when providing person-centered nutrition care and dining services. An RD in ECS must answer to individuals, employers, boards of dietetics licensure, and the legal system if care is compromised. Therefore, RDs must monitor nutrition and food safety outcomes associated with work done by DTRs and support personnel as defined in rules, regulations, occupational codes, compliance laws, state licensure, certification, and/or registration statutes (25-27).

Nutrition care of individuals in the ECS not only focuses on person-centered, RD-recommended, and physician-ordered diet, but also how the food is ordered, received, stored, planned, prepared, and delivered (dining services). RDs in ECS must apply the interpretive guidance of CMS State Operations Manual, state licensing regulations, and the US Department of Agriculture Food Code or their state's administrative code for food safety (17,28) when auditing dining services operations, in-servicing facility staff, and interacting with federal and state surveyors.

Role	*Examples uses of SOP and SOPP documents by RDs in different practice roles*		
	Competent	**Proficient**	**Expert**
Clinical	The RD employed in an ECS works at a competent level of clinical practice and is an advocate for all aspects of nutrition care whether full or part time. The RD notices an increase in the number of new admissions with diabetes and who are on peritoneal dialysis. The RD reviews available resources regarding nutrition and nephrology care; recognizes a need for specific skills and knowledge and reviews the SOP/SOPP for ECS and the SOP/SOPP for nephrology care to evaluate individual skills and competencies necessary for providing quality nephrology care to individuals needing peritoneal dialysis. He or she consults with a nephrology RD who works with peritoneal dialysis patients. The ECS RD identifies learning needs and sets goals to improve competencies.	An RD at the proficient level has developed skills and competencies to assign, lead and mentor others through the clinical pathways, always in support and as an advocate for nutritional care of the individual. An understanding of clinical competency factors and expectation is essential. The RD has acquired proficient specialization knowledge, based on complex decision-making skills and clinical competencies. The RD remains current on evidence-based research protocols and position and practice papers. The RD follows facility policies and procedures as well as all regulations to evaluate standards within the facility, meet expectations, and attain positive outcomes. The RD is an integral part of the interdisciplinary team (IDT); good communication and interpersonal skills are essential. The RD reviews the SOP and SOPP for RDs in ECS to develop his or her Professional Development Portfolio with the goal of advancing his or her practice.	An RD at the expert level is the expert in managing, setting protocols for nutrition-related co-morbidities, advocating for the individual/surrogate decision maker, developing person-centered care, beginning conversations for risk–benefit analysis, and self-determination discussions/decisions and all aspects of the Nutrition Care Process. The RD may participate in research in a variety of venues and be a leader within the state and/or national organizations to establish clinical standards. The RD reviews the SOP and SOPP for RDs in ECS to develop his or her Professional Development Portfolio with the goal of mentoring others and advancing his or her practice.
Home Care	An RD employed with a Home Health Agency at the competent level provides nutritional care to individuals identified at risk by the agency screening process. The RD follows the Nutrition Care Process; has knowledge of regulatory standards, billing processes, and company guidelines; and a knowledge base of nutrition care and needs of the older adult in the community. The RD reviews the SOP and SOPP for RDs in ECS to develop his or her Professional Development Portfolio with the goal of advancing his or her practice.	An RD employed with a Home Health Agency at the proficient level has extensive experience interacting with this population and mentoring others to advocate for the care and services of these members of the community. The RD may look to improve materials and outcomes of services by advancing his or her level of expertise. The RD reviews nutrition assessment and intervention sections of the SOP and SOPP for RDs in ECS to determine necessary knowledge, skills, and demonstrated competencies to maintain proficient practice and sets applicable goals, including a goal to successfully attain the Board Certified Specialist in Gerontological Nutrition (CSG) credential.	An RD practicing at the expert level in Home Health continues to build from the proficient level and moves to an upper-level position (eg, manager of the agency, Quality Assurance specialist, grant writer, project/program developer, research specialist or becomes the educator/trainer for the entire agency staff). This RD may have a graduate degree in a related field (eg, Education, Public Health) and holds the CSG credential. The RD reviews the SOP and SOPP for RDs in ECS to develop his or her Professional Development Portfolio with the goal of advancing his or her practice.
Management	A nutrition services manager at the competent level oversees a number of nutrition professionals providing food and dining services and/or clinical nutrition services to individuals in a variety of ECS settings. This may include, but is not limited to, employment as an independent consultant, a part-time or full-time employee in a long-term care setting, rehab setting, congregate meal sites, and/or corrections. The manager may also work as a contractor that operates to provide services for these settings. The RD investigates his or her institution's policies and procedures, the local and state regulations for education, training, and competency. The manager considers and recognizes the SOP and SOPP for RDs in ECS when determining needed expertise, work assignments, and use of the Nutrition Care Process. The manager assists staff in evaluating their competency and individual needs for additional knowledge and/or skills and as the basis for identifying personal performance plans.	A nutrition services manager at the proficient level manages, assigns, and evaluates duties and responsibilities for a number of nutrition professionals providing care and services (may be food and dining services and clinical services) to individuals in a variety of settings and situations. A proficient manager may be a nutrition professional working for a company that operates to provide such services. The RD investigates the institution's policies and procedures; the local and state regulations; and assists in the education, training, and evaluating competency of staff under his or her supervision. The manager considers the SOP and SOPP for RDs in ECS when establishing policies and procedures to be followed in the facilities. The manager recognizes the SOP and SOPP as important tools to use to assess competency, identify performance expectations, guide determining job roles, and identify training needs. The manager also recognizes the SOP and SOPP as an important tool to identify and encourage professional development to advance the staff's levels of practice, including a goal to successfully attain the CSG credential.	A nutrition services manager at the expert level is the full-time director, corporate RD, or RD business owner who is responsible for all aspects of care and services as well as developing relationships with other department heads, business owners, vendors. The RD develops his or her facility and business policies and procedures; has extensive understanding of local, state, and federal regulatory policies; and is responsible for the education, training, and competency of all staff. Utilizing critical-thinking skills, the RD uses the SOP/SOPP to develop criteria to determine nutrition professionals' competencies for various care settings which includes application of the Nutrition Care Process and oversight of individual nutrition care and/or dining services. The RD reviews the SOP and SOPP for RDs in ECS to develop his or her Professional Development Portfolio with the goal of advancing his or her practice and to identify and encourage professional development of his or her staff to advance their levels of practice and consider a goal to successfully attain the CSG credential.

(continued)

Figure 5. Case examples of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for registered dietitians (RDs) (competent, proficient, and expert) in Extended Care Settings (ECS).

Role	Examples uses of SOP and SOPP documents by RDs in different practice roles		
	Competent	Proficient	Expert
Researcher	An RD takes a new position working for a research study that will compare the nutritional risk levels of elders living in ECS with their mortality rate. The RD will collect data for study participants on a monthly basis for 2 years. The RD documents admission, quarterly significant change, annual assessments, hospital readmission risk factors, and nutritional intake. The RD will review the SOP and SOPP for RDs in ECS to assess his or her competencies and identify knowledge and skills that may require growth and further education to demonstrate ability for this new role. The RD sets goals to attain needed competencies before working with study participants.	An RD is hired as a study coordinator for an ECS institutional review board–approved research study that will determine whether nutritional risk levels of elders living in an ECS affect their mortality rate. He or she develops the screening process for facilities, data collectors, and participants. He or she screens individual facilities and data collectors for appropriateness to participate in the study, conducts the informed consent process, and oversees the participant data collection. He or she evaluates the data collected, makes recommendations for change, develops tools to assist practitioners in improving elder nutritional care interventions based on the research results, and collaborates on submitting article for publication. He or she reviews the SOP and SOPP for RDs in ECS to ensure that his or her knowledge, skills, and competencies are consistent with the proficient level of practice and to determine knowledge, skills, and competencies needed to advance practice. He or she develops a plan for further education to attain needed competencies before working in this role.	After conducting a review of current literature, an expert practice RD submits a research proposal to a funding agency for a new research study where the RD will be the principal investigator. The clinical trial will seek to determine the effect of nutritional intake and co-morbidities on the mortality rate of elders living in the ECS. As part of the research, he or she consults with other health care professionals, and university departments (eg, research consulting unit or institutional review board). He or she reviews the SOP and SOPP for RDs in ECS for guidance on areas of knowledge, skills, and competencies that may require growth and further education to demonstrate ability for this new role. He or she develops a plan to attain needed competencies before working in this role.

Figure 5. Continued

ADA SOP AND SOPP FOR RDs IN ECS

An RD may use the ADA SOP and SOPP (competent, proficient, and expert) for RDs in the ECS to:

- identify the competencies needed to provide nutrition care and dining services in the ECS;
- self-assess if he or she has the appropriate knowledge base and skills to provide safe and effective nutrition care and dining services in the ECS for their level of practice;
- identify the areas in which additional knowledge and skills are needed to practice at the competent, proficient, or expert level of nutrition care and dining services in the ECS;
- provide a foundation for public and professional accountability for nutrition care and dining services in the ECS;
- assist management in the planning of nutrition care and dining services in the ECS;
- enhance professional identity and communicate the nature of nutrition care and dining services in the ECS;
- guide the development of nutrition care in the ECS-related education and continuing education programs, job descriptions, and career pathways; and
- assist educators and preceptors in teaching students and interns the knowledge, skills, and competencies needed to work in nutrition care and dining services in the ECS and an understanding of the full scope of this profession.

APPLICATION TO PRACTICE

The Dreyfus model (29) identifies levels of proficiency (novice, advanced beginner, competent, proficient, and expert) (refer to Figure 1, available online at www.adajournal.org) during the acquisition and development of knowledge and skills. This model is helpful in understanding the levels of practice described in the SOP and SOPP for RDs in the ECS. In ADA focus area SOP and SOPP, the stages are represented as competent, proficient, or expert practice levels.

All RDs, even those with significant experience in other practice areas, must begin at the competent level when practicing in a new setting. At the competent level, an RD in the

ECS is learning the principles that underpin this focus area and is developing skills for effective ECS practice. This RD, who may be an experienced RD or may be new to the profession, has a breadth of knowledge in nutrition overall and may have proficient or expert knowledge/practice in another area. However, an RD new to the ECS focus area may experience a steep learning curve.

At the proficient stage, an RD may possess a specialist credential such as Board Certified Specialist in Gerontological Nutrition. This RD has developed a deeper understanding of nutrition care and dining services in the ECS and is better equipped to apply evidence-based guidelines and best practices than at the competent level. Unique situations for this RD include ability to modify the intervention based on the current needs of individuals. For example, an individual receiving nectar or honey thick liquids secondary to dysphagia continuously drinks thin liquids due to thirst, increasing risk for aspiration pneumonia. An RD works with the individual and IDT in initiating the Frazier Free Water Protocol (30), a safe method of drinking thin water by individuals with dysphagia.

At the expert stage, an RD—who may possess an advanced credential—thinks critically about dietetics in ECS, demonstrates a more intuitive understanding of ECS nutrition care and dining services, displays a range of highly developed clinical and technical skills, and formulates judgments acquired through a combination of practice experience and education. Essentially, practice at the expert level requires the application of composite dietetics knowledge, with practitioners drawing not only on their clinical experience, but also on the experience of ECS dietetics practitioners in various disciplines and practice settings. Experts, with their extensive experience and ability to see the significance and meaning of nutrition care and dining services in the ECS within a contextual whole, are fluid and flexible and, to some degree, autonomous in practice. They not only implement nutrition care and dining services in the ECS, they also drive and direct clinical practice, conduct and collaborate in research, contribute to multidisciplinary teams, and lead the advancement of nutrition care and dining services in the ECS.

Indicators for the SOP (Figure 2, available online at www.adajournal.org) and SOPP (Figure 3, available online at www.adajournal.org) for RDs in the ECS are measurable action statements that illustrate how each standard may be applied in practice. Within the SOP and SOPP for RDs in the ECS, an X in the competent column indicates that an RD who is caring for individuals in ECS is expected to complete this activity and/or seek assistance to learn how to perform at the level of the standard. A competent RD in the ECS could be an entry-level RD just starting practice after registration or an experienced RD who has newly assumed responsibility to provide nutrition care and dining services for individuals in the ECS. An X in the proficient column indicates that an RD who performs at this level has a deeper understanding of nutrition care and dining services in the ECS and has the ability to modify therapy to meet the needs of individuals in various situations (eg, an individual receiving enteral feedings adequate to meet estimated nutrition needs continues to lose weight. This RD, in addition to collaborating with the IDT to identify physical reasons for weight loss, would review facility systems specific to enteral feeding and evaluate their effectiveness). A proficient RD may hold a specialist credential. An X in the expert column indicates that an RD who performs at this level possesses a comprehensive understanding of nutrition care and dining services in the ECS and a highly developed range of skills and judgments acquired through a combination of experience and education. An expert RD builds and maintains highest level of knowledge, skills, and behaviors, including leadership, vision, and credentials.

Standards and indicators represented in Figure 2 in boldface type originate from ADA's Revised 2008 SOP in Nutrition Care and SOPP for RDs (1) and apply to RDs in all three categories. Several indicators not in boldface type are identified as applicable to all levels of practice. Where Xs are placed in all three categories of practice, it is understood that all RDs in the ECS are accountable for practice within each of these indicators. However, the depth with which an RD performs each activity will increase as the individual moves beyond the competent level. Level of practice considerations warrant taking a holistic view of the SOP and SOPP for RDs in the ECS. It is the totality of individual practice that defines the level of practice and not any one indicator or standard.

RDs should review the SOP and SOPP in the ECS at regular intervals to evaluate individual focus area nutrition knowledge, skill, and competence. Regular self-evaluation is important because it helps identify opportunities to improve and/or enhance practice and professional performance. This self-appraisal also enables ECS dietitians to better utilize the Commission on Dietetic Registration's *Professional Development Portfolio* (31) for self-assessment, planning, improvement, and commitment to lifelong learning (31). These standards may be used in each of the five steps in the *Professional Developmental Portfolio* process (Figure 4). RDs are encouraged to pursue additional training, regardless of practice setting, to maintain currency and to expand individual scope of practice within the limitations of the legal scope of practice, as defined by state law. Individuals are expected to practice only at the level at which they are competent, and this will vary depending on education, training, and experience (32). See Figure 5 for case examples of how RDs in different roles, at different levels of practice, use the SOP and SOPP in the ECS.

In some instances, components of the SOP and SOPP for RDs in the ECS do not specifically differentiate between proficient and expert level practice. In these areas, it was the consensus of the content experts that the distinctions are subtle, captured in the knowledge, experience, and intuition demonstrated in the context of advanced practice, which combines dimensions of understanding, performance, and value as an integrated whole (33). A wealth of knowledge is embedded in the experience, discernment, and practice of expert level RD practitioners. The knowledge and skills acquired through practice will continually expand and mature. The indicators will be refined as expert level RDs systematically record and document their experience using the concept of clinical exemplars. Clinical exemplars include a brief description of the need for action and the process used to change the outcome. An experienced practitioner observes clinical events, analyzes them to make new connections between events and ideas,

and produces a synthesized whole. Clinical exemplars provide outstanding models of the actions of individual ECS dietitians in clinical settings and the professional activities that have enhanced client care.

FUTURE DIRECTIONS

The SOP and SOPP for RDs in the ECS are innovative and dynamic documents. Future revisions will reflect changes in practice, dietetics education programs, and outcomes of practice audits. The authors acknowledge that the three practice levels require more clarity and differentiation in content and role delineation and that competency statements that better characterize differences among the practice levels are needed. Creation of this clarity, differentiation, and definition are the challenges of today's ECS dietitians to better serve tomorrow's practitioners and their patients, clients, and customers.

CONCLUSIONS

The SOP and SOPP for RDs in the ECS are complementary documents and are key resources for RDs at all knowledge and performance levels. These standards can and should be used by RDs in daily practice to consistently improve and appropriately demonstrate competency and value as providers of safe and effective nutrition care and dining services. These standards also serve as a professional resource for self-evaluation and professional development for RDs specializing in nutrition care and dining services in the ECS. The development and evaluation process is dynamic. Just as a professional's self-evaluation and continuing education process is an ongoing cycle, these standards are also a work in progress and will be reviewed and updated every 5 years. Current and future initiatives of ADA will provide information to use in these updates and in further clarifying and documenting the specific roles and responsibilities of RDs at each level of practice. As a quality initiative of ADA and the DHCC Dietetic Practice Group, these standards are an application of continuous quality improvement and represent an important collaborative endeavor.

These 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 within the sole authority and discretion of the user.

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Standards of Practice are authoritative statements that describe practice demonstrated through nutrition assessment, nutrition diagnosis (problem identification), nutrition intervention (planning, implementation), and outcomes monitoring and evaluation (four separate standards) and the responsibilities for which registered dietitians (RD) are accountable. The Standards of Practice in Extended Care Settings presuppose that the RD uses critical thinking skills, analytical abilities, theories, best available research findings, current accepted dietetics and medical knowledge, and the systematic holistic approach of the Nutrition Care Process as they relate to the application of the standards. Standards of Professional Performance in Extended Care Settings are authoritative statements that describe behavior in the professional role, including activities related to provision of services; application of research; communication and application of knowledge; utilization and management of resources; quality in practice; and continued competence and professional accountability (six separate standards).

Standards of Practice and Standards of Professional Performance are complementary sets of standards—both serve to describe the practice and professional performance of RDs. All indicators may not be applicable to all RDs' practice or to all practice settings and situations. RDs must comply with federal, state, and local laws and regulations affecting their practice as well as organizational policies, procedures, and guidelines. The standards are a resource but do not supersede laws, regulations, policies, procedures, and/or guidelines.

The term individual is used in this evaluation resource as a universal term. Individual may also mean resident, client/patient, customer, participant, consumer, or any individual or group who receives food and nutrition services. These services are provided to individuals of all ages. These Standards of Practice and Standards of Professional Performance are not limited to the clinical setting. In addition, it is recognized that the family and caregiver(s) of patients of all ages, including individuals with special health care needs, play critical roles in overall health and are important members of the team throughout the assessment and intervention process. The term "appropriate" is used in the standards to mean: Selecting from a range of best practice or evidence-based possibilities, one or more of which would give an acceptable result in the circumstances.

Each standard is equal in relevance and importance and includes a definition, a rationale statement, indicators, and examples of desired outcomes. A standard is a collection of specific outcome focused statements against which a practitioner's performance can be assessed. The rationale statement describes the intent of the standard and defines its purpose and importance in greater detail. Indicators are measurable action statements that illustrate how each specific standard can be applied in practice. Indicators serve to identify the level of performance of competent practitioners and to encourage and recognize professional growth.

Standard definitions, rationale statements, core indicators, and examples of outcomes found in American Dietetic Association Standards of Practice in Nutrition Care and Standards of Professional Performance have been adapted to reflect three levels of practice (competent, proficient and expert) in extended care settings (see figure below). In addition, the core indicators have been expanded to reflect the unique competence expectations of the RD in extended care settings.

Standards described as proficient level of practice in this document are not equivalent to the Commission on Dietetic Registration (CDR) certification, Board Certified as a Specialist in Gerontological Nutrition (CSG). Rather, the CSG designation recognizes the skill level of an RD who has developed gerontological nutrition knowledge and application beyond the competent practitioner and demonstrates, at a minimum, proficient level skills. An RD with a CSG designation is an example of an RD who has demonstrated additional knowledge, skills and experience in gerontological nutrition by the attainment of a specialist credential.

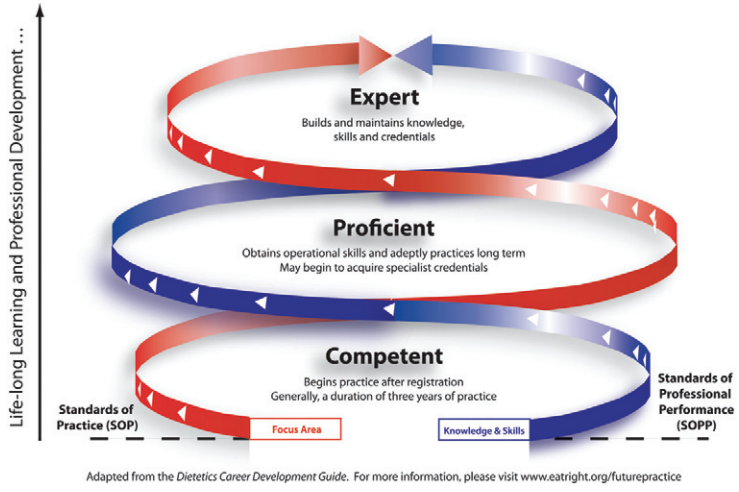

Figure 1. Standards of Practice and Standards of Professional Performance for Registered Dietitians (Competent, Proficient and Expert) in Extended Care Settings.

Standards of Practice for Registered Dietitians in Extended Care Settings (ECS)

Standard 1: Nutrition Assessment
The registered dietitian (RD) uses 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 in order 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 individual or community needs. It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process.

Indicators for Standard 1: Nutrition Assessment						
Bold Font Indicators are ADA Core RD Standards of Practice Indicators				**The "X" signifies the indicators for the level of practice**		
Each RD:				**Competent**	**Proficient**	**Expert**
1.1	**Evaluates nutrition intake for factors that affect health and conditions including nutrition risk**			**X**	**X**	**X**
	1.1A	**Evaluates adequacy and appropriateness of food, beverage, and nutrient intake (eg, macro and micronutrients; meal patterns; food allergies)**		**X**	**X**	**X**
		1.1A1	Considers individual's normal intake, adequacy of intake, and variation from usual/customary intake through visual observation, review of intake records and/or communication with the interdisciplinary team (IDT)[a]	X	X	X
		1.1A2	Determines whether specific food groups are lacking in the diet	X	X	X
		1.1A3	Considers whether individual's food allergies/intolerances/dietary restrictions inhibit adequacy of diet	X	X	X
	1.1B	**Evaluates adequacy and appropriateness of current diet prescription**		**X**	**X**	**X**
		1.1B1	Evaluates condition-specific food/nutrition requirement (eg, dysphagia, food intolerances, allergies, diet liberalization, pressure ulcers, involuntary weight loss)	X	X	X
		1.1B2	Evaluates the nutrition prescription in relationship to current reference standards and dietary guidelines, and the individual's health status	X	X	X
1.2	**Evaluates health and disease condition(s) for nutrition-related consequences**			**X**	**X**	**X**
	1.2A	**Evaluates medical and family history and co-morbidities**		**X**	**X**	**X**
		1.2A1	Considers impact of medical history on current/future health status	X	X	X
		1.2A2	Determines complexity of the individual's status using critical thinking skills		X	X
	1.2B	**Evaluates physical findings (eg, physical or clinical exam)**		**X**	**X**	**X**
		1.2B1	**Evaluates body systems, weight changes, dentition, swallowing function/ability, appetite, sense of smell, dexterity**	**X**	**X**	**X**
		1.2B2	Uses nutrition-focused physical exam that includes, but is not limited to, oral health and structures, skin, alterations in taste, edema, muscle and subcutaneous fat wasting		X	X
		1.2B3	Performs nutrition focused physical exam to identify presence of sarcopenia (eg, hand grasp strength, muscle wasting, affect on activities of daily living [ADL])			X
	1.2C	**Assesses medication management to include dosage and timing of medications (eg, prescription, over-the-counter, and herbal medications; medication allergies; medication/food interaction; and adherence) for impact on nutrition status and meal intake**		**X**	**X**	**X**
		1.2C1	Evaluates complementary and alternative medicine usage, safety, and efficacy		X	X
		1.2C2	Reviews medication(s) and outcomes of care (eg, diabetes medication[s] in relation to carbohydrate intake, affect on chewing and swallowing, gastrointestinal [GI] function, renal function)		X	X

Figure 2. Standards of Practice for Registered Dietitians in Extended Care Settings, Standard 1: Nutrition Assessment.

Indicators for Standard 1: Nutrition Assessment						
Bold Font Indicators are ADA Core RD Standards of Practice Indicators				**The "X" signifies the indicators for the level of practice**		
Each RD:				**Competent**	**Proficient**	**Expert**
	1.2D	**Evaluates complications and risks**		**X**	**X**	**X**
		1.2D1	Assesses evidence-based indicators of nutrition-related complications for acute and chronic disease states (eg, lab values, weight status, protein-energy depletion)		X	X
		1.2D2	Evaluates the impact of multiple comorbidities (eg, weight loss, pressure ulcers, obesity, enteral feedings, dialysis)		X	X
	1.2E	**Evaluates diagnostic tests, procedures, evaluations**		**X**	**X**	**X**
		1.2E1	Reviews lab results, findings of diagnostic tests/procedures and evaluates relevance to nutritional status using evidence-based criteria (eg, hemoglobin/hematocrit [H/H], glucose, vitamin D, albumin, blood lipids, swallow evaluation, indirect calorimetry (IDC), barium swallow study, allergen testing)	X	X	X
		1.2E2	Reviews and evaluates outcomes of labs/test/procedures and determines whether additional testing is warranted		X	X
		1.2E3	Reviews and evaluates appropriateness of tests to assess current status and potential complications		X	X
		1.2E4	Guides organization practices on tests and procedures used to evaluate nutritional status			X
	1.2F	**Evaluates physical activity, habits, and restrictions**		**X**	**X**	**X**
		1.2F1	Reviews and evaluates cognitive and physical ability to engage in nutrition-related ADLs (eg, self-feeding, ability to use adaptive eating devices, requiring assistance to complete meals)	X	X	X
		1.2F2	Reviews and evaluates physical activity engaged in by the individual (eg, history, type, intensity, involuntary physical movement)	X	X	X
	1.2G	**Evaluates population-, ethnic-, and culture-based trends as applies to the individual's needs**		**X**	**X**	**X**
1.3	**Evaluates psychosocial, socioeconomic, functional, and behavioral factors related to food access, selection, preparation, and understanding of health condition**			**X**	**X**	**X**
	1.3A	**Reviews/evaluates individual's developmental, functional, and mental status, and cultural, ethnic, and lifestyle factors as appropriate; consults with other professionals as needed**		**X**	**X**	**X**
	1.3B	Considers individual's ability to make needs known, adhere to diet prescription, avoidance of foods, binging/purging, and behaviors at mealtimes			X	X
	1.3C	Considers individual's ability to understand the risks and benefits of nutrition care			X	X
1.4	**Evaluates individual's knowledge, readiness to learn, and potential for behavior changes**			**X**	**X**	**X**
	1.4A	**Evaluates history of previous nutrition care services/medical nutrition therapy**		**X**	**X**	**X**
	1.4B	Evaluates the individual's ability to understand concepts (eg, dementia)			X	X
	1.4C	Evaluates individual's understanding of the risks and benefits from self-determination of food choices			X	X
1.5	**Identifies standards by which data will be compared (eg, American Diabetes Association, National Kidney Foundation [NKF], ADA Evidence Analysis Library [EAL], American Society for Parenteral and Enteral Nutrition [A.S.P.E.N.], National Pressure Ulcer Advisory Panel [NPUAP], American Medical Directors Association [AMDA], Agency for Healthcare Research and Quality [AHRQ])**			**X**	**X**	**X**

Figure 2. Continued

Indicators for Standard 1: Nutrition Assessment						
Bold Font Indicators are ADA Core RD Standards of Practice Indicators				**The "X" signifies the indicators for the level of practice**		
Each RD:				**Competent**	**Proficient**	**Expert**
1.6	**Identifies possible problem areas for determining nutrition diagnoses**			**X**	**X**	**X**
	1.6A		Identifies general nutrition concerns such as food allergies, intolerances, preferences, and issues of clinical significance such as cachexia, sarcopenia, alteration in taste and smell, and ability to feed self	X	X	X
	1.6B		Identifies more complex nutrition issues related to food intake and clinical complications		X	X
	1.6C		Identifies the most complex issues related to food intake (oral or tube fed) and clinical complications, along with their management within multi-disciplinary treatment			X
1.7	**Documents and communicates:**			**X**	**X**	**X**
	1.7A		**Date and time of assessment**	**X**	**X**	**X**
		1.7A1	Assigns/completes the assessment following federal and state guidelines/regulations for timelines	X	X	X
		1.7A2	Initiates in-depth assessment upon referral for high-risk individuals as needed and in accordance with facility policy/state regulations/practice standards (eg, recurring trends, significant/insidious weight change, pressure ulcer, enteral or parenteral feedings)	X	X	X
		1.7A3	Completes nutritional consults upon request/referral in a timely manner	X	X	X
	1.7B		**Pertinent data and comparison to standards**	**X**	**X**	**X**
		1.7B1	Reviews information gathered from nutritional screening, nutritional assessment, medical and social history	X	X	X
		1.7B2	Compares data to standards to determine current status (eg, labs, weight history, food and fluid intake, medications, drug nutrient interactions)	X	X	X
	1.7C		**Individual's perceptions, values and motivation related to present problem(s) and their cognitive ability/willingness to participate in resolving the issue(s)**	**X**	**X**	**X**
	1.7D		**Changes in individual's/surrogate decision maker's perceptions, values and motivation related to current issues**	**X**	**X**	**X**
	1.7E		**Reason for discharge/discontinuation or referral if appropriate**	**X**	**X**	**X**
		1.7E1	Documents appropriate nutritional care information when status changes (ie, discharge or transfer to another level of care, another facility, transfer home)	X	X	X
		1.7E2	Documents nutritional care information when status changes for referral (eg, speech language pathologist [SLP] for chewing/swallowing; occupational therapist [OT] for feeding skills decline; social services for dental consult)	X	X	X

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 utilized
- Problems that require consultation with or referral to another provider are recognized
- Documentation and communication of assessment are complete, relevant, accurate and timely

Figure 2. Continued

Standard 2: Nutrition Diagnosis

The registered dietitian (RD) identifies and labels specific nutrition problem(s) that the registered dietitian 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 individual 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

(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)				**The "X" signifies the indicators for the level of practice**		
Each RD:				**Competent**	**Proficient**	**Expert**
2.1	**Derives the nutrition diagnosis(es) from the assessment data**			**X**	**X**	**X**
	2.1A	**Identifies and labels the problem using standardized language**		**X**	**X**	**X**
	2.1B	**Determines etiology (cause/contributing risk factors)**		**X**	**X**	**X**
		2.1B1	Evaluates multiple factors that may impact nutrition diagnosis(es) to identify major causes likely to respond to interventions in the Nutrition Care Process (eg, root cause) through interview, observation, medical records and IDT communications	X	X	X
	2.1C	**Supports nutrition diagnosis with signs and symptoms**		**X**	**X**	**X**
		2.1C1	Identifies through nutrition assessment data the signs and symptoms to support Nutrition Diagnosis (eg, 5% weight loss in 1 month, physical findings)	X	X	X
		2.1C2	Evaluates findings systematically when formulating the nutrition diagnosis (ie, inadequate energy intake related to 5% weight loss in 1 month)	X	X	X
2.2	**Ranks (classifies) the nutrition diagnosis(es)**			**X**	**X**	**X**
	2.2A	Evaluates assessment data to prioritize nutrition diagnosis(es) and uses standardized language to identify within problem statement		X	X	X
	2.2B	Evaluates assessment data to combine problems into an overall nutrition diagnosis(es) using standardized language			X	X
	2.2C	Uses critical thinking skills and experiences to rank nutrition diagnoses in order of importance and urgency for the individual (eg, consideration of end-of-life wishes, risks and benefits, and outcomes)				X
2.3	**Determines the nutrition diagnosis(es) and discusses the diagnosis with the individual, and/or surrogate decision maker, and members of the IDT when possible and appropriate**			**X**	**X**	**X**
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) (PES statement[s])**			**X**	**X**	**X**
	2.4A	Presents the nutrition diagnosis in a PES statement (eg, suboptimal/inadequate oral intake related to difficulty swallowing, as evidenced by a significant weight loss of 5% in 30 days)		X	X	X
2.5	**Re-evaluates and revises nutrition diagnosis(es) when additional assessment data become available**			**X**	**X**	**X**

Examples of Outcomes for Standard 2: Nutrition Diagnosis

- Nutrition Diagnostic Statements that are:
  - Clear and concise
  - Specific—individual 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

Figure 2. Continued

Standard 3: Nutrition Intervention
The registered dietitian (RD) identifies and implements 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 interrelated components—planning and implementation. Planning involves prioritizing the nutrition diagnoses, conferring with the individual 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 individual's response. The registered dietitian performs the interventions or assigns the nutrition care that a dietetic technician, registered (DTR) and support personnel may provide in accordance with federal, state, and local laws and regulations.

Indicators for Standard 3: Nutrition Intervention					
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
Plans the Nutrition Intervention:					
3.1	**Prioritizes the nutrition diagnosis(es) based on problem severity, safety, individual needs, likelihood that nutrition intervention will impact problem and individual/surrogate decision maker's perception of importance**		**X**	**X**	**X**
	Prioritization considerations may include:				
	3.1A	Prioritizing the nutrition diagnosis and the impact on individual's outcomes (eg, inadequate energy intake, inadequate oral intake, inadequate fluid intake, excessive carbohydrate intake)	X	X	X
	3.1B	Prioritizing the nutrition diagnosis and complications of co-morbid diseases or conditions (eg, diabetes, hypertension [HTN], anemia, chronic kidney disease [CKD], GI disorders, cerebral vascular accident [CVA], urinary tract infection [UTI], dysphagia)	X	X	X
	3.1C	Consideration and possible integration of quality-of-life preferences and/or end-of-life decisions (eg, tube feeding, hospice care)		X	X
	3.1D	Consideration and possible integration of individual/surrogate decision maker expectations and desired outcomes and adherence to plan		X	X
3.2	**Bases intervention plan on best available evidence (eg, national guidelines, published research, evidence-based libraries and databases) (eg, EAL, A.S.P.E.N., NPUAP, AMDA, AHRQ)**		**X**	**X**	**X**
	3.2A	Considers risks and benefits of initiating, modifying or liberalizing diet/meal plan or initiation/removing tube feeding. Recommends a change in nutrition care plan to physician as appropriate.	X	X	X
	3.2B	Adjusts use and implementation of evidence-based protocols, based on the individual's needs, desires, and progress of interventions		X	X
	3.2C	Recognizes when it's appropriate and safe to deviate from established nutrition guidelines and protocols		X	X

Figure 2. Continued

Indicators for Standard 3: Nutrition Intervention					
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
3.3	**Refers to policies, program standards and regulations**		**X**	**X**	**X**
	3.3A	Refers to policies, procedures and protocols throughout the planning process to promote positive nutrition outcomes based on individual's choices	X	X	X
	3.3B	Revises and implements nutrition protocols as appropriate to facilitate goal achievement consistent with individual's choices		X	X
	3.3C	Develops nutrition protocols and guidelines reflecting knowledge of evidence-based guidelines, regulations, and needs of the populations served by the facility or organization			X
3.4	**Confers with individual, surrogate decision maker, caregivers, and IDT**		**X**	**X**	**X**
	3.4A	Considers policies and standards as appropriate in planning for risks and benefits of nutrition care options	X	X	X
	3.4B	Explains to individual and surrogate decision maker the risks and benefits of nutrition care options	X	X	X
	3.4C	Initiates and directs communication with health care providers, and/or individual and/or surrogate decision maker regarding nutrition care	X	X	X
3.5	**Determines individual-focused goals and expected outcomes**		**X**	**X**	**X**
	3.5A	Based on PES statement and individual's wishes, develops nutrition goals and expected outcomes (eg, individual will gain 1 pound in the next 30 days)	X	X	X
3.6	**Details the nutrition prescription**		**X**	**X**	**X**
	3.6A	Selects specific intervention strategies that are focused on etiology of the problem(s)	X	X	X
	3.6B	Individualizes nutrition prescription for least restrictive diet plan for the individual	X	X	X
	3.6C	Details the nutritional needs of the individual receiving enteral or parenteral nutrition		X	X
3.7	**Defines time, frequency, and duration of nutrition prescription** (eg, super cereal daily at breakfast for 30 days, supplement shakes 3 times a day at 10 AM, 2 PM, 8 PM for 30 days)		**X**	**X**	**X**
3.8	**Utilizes standardized language for describing interventions**		**X**	**X**	**X**
3.9	**Identifies resources and/or referrals needed**		**X**	**X**	**X**
	3.9A	Identifies resources to assist the individual/surrogate decision maker(s) in using educational services and community programs appropriately (eg, support groups, health care services, meal programs, evidence-based Web sites)	X	X	X
	3.9B	Identifies referrals as needed to assist the individual/surrogate decision maker(s) with related care issues (eg, financial, psychological and functional status)	X	X	X

Figure 2. Continued

Indicators for Standard 3: Nutrition Intervention					
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
Implements the Nutrition Intervention:					
3.10	**Collaborates with colleagues to facilitate and foster active communication and learning with the IDT and others as appropriate**		**X**	**X**	**X**
3.11	**Communicates the nutrition plan of care (goals and approaches) to the individual and/or surrogate decision maker and IDT, verbally or in writing**		**X**	**X**	**X**
3.12	**Initiates the nutrition plan of care (goals and approaches)**		**X**	**X**	**X**
	3.12A	Utilizing analytical and critical thinking skills, personalizes nutrition interventions and prioritizes plans to meet specific individual's needs in correlation with their wishes, preferences, and goals		X	X
	3.12B	Utilizes knowledge regarding the population's unique needs and implements the plan of personalized nutritional care based on individuals' needs, goals, preferences, priorities, and willingness for change		X	X
	3.12C	Uses knowledge of the population and environment to develop creative approaches to meeting individual's needs and preferences to achieve nutrition outcomes			X
3.13	**Continues data collection**		**X**	**X**	**X**
	3.13A	Collaborates with the IDT in the collection of pertinent data, such as changes in food and fluid intakes, labs, skin condition, advance directives, weights	X	X	X
	3.13B	Analyzes data to revise the personalized nutritional plan of care to meet individuals' needs appropriately	X	X	X
	3.13C	Pulls together data and insight from other IDT members to reflect on individual's progress to determine whether changes are indicated			X
3.14	**Individualizes nutrition intervention**		**X**	**X**	**X**
	3.14A	Uses interpersonal teaching, coaching, counseling and/or technological approaches, tools, materials, aids as appropriate to meet the individual's needs	X	X	X
	3.14B	Utilizes current, evidence-based research knowledge about the individual population to personalize strategies	X	X	X
	3.14C	Applies critical-thinking skills to combine multiple approaches as appropriate		X	X
	3.14D	Tailors nutrition intervention to the cognitive stage of the individual and makes changes to the interventions as appropriate		X	X
3.15	**Follows up and verifies that nutrition intervention is occurring**		**X**	**X**	**X**
	3.15A	Consults the medical record documentation and communicates with IDT to determine whether recommendations have been acted upon	X	X	X
3.16	**Adjusts intervention strategies, if needed, as response occurs**		**X**	**X**	**X**
	3.16A	Makes adjustments in unpredictable situations		X	X

Figure 2. Continued

Indicators for Standard 3: Nutrition Intervention					
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)			The "X" signifies the indicators for the level of practice		
Each RD:			Competent	Proficient	Expert
3.17	Documents:				
	3.17A	Date and time	X	X	X
	3.17B	Specific treatment goals and expected outcomes	X	X	X
	3.17C	Recommended interventions	X	X	X
	3.17D	Adjustments to the plan and justification	X	X	X
	3.17E	Individual/surrogate decision maker/IDT members' receptivity	X	X	X
	3.17F	Individual/surrogate decision maker's comprehension of risks and benefits	X	X	X
	3.17G	Individual preferences influencing optimal nutritional outcomes (eg, declines thickened liquids)	X	X	X
	3.17H	Referrals made and resources used	X	X	X
	3.17I	Other information relevant to providing care and monitoring progress over time	X	X	X
	3.17J	Plans for follow up and frequency of care	X	X	X
	3.17K	Rationale for discharge if applicable	X	X	X

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

Figure 2. Continued

Standard 4: Nutrition Monitoring and Evaluation

The registered dietitian (RD) monitors and evaluates 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, the RD identifies important measures of change or individual 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. The RD may assign further nutrition interventions based on reassessment to competent dietetic technicians, registered (DTRs), and support personnel.

Indicators for Standard 4: Nutrition Monitoring and Evaluation						
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)				**The "X" signifies the indicators for the level of practice**		
Each RD:				**Competent**	**Proficient**	**Expert**
4.1	**Monitors progress:**			**X**	**X**	**X**
	4.1A	**Determines individual/surrogate decision maker's understanding, compliance, and acceptance of nutrition intervention**		**X**	**X**	**X**
	4.1B	**Determines whether the intervention is being implemented as prescribed**		**X**	**X**	**X**
	4.1C	**Provides evidence that the nutrition intervention is or is not changing the individual behavior or status**		**X**	**X**	**X**
		4.1C1	Uses multiple data sources to assess progress. Examples include:			
			Assesses adequacy of nutrient intake from all sources	X	X	X
			Evaluates changes in body weight, body composition	X	X	X
			Considers positive/negative effects of pertinent medications and dietary supplements	X	X	X
			Considers laboratory and other data		X	X
			Conducts nutrition focused physical exam		X	X
		4.1C2	Evaluates factors (physical, social, cognitive, environmental) that may influence response to nutrition intervention	X	X	X
		4.1C3	Modifies intervention as appropriate to address individual needs and desires (includes surrogate/decision-maker)	X	X	X
	4.1D	**Identifies positive or negative outcomes**		**X**	**X**	**X**
		4.1D1	Evaluates positive and/or negative effects related to interventions, complex problems, and related co-morbidities		X	X
		4.1D2	Uses extensive knowledge of the population and critical thinking in identifying changes in condition, impact of interventions, and other factors on achievement of outcomes			X
	4.1E	**Gathers information from the individual/surrogate decision maker and IDT to indicate progress or reasons for lack of progress**		**X**	**X**	**X**
		4.1E1	Critically evaluates subjective responses from individual/surrogate decision maker and IDT members; Uses critical thinking skills to identify stage of compliance (consistent with individual goals)		X	X
		4.1E2	Identifies complex issues beyond the scope of nutrition that are interfering with interventions and recommends new approach or intervention			X
	4.1F	**Supports conclusions with evidence**		**X**	**X**	**X**

Figure 2. Continued

Indicators for Standard 4: Nutrition Monitoring and Evaluation						
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)				The "X" signifies the indicators for the level of practice		
Each RD:				**Competent**	**Proficient**	**Expert**
4.2	**Measures evidenced-based outcome indicator(s) relevant to the individual/surrogate decision maker that directly relate to the nutrition diagnosis and the goal(s) established in the intervention(s):**			**X**	**X**	**X**
	4.2A	**Selects the nutrition care outcome indicator(s) to measure**		**X**	**X**	**X**
		4.2A1	Reviews the PES statement to identify indicators and monitoring data consistent with resolving the nutrition diagnosis	X	X	X
		4.2A2	Considers individual-centered outcomes (eg, quality of life, functional status, socialization, individual satisfaction)	X	X	X
		4.2A3	Considers co-morbidities as related to the nutritional needs of the individual (eg, biochemical data, medical tests and procedures, energy needs, fluid needs, nutrient needs, skin condition, physical findings)		X	X
	4.2B	**Uses standardized nutrition care outcome indicator(s)**		**X**	**X**	**X**
4.3	**Evaluates outcomes:**			**X**	**X**	**X**
	4.3A	**Uses standardized indicators to compare current findings with previous status, intervention goals, and/or reference standards**		**X**	**X**	**X**
		4.3A1	Completes a more detailed analysis of the indicators for each problem area and determines whether changes in interventions are recommended		X	X
		4.3A2	Educates/counsels individual on the risks and benefits of refusal and offers alternative interventions		X	X
		4.3A3	Evaluates impact of individual's right to self-determination and its affect on the planned interventions			X
	4.3B	**Evaluates impact of the sum of all interventions on overall individual health outcomes**		**X**	**X**	**X**
	4.3C	Revises nutrition diagnosis(es) and intervention(s) as indicated		X	X	X
		4.3C1	Experience and insight with the population and ability to respond to analysis of data is reflected in revised nutrition diagnosis and/or interventions when outcomes are not achieved			X

Figure 2. Continued

Indicators for Standard 4: Nutrition Monitoring and Evaluation						
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)				The "X" signifies the indicators for the level of practice		
Each RD:				Competent	Proficient	Expert
4.4	**Documents and Communicates:**			**X**	**X**	**X**
	4.4A	**Date and time**		**X**	**X**	**X**
	4.4B	**Specific indicators measured, results, and the method for obtaining measurement**		**X**	**X**	**X**
		4.4B1	Progress toward goals, including small incremental changes	X	X	X
	4.4C	**Criteria to which the indicator is compared (eg, nutrition prescription/goal, evidence-based guidelines, reference standards, or national and international guidelines)**		**X**	**X**	**X**
	4.4D	**Factors facilitating or hampering progress**		**X**	**X**	**X**
		4.4D1	Changes in individual level of understanding and food-related behaviors	X	X	X
		4.4D2	Changes in clinical, health status, or functional outcomes	X	X	X
		4.4D3	Changes in family situation, surrogate decision maker, caregiver	X	X	X
		4.4D4	Changes in acceptance of nutrition intervention(s)	X	X	X
		4.4D5	Self-determination decisions by individual/surrogate decision maker affecting acceptance of nutrition interventions	X	X	X
	4.4E	**Other positive or negative outcomes**		**X**	**X**	**X**
	4.4F	**Future plans for nutrition care, nutrition monitoring, and follow up or discharge**		**X**	**X**	**X**
		4.4F1	Changes in nutrition interventions	X	X	X
		4.4F2	Changes in nutrition-related goals	X	X	X
		4.4F3	Communication with physician and/or IDT	X	X	X

Examples of Outcomes for Standard 4: Nutrition Monitoring and Evaluation

- The individual/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, complications)
  - Individual-centered outcomes (eg, quality of life, satisfaction, self-efficacy, self-management, 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, prevented or delayed nursing home admissions)
  - Data from monitoring is used to evaluate, validate, or revise individual's goals and interventions
- Documentation of nutrition monitoring and evaluation is:
  - Comprehensive
  - Specific
  - Accurate
  - Relevant
  - Timely
  - Dated and Timed

[a]IDT members who care for individuals are specific to the organization and may include the physician, nurse, MDS coordinator, social worker, therapists (physical, occupational, recreational, speech-language), pharmacist, dietitian, dietetic technician, chef, dietary manager, and food production/safety/sanitation supervisor.

Figure 2. Continued

Standards of Professional Performance for Registered Dietitians in Extended Care Settings (ECS)

Standard 1: Provision of Services
The registered dietitian (RD) provides quality service based on an individual's expectations and needs.

Rationale: Quality service is provided, facilitated and promoted based on the RD's knowledge, experience, and understanding of individual needs and expectations. The RD ensures that dietetic technicians, registered (DTRs) and support personnel are competent to provide assigned nutrition care and dining services.

Indicators for Standard 1: Provision of Services					
Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
1.1	**Provides input and is active in the development of nutrition screening parameters**		**X**	**X**	**X**
	1.1A	Complies with evidence-based standards for extended care settings (ECS)	X	X	X
	1.1B	Utilizes evidence-based research findings to determine screening parameters applicable to population		X	X
	1.1C	Evaluates the effectiveness of the screening tool(s)		X	X
	1.1D	Leads the interdisciplinary team[a] (IDT) on changes and process revisions as needed/indicated			X
1.2	**Audits nutrition screening processes for efficiency and effectiveness**		**X**	**X**	**X**
	1.2A	Collects data to evaluate the effectiveness of the nutrition screening process		X	X
	1.2B	Reviews and revises nutrition screening process as necessary		X	X
	1.2C	Develops and implements changes to improve/update the nutrition screening process		X	X
1.3	**Contributes to and designs referral process and systems to facilitate individual access to dietetic practitioners**		**X**	**X**	**X**
	1.3A	Evaluates the effectiveness of the current referral systems	X	X	X
	1.3B	Receives referrals from and makes referrals to other health care professionals	X	X	X
	1.3C	Leads IDT on changes to referral forms and systems		X	X
	1.3D	Directs and manages dietetic practitioner's referral processes			X
1.4	**Collaborates with individual/surrogate decision maker to assess needs, background, and resources and to set priorities, establish mutual goals, and create individualized care plans**		**X**	**X**	**X**
	1.4A	Understands behavior change and counseling theories and is able to apply theoretical strategies for change	X	X	X
	1.4B	Recognizes the influences that culture, health literacy, and socioeconomic status have on health/illness experiences and the individual's use of health care services and on end-of-life decisions	X	X	X
	1.4C	Adapts practice to meet the ethnic and cultural diversity of the individual and family so as to positively influence outcomes (eg, using interpreters, selecting appropriate interventions, adapting individual education/counseling approaches and materials)	X	X	X
	1.4D	Documents individual's decisions for treatment priorities, goals and plans	X	X	X
	1.4E	Facilitates IDT discussion and care planning for individuals with complex nutrition needs to achieve nutrition outcomes		X	X
	1.4F	Directs systematic process to identify, track, and monitor resources used by the population(s)			X

Figure 3. Standards of Professional Performance for Registered Dietitians in Extended Care Settings (ECS), Standard 1: Provision of Services.

Indicators for Standard 1: Provision of Services					
Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
1.5	**Informs and involves individual/surrogate decision maker in decision making**		**X**	**X**	**X**
	1.5A	Ensures that individual/surrogate decision maker exercises his or her rights to make informed choices effectively through facility discussion of nutrition options prior to developing the nutrition care plan	X	X	X
	1.5B	Designs the nutrition plan of care according to the individual's needs with consideration of and input from individual/surrogate decision maker and other health care providers, when appropriate		X	X
	1.5C	Assists the individual/surrogate decision maker with decision making and goal setting to maximize desired quality-of-life outcomes		X	X
	1.5D	Leads discussion with individual/surrogate decision maker for end-of-life decisions related to use of enteral or parenteral nutrition			X
1.6	**Recognizes individual's known values, cultural beliefs and concepts of illness**		**X**	**X**	**X**
	1.6A	Adapts practice to meet the needs of a diverse population	X	X	X
	1.6B	Seeks additional resources and collaborates with health care professionals to communicate available options to facilitate individual's decision-making	X	X	X
	1.6C	Connects individual/surrogate decision maker with established resources and services within their community		X	X
1.7	**Applies knowledge and principles of disease prevention and behavioral change appropriate for diverse populations**		**X**	**X**	**X**
1.8	**Collaborates and coordinates with colleagues**		**X**	**X**	**X**
	1.8A	Shares nutrition diagnosis, proposed nutrition interventions, nutrition monitoring tools, and individual's nutrition goals with IDT in the collaboration and development of the individual's plan of care	X	X	X
	1.8B	Develops facility nutrition protocols for the IDT based upon regulatory mandates and industry trends		X	X
	1.8C	Serves as the advisor for the facility's dining services; this includes standard operations, regulatory mandates, and industry trends		X	X
1.9	**Applies knowledge and skills to determine appropriate plan of care**		**X**	**X**	**X**
	1.9A	Evaluates scientific evidence and individual-based preferences to apply knowledge and skills to determine the most appropriate plan of care that may include consults or referrals to other members of the IDT	X	X	X

Figure 3. Continued

Indicators for Standard 1: Provision of Services					
Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
1.10	**Develops policies and procedures that reflect best evidence and applicable laws and regulations**		**X**	**X**	**X**
	1.10A	Utilizes resources (eg, Centers for Medicare & Medicaid Services [CMS] regulations, interpretive guidance, state regulations for populations served, state dietetic practice acts, local regulations, and applicable sanitation regulations) to create and/or update policies and procedures	X	X	X
	1.10B	Utilizes evidence-based practices set forth by professional organizations (eg, ADA, American Medical Directors Association [AMDA], American Diabetes Association) to create and/or update policies and procedures		X	X
	1.10C	Interprets laws, regulations, and best evidence to develop nutrition and dining service delivery systems considering individuals served			X
1.11	**Advocates for the provision of food and nutrition services as part of public policy**		**X**	**X**	**X**
	1.11A	Participates in local, state and federal initiatives that promote positive nutrition outcomes for individuals in ECS	X	X	X
	1.11B	Swiftly disseminates public policy information to ECS stakeholders for use in commenting or implementation of such policy	X	X	X
	1.11C	Makes comments or writes letters of support/dissent to lawmakers and regulatory agencies on issues impacting nutrition care and food safety for individuals in ECS		X	X
	1.11D	Offers expertise to lawmakers and regulators relating to individual nutrition outcomes and dining service programs		X	X
	1.11E	Provides expertise when collaborating with ADA and other stakeholder organizations in the development of public policy positions impacting nutrition and food safety in ECS			X
1.12	**Maintains records of services provided**		**X**	**X**	**X**
	1.12A	Maintains records of nutrition referrals (eg, weight reports, pressure ulcer reports), documentation and recommendations for individuals	X	X	X
	1.12B	Completes timely reports as directed by facility policy and procedures	X	X	X
1.13	**Develops nutrition protocols and policies for target populations**		**X**	**X**	**X**
	1.13A	In-services staff on changes in protocols and policies; monitors the success of protocols/ policies and amends as needed	X	X	X
	1.13B	Reviews nutrition care policies/protocols and submits for approval by the facility medical director and Quality Assurance (QA) team prior to implementation	X	X	X
	1.13C	References evidence based protocols from ADA, National Pressure Ulcer Advisory Panel (NPUAP), National Kidney Foundation (NKF), AMDA, and other organizations in the development or updating of protocols and policies for the individuals of ECS		X	X
	1.13D	Systematically evaluates outcomes of nutrition care protocols and collaborates with IDT to revise to improve outcomes where necessary			X

Figure 3. Continued

Indicators for Standard 1: Provision of Services					
Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
1.14	**Implements food/formulary delivery systems to support the nutrition status, health and well-being of target populations**		**X**	**X**	**X**
	1.14A	Monitors individual nutrition outcome post change and amends food/formulary as needed	X	X	X
	1.14B	Provides nutrition expertise in the selection and implementation of enteral formulary products, nutritional supplements, and enhanced foods	X	X	X
	1.14C	Reviews industry dining service operations for ECS and compares to facility's current systems; advocates for changes in facility systems based on industry standards and individual preferences		X	X
	1.14D	Provides dining services operations expertise in systems modification		X	X
	1.14E	Directs the design of new or renovation of existing dining and food production facilities			X
1.15	Collaborates with the IDT on the training of staff on policies and procedures set forth by the facility to comply with evidence based standards, best practice and regulatory mandates. (see 1.10)		X	X	X

Examples of Outcomes for Standard 1: Provision of Services

- Individuals participate in establishing goals
- Individuals' needs are met
- Individuals are satisfied with services and products
- Evaluations reflect expected outcomes
- Effective screening and referral services are established
- Individuals have access to food assistance
- Individuals have access to nutrition services
- Staff follow facility policies and procedures

Figure 3. Continued

Standard 2: Application of Research
The registered dietitian (RD) applies, participates in or generates 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					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
2.1	**Accesses and reviews best available research findings for application to dietetics practice**		**X**	**X**	**X**
	2.1A	Demonstrates understanding of research design and its methodology	X	X	X
	2.1B	Identifies resources for accessing timely research publications (Dietetics in Health Care Communities [DHCC], NPUAP, AMDA, Pioneer Network, ADA's Evidence Analysis Library [EAL])	X	X	X
	2.1C	Identifies key clinical and management questions and utilizes systematic methods to extract evidence-based research to answer questions		X	X
	2.1D	Interprets study conclusions and evaluates relevance to practice setting		X	X
2.2	**Bases practice on significant scientific principles and best evidence**		**X**	**X**	**X**
	2.2A	Shares available scientific literature and evidence-based practice guidelines with the IDT	X	X	X
	2.2B	Leads in the development of nutrition care evidence-based guidelines			X
2.3	**Integrates best evidence with clinical and managerial expertise and individual values**		**X**	**X**	**X**
	2.3A	Interprets research findings for use in nutrition and dining services protocols for the nutrition care of individuals		X	X
	2.3B	Applies research findings into nutrition and dining services to promote positive nutrition outcomes for individuals		X	X
	2.3C	Investigates application of research findings across the industry to determine and apply best practices within organization			X
2.4	**Promotes research through alliances and collaboration with dietetics and other professionals and organizations**		**X**	**X**	**X**
	2.4A	Participates in organized discussions of current research and related topics (eg, journal clubs, focus groups)	X	X	X
	2.4B	Collaborates with IDT and/or intra-organizational team to perform and disseminate geriatric or practice-based research		X	X
	2.4C	Presents research applicable to nutrition care and dining services for populations served to professional and community groups to increase knowledge and understanding of issues impacting the ECS			X

Figure 3. Continued

Indicators for Standard 2: Application of Research					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			The "X" signifies the indicators for the level of practice		
Each RD:			**Competent**	**Proficient**	**Expert**
2.5	**Contributes to the development of new knowledge and research in nutrition care and dining services**		**X**	**X**	**X**
	2.5A	Participates in data collection for facility and Institutional Review Board (IRB)–approved research studies	X	X	X
	2.5B	Contributes to the design, approval, and implementation of research studies focused on nutrition care and dining service delivery		X	X
	2.5C	Serves as a primary or senior investigator in collaborative research teams that examines the relationship between nutrition, dining services and outcomes in ECS			X
2.6	**Collects measurable data and documents outcomes within practice setting**		**X**	**X**	**X**
2.7	**Communicates nutrition and dining services research data and activities from ECS through publications and presentations**		**X**	**X**	**X**
	2.7A	Presents evidence-based research to local groups and colleagues	X	X	X
	2.7B	Presents evidence-based research to health care professionals via oral presentations at conferences (regional, national, international) and written articles (newsletters, pocket resources, professional journals, education materials)		X	X
	2.7C	Serves in a leadership role planning and organizing educational conferences (local, regional, national, international)		X	X
	2.7D	Writes and edits peer-reviewed materials (eg, newsletters, journals articles, pocket resources, books)		X	X

Examples of Outcomes for Standard 2: Application of Research

- Individual 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

Figure 3. Continued

Standard 3: Communication and Application of Knowledge
The registered dietitian (RD) effectively applies knowledge and communicates with others.

Rationale: Registered dietitians work with and through others (ie, dietetic technicians, registered (DTRs), support personnel, nurses, administrators, quality and safety officers) 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					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
3.1	**Exhibits knowledge of nutrition and dining services in ECS**		**X**	**X**	**X**
	3.1A	Utilizes educational publications, evidence-based practice guidelines, and resources in practice	X	X	X
	3.1B	Contributes to the body of knowledge for the profession (eg, presentations, publications, research, officer/committee volunteer)	X	X	X
	3.1C	Interprets regulatory, accreditation, reimbursement programs and standards (facilities and health care providers), specific to individual care, and education in ECS (eg, federal, state, local, The Joint Commission)		X	X
	3.1D	Evaluates industry trends and applies to the practice setting		X	X
	3.1E	Acts as an expert for other health care providers, community and outside agencies related to nutritional needs of the ECS individual			X
3.2	**Communicates and applies scientific principles, research and theory**		**X**	**X**	**X**
	3.2A	Builds and maintains relationships between research and decision makers to facilitate effective knowledge transfer			X
	3.2B	Provides analysis and commentary on relevant information			X
3.3	**Selects appropriate information and best method or format for presenting in writing or verbally when communicating information**		**X**	**X**	**X**
	3.3A	Adapts communications with individual/surrogate decision maker to reflect health literacy, culture, preferred language, educational level and hearing or vision disabilities	X	X	X
	3.3B	Assesses dining service staff's needs and ability to comprehend information presented and adjust accordingly. Considers staff's literacy, reading comprehension, primary language, and education level.		X	X
	3.3C	Identifies community resources to provide consultation and training for facility staff on communication approaches and/or tools to assist individual/surrogate decision maker with special needs		X	X
3.4	**Integrates knowledge of food and human nutrition with knowledge of health, social sciences, communication, and management**		**X**	**X**	**X**
	3.4A	Demonstrates/integrates new knowledge of nutrition care and dining services management in ECS applicable to the population served		X	X
	3.4B	Integrates innovative knowledge of nutrition and dining services to address comorbidities present in the population served			X

Figure 3. Continued

Indicators for Standard 3: Communication and Application of Knowledge					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
3.5	**Shares knowledge and information with individuals, colleagues, and the public**		**X**	**X**	**X**
	3.5A	Contributes formally and informally to the individual and IDT (eg, shares relevant articles, investigates queries, shares new knowledge)	X	X	X
	3.5B	Authors articles/educational pieces for individuals, consumers and other health care providers of nutrition care and dining services	X	X	X
	3.5C	Participates on planning committees (program planning, publication planning) or professional committees focused on issues in the ECS		X	X
	3.5D	Serves as a local, national, and international nutrition and dining services in ECS media spokesperson			X
	3.5E	Facilitates and initiates change of practice for emerging issues for nutrition and dining services in ECS			X
3.6	**Guides students, interns in the application of knowledge and skills**		**X**	**X**	**X**
	3.6A	Participates as an educator (informal/formal), mentor or preceptor to students, interns, and other health care professionals within or outside the profession of dietetics	X	X	X
	3.6B	Develops educational programs for students and ECS providers that promote individual-centered nutrition and dining services in ECS		X	X
	3.6C	Fulfills teaching or faculty roles for educational programs for physicians and other health care professionals in pursuit of nutrition-related fellowship training and/or certification			X
3.7	**Seeks current and relevant information related to practice**		**X**	**X**	**X**
	3.7A	Reads, participates in and discusses current topics. (eg, via lay and peer-reviewed journals, Web sites, electronic mailing lists (EML), seminars, and webinars)	X	X	X
	3.7B	Investigates/researches food management and nutrition topics for application to practice and sharing with others	X	X	X
	3.7C	Analyzes and communicates relevant information to advance practice		X	X
3.8	**Contributes to the development of new knowledge**		**X**	**X**	**X**
	3.8A	Participates in focus groups	X	X	X
	3.8B	Collaborates with peers working in the ECS to share best practices and collaborate on projects to advance practice in ECS		X	X
	3.8C	Leads in the generation of expert knowledge (eg, guidelines, protocols, programs, policies, and research)			X

Figure 3. Continued

Indicators for Standard 3: Communication and Application of Knowledge					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			The "X" signifies the indicators for the level of practice		
Each RD:			**Competent**	**Proficient**	**Expert**
3.9	**Uses information technology to communicate, manage knowledge, and support decision making**		**X**	**X**	**X**
	3.9A	Identifies and utilizes computerized reports/electronic health records to organize data, complete assessments and reports; and communicate to individuals and IDT	X	X	X
	3.9B	Identifies new electronic resources and provides timely accurate communication on practice applications		X	X
	3.9C	Leads in education on the use of electronic resources to RDs, DTRs, and other health care team members			X
3.10	**Contributes to the multidisciplinary approach by promoting food and nutrition strategies that impact health and quality of life outcomes for individuals of ECS**		**X**	**X**	**X**
	3.10A	Consults with the IDT on clinical and other health-related issues	X	X	X
	3.10B	Communicates with the IDT regarding nutritional strategies to provide evidence-based practices that optimize individual outcomes	X	X	X
	3.10C	Contributes nutrition-related expertise to local, regional, or national projects and professional organizations as needed (eg, state initiatives, AMDA, Pioneer Network, NPUAP, American Health Care Association (AHCA), The Joint Commission, American Geriatric Society)		X	X
	3.10D	Negotiates and/or establishes privileges at a systems level for new advances in practice			X
3.11	**Establishes credibility as a resource within the multidisciplinary health care or management team**		**X**	**X**	**X**
	3.11A	Advocates for recognition of the extended care RD as the nutrition care expert and/or source of scientific information by ECS colleagues and the medical community	X	X	X
	3.11B	Educates members of the IDT regarding the specialized knowledge and skills of the RD and Board Certification as a Specialist in Gerontological Nutrition (CSG)		X	X

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

Figure 3. Continued

Standard 4: Utilization and Management of Resources
The registered dietitian (RD) uses resources effectively and efficiently.

Rationale: Mindful management of time, money, facilities, staff, and other resources demonstrates organizational citizenship. The RD ensures the competence of dietetic technicians, registered (DTRs) and support personnel when managing nutrition care and dining services.

Indicators for Standard 4: Utilization and Management of Resources					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
4.1	**Uses a systematic approach to maintain and manage resources in the provision of dietetic services**		**X**	**X**	**X**
	4.1A	Participates in the operational planning of nutrition and dining services (eg, staffing, budgeting, menu planning, purchasing)	X	X	X
	4.2B	Oversees the effective delivery of nutrition and dining services	X	X	X
	4.2C	Evaluates the effective delivery of nutrition services in the ECS and utilizes benchmark data		X	X
	4.2D	Leads in strategic and operational planning, implementation and monitoring			X
4.2	**Evaluates safety, effectiveness, and value while planning and delivering services and products in the ECS**		**X**	**X**	**X**
	4.2A	Assures nutrition and dining service practices comply with local, state, and federal regulations	X	X	X
	4.2B	Advocates for staffing that supports the individual acuity level, census level, and approved nutrition and dining service delivery model	X	X	X
	4.2C	Participates in the evaluation of new products and equipment, at the systems level, to assure optimal delivery of nutrition services		X	X
	4.2D	Analyzes at the system level the safety, effectiveness and cost in planning and delivering services and products for nutrition and dining services		X	X
	4.2E	Designs, promotes, and seeks executive commitment to new services that will meet corporate or ECS goals for nutrition and dining services		X	X
	4.2F	Leads in the development of appropriate products and services not yet realized			X

Figure 3. Continued

Indicators for Standard 4: Utilization and Management of Resources					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
4.3	**Participates in Quality Assessment and Assurance (QAA) and documents outcomes relative to resource management**		**X**	**X**	**X**
	4.3A	Develops and implements QAA data collection and evaluation tools for nutrition and dining services in ECS. Evaluates results and alters procedures as needed to enhance the quality of care for the individuals of ECS.	X	X	X
	4.3B	Reports findings at the QAA meetings; develops or revises procedures reflecting IDT or facility decisions	X	X	X
	4.3C	Proactively and systematically recognizes needs, anticipates outcomes and consequences of various approaches, and modifies plans to achieve desired outcomes as needed		X	X
	4.3D	Plans and coordinates facility QAA audits; analyzes data collected, interprets results; and collaborates with facility staff to develop action plan(s), as applicable			X
4.4	**Assists individuals and groups to identify and secure appropriate and available resources and services**		**X**	**X**	**X**
	4.4A	Utilizes available resources and contacts within facility to assist individual/family with obtaining information and assistance	X	X	X
	4.4B	Develops a referral base in collaboration with social services to assist the individuals and/or families with additional information and services (eg, home health, cancer, Alzheimer's, Area Agencies on Aging, community support groups)		X	X
	4.4C	Exercises leadership to achieve desired outcomes using influence gained through expert competence to identify and secure appropriate and available resources and services			X

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

Figure 3. Continued

Standard 5: Quality in Practice
The registered dietitian (RD) systematically evaluates the quality of services and improves practice based on evaluation results.

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

Indicators for Standard 5: Quality in Practice					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
5.1	**Knows, understands and complies with federal, state, and local laws and regulations for ECS (eg, CMS, Omnibus Budget Reconciliation Act [OBRA], Resident Assessment Instrument [RAI], US Food Code, State [ECS licensing, dietetic licensing, sanitation regulations] and local regulations)**		**X**	**X**	**X**
	5.1A	Shares knowledge and compliance standards with health care professionals	X	X	X
	5.1B	Benefits individual population served by introducing or influencing policies/laws/regulations		X	X
5.2	**Understands pertinent national quality and safety initiatives (eg, Institute of Medicine, National Quality Forum [NQF], Institute for Healthcare Improvement, National Institutes of Health [NIH], Centers for Disease Control and Prevention [CDC])**		**X**	**X**	**X**
	5.2A	Educates colleagues and other health care professionals on quality and safety initiatives pertinent to ECS and food and nutrition practice		X	X
5.3	**Implements an Outcomes Management System to evaluate the effectiveness and efficiency of practice**		**X**	**X**	**X**
	5.3A	Seeks out and utilizes existing systems to benchmark against to evaluate nutrition care and dining services		X	X
	5.3B	Directs the development, monitoring and evaluation of practice specific benchmarks that impact quality of care			X
5.4	**Understands and continuously measures quality of dietetic services in terms of structure, process and outcomes**		**X**	**X**	**X**
	5.4A	Participates in continuous quality improvement activities, including data collection, evaluation of performance, and implementation of corrective actions	X	X	X
	5.4B	Leads in peer comparison of services (eg, external benchmarking, Department of Aging surveys)			X
5.5	**Identifies performance improvement criteria to monitor effectiveness of services**		**X**	**X**	**X**
	5.5A	Completes dining services and nutrition care audit to identify performance deficiencies	X	X	X
	5.5B	Assists with development and implementation of appropriate quality measures for dining services and nutrition care	X	X	X

Figure 3. Continued

Indicators for Standard 5: Quality in Practice					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
5.6	**Contributes to the design and testing of interventions to change processes and systems of nutrition care and dining services with the objectives of improving overall quality and services**		**X**	**X**	**X**
	5.6A	Designs and tests QAA interventions, collaborating with other health care professionals to address process and outcome goals for the organization		X	X
5.7	**Identifies and addresses errors and hazards in dietetic services**		**X**	**X**	**X**
	5.7A	Conducts and documents audits at least monthly to identify nutrition and dining service deficiencies and works with department staff and facility representatives to reduce errors and hazards	X	X	X
	5.7B	Identifies industry wide trends in nutrition and dining system deficient areas and solicits remedies from health care leaders			X
5.8	**Identifies expected outcomes for quality dietetic services**		**X**	**X**	**X**
5.9	**Documents outcomes following facility or published practice guidelines**		**X**	**X**	**X**
5.10	**Compares actual performance to expected outcomes**		**X**	**X**	**X**
	5.10A	Compares individual performance to self-directed goals and expected outcomes	X	X	X
	5.10B	Compares departmental/organizational performance to goals and expected outcomes	X	X	X
	5.10C	Participates in organizational review in response to benchmark data		X	X
	5.10D	Leads in organizational review in response to benchmark data			X
5.11	**Documents actions taken when discrepancies exist between actual performance and expected outcomes**		**X**	**X**	**X**
	5.11A	Develops a revised plan of action in association with individuals served, department staff, and facility representatives to meet expected outcomes	X	X	X
5.12	**Continuously evaluates and refines services based on measured outcomes**		**X**	**X**	**X**
	5.12A	Systematically improves the processes of nutrition care and dining services in ECS to improve outcomes reflecting understanding of discrepancies		X	X
	5.12B	Leads in creating and evaluating systems, processes, and programs that support institutional and extended care related core values and objectives			X

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

Figure 3. Continued

Standard 6: Competence and Accountability
The registered dietitian (RD) engages in lifelong learning.

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

Indicators for Standard 6: Competence and Accountability					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			**The "X" signifies the indicators for the level of practice**		
Each RD:			**Competent**	**Proficient**	**Expert**
6.1	**Conducts self-assessment of strengths and weakness at regular intervals**		**X**	**X**	**X**
	6.1A	Completes and submits the Professional Development Portfolio (PDP) per Commission on Dietetic Registration (CDR) standards. Evaluates current practices, as compared to individual goals and objectives, regulations, and published practice guidelines.	X	X	X
	6.1B	Evaluates current practice at the individual and systems level in light of current research findings and regulatory requirements at the extended care proficient practice level		X	X
	6.1C	Evaluates current practice at the individual and systems level in light of current research findings and regulatory requirements for expert practice considering a variety of sources/disciplines			X
6.2	**Identifies needs for development from a variety of sources**		**X**	**X**	**X**
	6.2A	Self-evaluates current practice setting and planned professional growth for future educational/development needs	X	X	X
	6.2B	Seeks formal/informal feedback from colleagues, health care team, and supervisors in the identification of development needs	X	X	X
6.3	**Participates in peer review**		**X**	**X**	**X**
	6.3A	Participates in peer evaluation, including but not limited to, peer supervision, clinical chart audits, and professional practice and performance evaluations, as applicable	X	X	X
	6.3B	Establishes levels of professional performance for reviewing, training, and guiding food and nutrition professionals in ECS		X	X
	6.3C	Serves as an author, reviewer, or editorial board member for professional organizations, journals, and books		X	X
	6.3D	Leads an editorial board for scholarly review, including, but not limited to, professional articles, chapters, and books			X
6.4	**Mentors others**		**X**	**X**	**X**
	6.4A	Develops mentoring, internship and preceptor opportunities for nutrition professionals in nutrition and dining services in ECS	X	X	X
	6.4B	Functions as preceptor for dietetic and dining service professionals in ECS	X	X	X
	6.4C	Leads professional development through implementation of supervised practices in ECS			X
6.5	**Develops and implements a plan for professional growth**		**X**	**X**	**X**
	6.5A	Engages in continuing education opportunities related to nutrition and dining services in the ECS as identified in the PDP	X	X	X
	6.5B	Develops and implements a continuing education plan for proficient practice		X	X
	6.5C	Develops and implements a continuing education plan for expert practice			X
6.6	**Documents development activities (eg, PDP, Curriculum Vitae [CV])**		**X**	**X**	**X**
	6.6A	Documents activities and how they enhanced professional practice at the proficient practice level (eg, PDP)		X	X
	6.6B	Documents activities and how they enhanced professional practice at the expert practice level (eg, PDP)			X

Figure 3. Continued

Indicators for Standard 6: Competence and Accountability					
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)			The "X" signifies the indicators for the level of practice		
Each RD:			Competent	Proficient	Expert
6.7	**Adheres to the ADA Code of Ethics**		**X**	**X**	**X**
6.8	**Assumes responsibility for actions and behaviors**		**X**	**X**	**X**
6.9	**Integrates the ADA Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for RDs in ECS into self-assessment and development plans**		**X**	**X**	**X**
	6.9A	Understands and utilizes the SOP/SOPP for RDs in ECS; identifies areas in own practice to target for additional learning and skill development to gain appropriate knowledge and skills, which leads to advancements in nutrition and dining services	X	X	X
	6.9B	Constructs realistic development plan and implements to gain appropriate knowledge and skills, which leads to advancement in nutrition and dining services in ECS and personal practice	X	X	X
6.10	**Applies research findings and best available evidence into practice**		**X**	**X**	**X**
	6.10A	Recognizes and utilizes evidence-based nutrition resources related to practice settings	X	X	X
	6.10B	Uses documented principles of behavior change to integrate research and advances in practice into personal practice	X	X	X
6.11	**Attains and maintains professional licensure/certification/advanced degrees in accordance with federal, state and local laws and regulations (eg, CSG, ServSafe®)**		**X**	**X**	**X**
6.12	**Takes an active leadership role commensurate with experience**		**X**	**X**	**X**
	6.12A	Utilizes good communication skills and collaborates with other health care and foodservice professionals	X	X	X
	6.12B	Serves on local and regional, committees/task forces for health professionals and industry	X	X	X
	6.12C	Serves on regional, national, or international committees/task forces for health care professionals and industry		X	X
	6.12D	Proactively seeks opportunities at local, regional, national, and international levels to promote nutrition and management standards developed by ADA and related health care and management organizations for (or applicable to) ECS		X	X
	6.12E	Leads in the development of innovative approaches to complex clinical and management issues in ECS			X
	6.12E	Identifies new opportunities for leadership across discipline boundaries to promote dietetic practice in a broader context			X

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 recertification requirements are met
- Participation in professional activities advancing practice in ECSs is achieved

[a]IDT members who care for individuals are specific to the organization and may include the physician, nurse, MDS coordinator, social worker, therapists (physical, occupational, recreational, speech-language), pharmacist, dietitian, dietetic technician, chef, dietary manager, and food production/safety/sanitation supervisor.

Figure 3. Continued