Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitian Nutritionists

The Academy Quality Management Committee

ABSTRACT

Registered dietitian nutritionists (RDNs) face complex situations every day. Competently addressing the unique needs of each situation and applying standards appropriately are essential to providing safe, timely, patient-/client-/customer-centered, quality nutrition and dietetics care and services. The Academy of Nutrition and Dietetics (Academy) leads the profession by developing standards that can be used by RDNs (who are credentialed by the Commission on Dietetic Registration) for self-evaluation to assess quality of practice and performance. The Standards of Practice reflect the Nutrition Care Process and workflow elements as a method to manage nutrition care activities with patients/clients/populations that include nutrition screening, nutrition assessment, nutrition diagnosis, nutrition intervention/plan of care, nutrition monitoring and evaluation, and discharge planning and transitions of care. The Standards of Professional Performance consist of six domains of professional performance: Quality in Practice, Competence and Accountability, Provision of Services, Application of Research, Communication and Application of Knowledge, and Utilization and Management of Resources. Within each standard, specific indicators provide measurable action statements that illustrate how the standard can be applied to practice. The Academy's Revised 2017 Standards of Practice and Standards of Professional Performance for RDNs, along with the Academy's Code of Ethics and the Revised 2017 Scope of Practice for the RDN, provide minimum standards and tools for demonstrating competence and safe practice and are used collectively to gauge and guide an RDN's performance in nutrition and dietetics practice.
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Editor's note: Figures 2 and 3 that accompany this article are available online at www.jandonline.org.

THE ACADEMY OF NUTRITION and Dietetics (Academy) leads the profession of nutrition and dietetics by developing standards from which the quality of practice and performance of Registered Dietitian Nutritionists (RDNs) can be evaluated. The following Academy foundational documents guide the practice and performance of RDNs in all practice settings: Revised 2017 Standards of Practice (SOP) in Nutrition Care and Standards of Professional Performance (SOPP) for RDNs, along with the Academy/Commission on Dietetic Registration (CDR) Code of Ethics[1] and the Revised 2017 Scope of Practice for the RDN.[2] RDNs are nutrition and dietetics practitioners credentialed by CDR who are specifically trained and qualified to provide nutrition and dietetics services and are accountable and responsible for their competent practice. The SOP in Nutrition Care and SOPP define minimum competent level of practice for RDNs.

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WHAT ARE THE SOP AND SOPP FOR RDNs?

The standards and indicators found within the SOP and SOPP reflect the minimum competent level of nutrition and dietetics practice and professional performance for RDNs. The SOP in Nutrition Care is composed of four standards that apply the Nutrition Care Process and Terminology in the care of patients/clients/populations (see Figure 1).[3] The SOPP for RDNs consist of standards representing six domains of professional performance (see Figure 1).

The SOP and SOPP reflect the education, training, responsibility, and accountability of the RDN. Both sets of standards and indicators (Figures 2 and 3, available at www.jandonline.org) comprehensively depict the minimum expectation for competent care of the patient/client/customer, delivery of services, and professional practice outcomes for the RDN. This article represents the 2017 update of the Academy's SOP in Nutrition Care and SOPP for RDNs.

WHY ARE THE STANDARDS IMPORTANT FOR RDNs?

The standards promote:

- safe, effective, quality, and efficient food, nutrition, and related services, and dietetics practice;

Approved August 2017 by the Quality Management Committee of the Academy of Nutrition and Dietetics (Academy) and the House of Delegates Leadership Team on behalf of the House of Delegates. ***Scheduled review date: June 2023.*** *Questions regarding the Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitian Nutritionists may be addressed to the Academy Quality Management Staff: Dana Buelsing, MS, manager, Quality Standards Operations; and Sharon M. McCauley, MS, MBA, RDN, LDN, FADA, FAND, senior director, Quality Management, at quality@eatright.org.*

All registered dietitians are nutritionists—but not all nutritionists are registered dietitians. The Academy's Board of Directors and Commission on Dietetic Registration have determined that those who hold the credential Registered Dietitian (RD) may optionally use "Registered Dietitian Nutritionist" (RDN). The two credentials have identical meanings. The same determination and option also applies to those who hold the credential Dietetic Technician, Registered (DTR) and Nutrition and Dietetics Technician, Registered (NDTR). The two credentials have identical meanings. In this document, the term *RDN* is used to refer to both registered dietitians and registered dietitian nutritionists, and the term *NDTR* is used to refer to both dietetic technicians, registered and nutrition and dietetics technicians, registered.

CLIENT/PATIENT/RESIDENT/FAMILY/CUSTOMER

Generally, these terms are interchangeable, with a specific term used in a given situation, dependent on the setting and the population receiving care or services. Examples of terms used include, but are not limited to: *patient/client, patient/client/customer, resident, participant, student, consumer*, or any *individual/person, group, population*, or *organization* to which the RDN provides service. In a clinical setting, the term *patient/client* is commonly used. As a universal term, the use of *customer* in the Standards of Professional Performance is intended to encompass all the other terms with the meaning taken by the reader reflecting the context of the situation and setting. Use of *customer* is not intended to imply monetary exchange.

- evidence-based practice and best practices;
- improved nutrition and health-related outcomes and cost-reduction methods;
- efficient management of time, finances, facilities, supplies, technology, and natural and human resources;
- quality assurance, performance improvement, and outcomes reporting;
- ethical and transparent business, billing, and financial management practices[9,10];
- verification of practitioner qualifications and competence because state and federal regulatory agencies, such as health departments and the Centers for Medicare and Medicaid Services (CMS), look to professional organizations to create and maintain standards of practice[7,11,12];
- consistency in practice and performance;
- nutrition and dietetics research, innovation, and practice development; and
- individual professional advancement.

The standards provide:

- minimum competent levels of practice and performance;
- common measurable indicators for self-evaluation;
- a foundation for public and professional accountability in nutrition and dietetics care and services;
- a description of the role of nutrition and dietetics and the unique services that RDNs offer within the health care team and in practice settings outside of health care;
- guidance for policies and procedures, job descriptions, competence assessment tools; and
- academic and supervised practice objectives for education programs.

The SOP in Nutrition Care:

- reflect the Nutrition Care Process and workflow elements as a method to manage nutrition care activities (ie, nutrition screening, nutrition assessment, nutrition diagnosis, nutrition intervention/plan of care, nutrition monitoring and evaluation, and discharge planning and transitions of care); and
- apply to RDNs who provide individualized nutrition assessment, intervention, and discharge planning for patients/clients/populations in acute and post-acute health care, ambulatory care, home-based, public health, and community settings.

The SOPP:

- are formatted according to six domains of professional performance (ie, Quality in Practice, Competence and Accountability, Provision of Services, Application of Research, Communication and Application of Knowledge, and Utilization and Management of Resources); and
- apply to all RDNs maintaining the RDN credential:
  - in all practice settings; and
  - not practicing in nutrition and dietetics.

Figure 1. What are the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs)?

HOW DOES THE ACADEMY'S SCOPE OF PRACTICE FOR THE RDN GUIDE THE PRACTICE AND PERFORMANCE OF RDNs IN ALL SETTINGS?

The Revised 2017 Scope of Practice for the RDN is composed of statutory and individual components, including codes of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics), and encompasses the range of roles, activities, and regulations within which RDNs perform. For credentialed practitioners, scope of practice is typically established within the practice act and interpreted and controlled by the agency or board that regulates the practice of the profession in a given state.[2] An RDN's statutory scope of practice can delineate the services an RDN is authorized to perform in a state where a practice act or certification exists. In 2017, 46 states had statutory provisions regarding professional regulations for dietitians and/or nutritionists (http://www.eatrightpro.org/resource/advocacy/legislation/all-legislation/licensure).

The RDN's individual scope of practice is determined by education, training, credentialing, experience, and demonstrating and documenting competence to practice. Individual scope of practice in nutrition and dietetics has flexible boundaries to

capture the depth and breadth of the individual's professional practice. The Scope of Practice Decision Tool (www.eatrightpro.org/scope), an online interactive tool, guides an RDN through a series of questions to determine whether a particular activity is within his or her scope of practice. The tool is designed to allow an RDN to critically evaluate his or her personal knowledge, skill, experience, judgment, and demonstrated competence using criteria resources.

WHY WERE THE STANDARDS REVISED?

Academy documents are reviewed and revised every 7 years and reflect the Academy's expanded and enhanced mission and vision of accelerating improvements in global health and well-being through food and nutrition. Regular reviews are indicated to reflect changes in health care and other business segments, public health initiatives, new or revised practice guidelines and research, performance measurement, consumer interests, technological advances, and emerging service delivery options and practice environments. Questions and input from credentialed practitioners, federal and state regulations, accreditation standards, and other factors necessitated review and revision of the 2012 "core" SOP in Nutrition Care and SOPP for the Registered Dietitian to assure safe, quality, and competent practice.[13] The 2012 core SOP in Nutrition Care and SOPP for Dietetic Technicians, Registered is also under review/revision and will be updated and published in 2018 in this *Journal*.[14]

Examples of significant changes since the published Revised 2012 SOP in Nutrition Care and SOPP for RDs are the updates in the CMS, Department of Health and Human Services Conditions of Participation for Hospitals and Critical Access Hospitals effective July 2014 and Long-Term Care in November 2016, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, and the national efforts to address malnutrition.

Acute and Critical Access Hospitals

The CMS Hospital and Critical Access Hospital Conditions of Participation now allow a hospital and its medical staff the option of including RDNs or other qualified nutrition professionals within the category of "non-physician practitioners" eligible for credentialing for appointment to the medical staff or be granted ordering privileges, without appointment to the medical staff, for therapeutic diets and nutrition-related services, if consistent with state law.[5,12]

To comply with regulatory requirements, an RDN's eligibility to be considered for ordering privileges must be approved through the hospital's medical staff rules, regulations, and bylaws, or other facility-specific processes.[6] The actual privileges granted will be based on the RDN's knowledge, skills, experience, specialist certification, if required, and demonstrated and documented competence. RDNs must review state laws, if applicable (eg, licensure, certification, and title protection) and health care regulations to determine whether there are any barriers or state-specific processes to address. For more information, please review the Academy's practice tips that outline the regulations and implementation steps for obtaining ordering privileges (www.eatrightpro.org/dietorders/).

Long-Term Care

The Long-Term Care Final Rule published October 4, 2016 in the *Federal Register* "allows the attending physician to delegate to a qualified dietitian or other clinically qualified nutrition professional the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law" and permitted by the facility's policies. The qualified professional works under the supervision of the physician.[8] The physician's supervision may include, for example, countersigning orders written by the qualified dietitian or clinically qualified nutrition professional, if required by state law.

RDNs who work in long-term care facilities should review the Academy's updates on CMS (www.eatrightpro.org/quality), which outline the regulatory changes to section 483.60 Food and Nutrition Services and considerations for developing the facilities process with medical director and orientation for attending physicians and review revisions to the CMS State Operations Manual, Appendix PP—Guidance to Surveyors for Long-Term Care Facilities.[7]

IMPACT Act—Implications for Hospitals and Post-Acute Care Conditions of Participation

The IMPACT Act of 2014 amends Title XVIII of the Social Security Act by adding a new section—Standardized Post-Acute Care Assessment Data for Quality, Payment, and Discharge Planning. Post-acute care providers include home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. In addition, the legislation includes new survey and medical review requirements for hospice care. The Act requires submission and reporting of specific standardized assessment and quality measure outcomes data with an overarching intent to reform post-acute care payment and reimbursement while ensuring continued beneficiary access to the most appropriate setting for care.

The Act includes quality measure domains that address, at a minimum, functional status, skin integrity, incidence of major falls, hospital readmissions, and the transfer of health information and care preferences when an individual transitions to a different care setting. These quality measure domains provide opportunities for RDNs and Nutrition and Dietetics Technicians, Registered (NDTRs) to help post-acute and long-term health care settings achieve positive clinical outcomes, quality measure improvement, and cost savings, as well as provide an improved quality of life. Obtain IMPACT Act practice resources on the Academy website at www.eatrightpro.org/impact.

In response to provisions of the IMPACT Act, CMS published a proposed rule in November 2015 (final action to be determined by November 2018; https://www.regulations.gov/docket?D=CMS-2015-0120) to revise the discharge planning requirements for hospitals including long-term care hospitals and inpatient rehabilitation facilities, home health agencies, and critical access hospitals. The provisions address discharge planning policies and procedures, applicable

patient types, timing, people involved (includes patient and caregiver), criteria for evaluation of discharge needs, discharge instructions, post-discharge follow-up, transfers (required medical information to the receiving facility), and other hospital requirements (eg, improving focus on behavioral health).[15]

In the proposed rule, CMS expressed concern with the variation in the discharge planning process. CMS is looking to require that all patients, including inpatients, outpatients under observation status, outpatients undergoing surgical procedures, and emergency department patients, receive a discharge plan. Another requirement deals with timing, that is, a copy of the discharge plan and summary must be sent to the practitioners responsible for the patient's follow-up care within 48 hours. The third change is for the hospital to establish a post-discharge follow-up process to check on patients who return home. Discharge planning, Hospital Conditions of Participation section 482.43, is highlighted to assist with limiting readmissions, which has a negative impact on the Medicare program.[16] Check the CMS Regulations and Guidance page regularly, as Hospital Conditions of Participation updates and revisions are released continuously (https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html).

Electronic Clinical Quality Measures for Malnutrition

Malnutrition electronic clinical quality measures were developed as part of the Malnutrition Quality Improvement Initiative when a variety of stakeholder organizations highlighted gaps in existing malnutrition care. The electronic clinical quality measures include screening, assessment, nutrition care plan, and diagnosis for malnutrition, with the goal for inclusion in the CMS federal programs across the continuum of care. In addition, the Malnutrition Quality Improvement Initiative Toolkit was established to evaluate clinical workflow processes and assist with standardizing malnutrition care. Find malnutrition and Malnutrition Quality Improvement Initiative resources at www.eatrightpro.org/malnutrition.

HOW WERE THE STANDARDS REVISED?

The members of the Quality Management Committee and its Scope/Standards of Practice Workgroup utilized collective experience and consensus in reviewing and revising statements, where needed, to support safe, quality practice and desirable outcomes. The review focused on definition of terms, illustrative figures and tables, consideration of services and activities in current practice, and enhancements to support future practice and advancement. The 2017 standards, rationales, and indicators were updated using information from questions received by the Academy's Quality Management Department; discussions with the Academy's Dietetic Practice Groups, Academy's Standing Committees (eg, Consumer Protection and Licensure Subcommittee, Nutrition Informatics Committee), Accreditation Council for Education in Nutrition and Dietetics, CDR; and member comments through focus area SOP and SOPP development.

HOW DO THE SOP IN NUTRITION CARE, THE SOPP, AND FOCUS AREA STANDARDS RELATE TO EACH OTHER?

The Academy's core SOP and SOPP for the RDN serve as blueprints for the development of focus area SOP and SOPP for RDNs. Of note, while the core SOP and SOPP for RDNs reflect the minimum competent level of nutrition and dietetics practice, focus area SOP and SOPP documents contain three levels (competent, proficient, and expert) to convey the continuum of practice as RDNs attain increasing levels of knowledge, skill, experience, and judgment in specific practice areas. The Academy's Nutrition and Dietetics Career Development Guide is a useful tool for practitioners for professional development and lifelong learning (https://www.eatrightpro.org/resource/practice/career-development/career-toolbox/dietetics-career-development-guide).

As of 2017, there are 17 published focus area SOPs and/or SOPPs for RDNs that can be accessed on the *Journal of the Academy of Nutrition and Dietetics* website or through the Academy's website at www.eatrightpro.org/sop:

- Adult Weight Management;
- Clinical Nutrition Management;
- Diabetes Care;
- Disordered Eating and Eating Disorders;
- Education of Dietetics Practitioners;
- Integrative and Functional Medicine;
- Intellectual and Developmental Disabilities;
- Long-Term and Post-Acute Care Nutrition;
- Management of Food and Nutrition Systems;
- Mental Health and Addictions;
- Nephrology Nutrition;
- Nutrition Support;
- Oncology Nutrition;
- Pediatric Nutrition;
- Public Health and Community Nutrition;
- Sports Nutrition and Dietetics; and
- Sustainable, Resilient, and Healthy Food and Water Systems.

WHAT IS THE RELATIONSHIP OF THE RDN AND NDTR IN DELIVERING PERSON-/CLIENT-/POPULATION-CENTERED CARE?

The RDN is responsible for supervising or providing oversight of any patient/client/population care activities assigned to professional, technical, and support staff, including the NDTR, and can be held accountable to the patients/clients/populations and others for services rendered. This description of "supervision" as it relates to the RDN/NDTR team is not synonymous with managerial supervision or clinical supervision used in medicine and mental health fields (eg, peer to peer), supervision of provisional licensees, and/or supervision of dietetics interns and students.[17] Additional information is available regarding the roles and practice of NDTRs in the following resources: Revised 2017 Scope of Practice for the NDTR,[18] Revised 2017 SOP in Nutrition Care and SOPP for NDTRs,[19] Practice Tips: The RDN-NDTR Team-Steps to Preserve,[20] and Practice Tips: What is Meant by "Under the Supervision of the RDN"?[17] (The Revised 2017 Scope of Practice for the NDTR and the Revised 2017 SOP and SOPP for NDTRs will be published in 2018).

In direct patient/client care, the RDN and NDTR work as a team[20] using a systematic process reflecting the Nutrition Care Process[3] and the

organization's manual or electronic documentation system, for example, an electronic health record that uses one of the available standardized terminologies that may incorporate the electronic Nutrition Care Process Terminology (eNCPT).[21] The RDN develops and oversees the system for delivery of nutrition care activities, often with the input of others, including the NDTR. Components of the nutrition care delivery system might include the following: policies and procedures, protocols, standards of care, forms, documentation standards, and roles and responsibilities of professional, technical, and support personnel participating in the care of patients/clients. The RDN is responsible for completing the nutrition assessment; determining the nutrition diagnosis or diagnoses; developing the care plan; implementing the nutrition intervention; evaluating the patient's/client's response; and also supervising the activities of professional, technical, and support personnel assisting with the patient's/client's care.[2,18]

Although NDTRs are not employed in all facilities, when they are available, NDTRs are important members of the care team. The NDTR is often the first staff from the nutrition team that a patient or client meets. The NDTR serves as a conduit of nutrition care information to RDNs and other team members at meetings and care conferences, and contributes to the continuum of care by facilitating communication between nutrition care and nursing staff.

The RDN assigns duties that are consistent with the NDTR's individual scope of practice. For example, the NDTR may initiate standard procedures, such as completing and/or following up on nutrition screening for assigned units/patients, performing routine activities based on diet order and/or policies and procedures, completing the intake process for a new clinic patient/client, and reporting to the RDN when a patient's/client's data suggest the need for an RDN evaluation. The NDTR actively participates in nutrition care by contributing information and observations, guiding patients/clients in menu selections, monitoring meals/snacks/nutritional supplements for compliance to diet order, and providing nutrition education on prescribed diets. The NDTR reports to the RDN on the patient's/client's response, including documenting outcomes or providing evidence signifying the need to adjust the nutrition intervention/plan of care.

HOW ARE THE STANDARDS STRUCTURED?

Each of the standards is presented with a brief description of the competent level of practice. The rationale statement describes the intent, purpose, and importance of the standard. Indicators provide measurable action statements that illustrate applications of the standard and examples of outcomes depict measureable results that relate the indicators to practice. Each standard is equal in relevance and importance (see Figures 2 and 3, available at www.jandonline.org).

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

RDNs should review the SOP in Nutrition Care and the SOPP at determined intervals. Regular self-evaluation is important because it helps identify opportunities to improve and enhance practice and professional performance. RDNs are encouraged to pursue additional training and experience, 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 in state law, if applicable, and federal and state regulations. Refer to Figure 4 for a flow chart that outlines how an RDN can apply the SOP and SOPP to their practice.

The standards can also be used as part of CDR's Professional Development Portfolio process[22] to develop goals and focus continuing education efforts. The Professional Development Portfolio process encourages CDR-credentialed nutrition and dietetics practitioners to incorporate self-reflection and learning needs assessment for development of a learning plan for improvement and commitment to lifelong learning. CDR's updated system implemented with the 5-year recertification cycle that began in 2015 incorporates the use of essential practice competencies for determining professional development needs.[23] In the 3-step process, the credentialed practitioner accesses an online Goal Wizard (step 1), which uses a decision algorithm to identify essential practice competency goals and performance indicators relevant to the RDN's area(s) of practice (essential practice competencies and performance indicators replace the learning need codes of the previous process). The Activity Log (step 2) is used to log and document continuing professional education over a 5-year period. The Professional Development Evaluation (step 3) guides self-reflection and assessment of learning and how it is applied. The outcome is a completed evaluation of the effectiveness of the practitioner's learning plan and continuing professional education. The self-assessment/self-evaluation information can then be used in developing the plan for the practitioner's next 5-year recertification cycle. (For more information, see https://www.cdrnet.org/competencies-for-practitioners.)

RDNs use the SOP and SOPP as a self-evaluation tool to support and demonstrate quality practice and competence. RDNs can:

- apply every indicator and achieve the outcomes in line with roles and responsibilities all at once, or identify areas to strengthen and accomplish;
- identify additional indicators and examples of outcomes (ie, outcomes measurement is a way to demonstrate value and competence) that reflect their individual practice/setting;
- apply only applicable indicators based on diversity of practice roles, activities, organization performance expectations, and work or volunteer practice settings; and
- refer to focus area SOPs and SOPPs to identify competence outcomes, demonstrate competence, and document learning in specific areas of practice.

The standards are written in broad terms to allow for an individual practitioner's handling of nonroutine situations. The standards are geared toward typical situations for practitioners with the RDN credential. Figure 5 provides role examples illustrating how RDNs can use the standards in a variety of settings. Strictly adhering to standards does not, in and of itself, constitute best care and service. It is the responsibility of individual practitioners to recognize and interpret situations and to know what standards apply and in what ways they apply.[24]

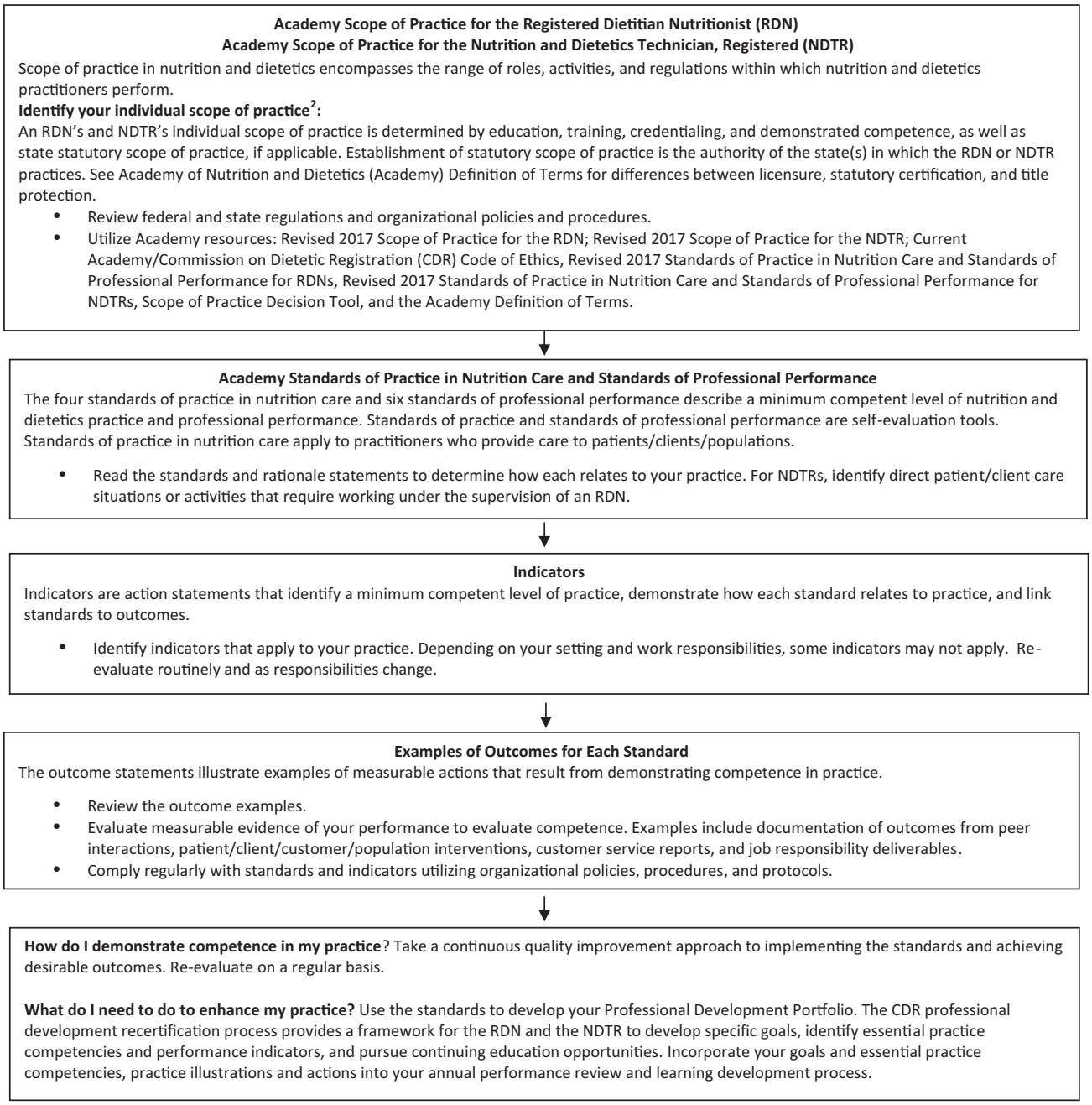

Figure 4. Flow chart on how to use the Academy of Nutrition and Dietetics Standards of Practice and Standards of Professional Performance.

SUMMARY

RDNs face complex situations every day. Competently addressing the unique needs of each situation and applying standards appropriately is essential to providing safe, timely, person-/client-/population-centered, quality care and service. All RDNs are advised to conduct their practice based on the most recent edition of the Academy/CDR Code of Ethics[1] and the Revised 2017 Scope of Practice for the RDN,[2] the Revised 2017 SOP in Nutrition Care and SOPP for RDNs, and any applicable focus area SOP and SOPP for RDNs. These resources provide minimum standards and tools for demonstrating competence and safe practice and are used collectively to gauge and guide an RDN's performance in nutrition and dietetics practice. The SOP and SOPP for the RDN are self-evaluation tools that promote quality assurance, performance improvement, and outcomes management.[25] Self-assessment provides opportunities to identify areas for enhancement, new learning, and skill development, and to encourage progression of career growth.

To ensure that RDNs always have access to the most current materials,

Role	Examples of use of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) documents by RDNs in different practice roles
Clinical practitioner, inpatient or outpatient care	A hospital-based RDN in general clinical practice has accepted a new coverage assignment that includes patients with gastrointestinal (GI) disorders. The RDN notes the types of GI disorders and reviews medical nutrition therapy resources and published practice guidelines to identify areas for enhancing knowledge and skills with continuing education and mentoring from a more experienced practitioner. Because the available focus area SOP and SOPP do not specifically address GI disorders, the RDN uses the SOP and SOPP for RDNs as the primary guide for self-evaluation. The RDN recognizes that this self-evaluation and review of GI-related resources will assist with revising their professional development plan to incorporate new competencies, if necessary, and to identify relevant continuing education activities.
Sales representative, national food distributor	An RDN with a management role in hospital foodservice has accepted a sales representative position with a national foodservice distributor. In reviewing resources for the new role, the RDN identifies knowledge and skill areas to strengthen for quality practice. The RDN reviewed the Academy of Nutrition and Dietetics (Academy)/Commission on Dietetic Registration (CDR) Code of Ethics,[1] the Academy's ethics resources, and the SOPP for RDNs to be reminded of areas to consider when in a business practice role. This self-evaluation process identifies knowledge/skill areas for continuing education and mentoring by more experienced RDN colleagues and others with expertise in business and sales. The RDN updates professional development plan to incorporate new practice competencies applicable to the new role in sales.
Quality improvement specialist, multi-hospital system	An RDN with experience as a clinical nutrition manager and as a clinical practitioner in oncology is recruited for an open position in the quality improvement/compliance monitoring department for the hospital system. In evaluating the position description and role expectations, the RDN identifies some knowledge and skill areas for development/enhancement. The RDN uses the SOP and SOPP for RDNs for self-evaluation reflecting on the standards and indicators with the perspective of the quality improvement role. The RDN identifies specific continuing-education activities, updates professional development plan with new essential competencies, and sets a goal to qualify for one of the quality credentials or certifications.
RDN practitioner in a rural community	An RDN who lives in a rural community works professionally in multiple settings (critical access hospital, clinic at the county health department, and the community's senior meal program) as a part-time employee or contractor. Because of varying professional roles, the RDN uses the SOP and SOPP for RDNs as the guiding self-evaluation resource with each role. This allows the RDN to direct attention to, and reflect on, any new/enhanced knowledge or skills needed for quality and competent practice. Applicable focus area SOP and SOPPs are reviewed as well, to inform this process and to identify any additional resources for investigation (eg, regulations, practice guidelines, professional organizations, websites, and literature citations). With each role, the RDN evaluates the need for any new essential practice competencies and updates professional development plan as needed.

(continued on next page)

Figure 5. Examples of use of the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) for self-evaluation and the promotion of competent practice.

Role	Examples of use of Standards of Practice (SOP) and Standards of Professional Performance (SOPP) documents by RDNs in different practice roles
Telehealth practitioner, nutrition and wellness	An RDN accepts a new position with a national company that provides telehealth wellness information and coaching to enrollees of private insurance providers. The RDN, who has more than 5 years of general clinical practice, including staffing a hospital's wellness center, investigates the requirements for providing telehealth services within the state. The RDN also explores limitations related to licensure and regulations for callers who live in other states. The RDN reviews the SOP and SOPP for RDNs as a self-evaluation tool, accesses the telehealth resources on the Academy's website, and participates in the company's training webinars that incorporate review of policies and procedures to assure legal and competent practice as a licensed practitioner. The RDN updates professional development plan and identifies continuing education opportunities to enhance coaching skills to ultimately qualify for one of the accredited coaching certifications.
RDN, nonpracticing	An RDN takes a leave of absence from the nutrition and dietetics workforce. Because the RDN is maintaining his or her credential, sustaining professional performance is an expectation. The RDN maintains and establishes networking and professional relationships. The RDN participates in and volunteers for the local and national nutrition and dietetics association. The RDN volunteers within the community to promote healthy lifestyles and responds to public policy calls to action by contacting representatives via social media, correspondence, and personal visits. The RDN obtains continuing professional education units for CDR certification requirement and licensure. The RDN recognizes the need to maintain skills at least at the minimally competent level identified within the SOP in Nutrition Care and SOPP for RDNs.

Figure 5. *(continued)* Examples of use of the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitian Nutritionists (RDNs) for self-evaluation and the promotion of competent practice.

The standards have been formulated for use by individuals in self-evaluation, practice advancement, and for indicators of quality. These standards do not constitute medical or other professional advice, and should not be taken as such. The information presented in the standards is not a substitute for the exercise of professional judgment by the nutrition and dietetics practitioner. The standards are not intended for disciplinary actions, or determinations of negligence or misconduct. The use of the standards for any other purpose than that for which they were formulated must be undertaken with the sole authority and discretion of the user.

each resource is maintained on, or accessed through, the Academy website. The documents are reviewed and updated as new trends in the profession of nutrition and dietetics, health care, public health, food science, and other external influences emerge.

References

1. American Dietetic Association/Commission on Dietetic Registration Code of Ethics for the Profession of Dietetics and process for consideration of ethical issues. *J Am Diet Assoc*. 2009;109(8):1461-1467.
2. Academy of Nutrition and Dietetics Quality Management Committee. Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Registered Dietitian Nutritionist. *J Acad Nutr Diet*. 2018;118(1):141-165.
3. Swan WI, Vivanti A, Hakel-Smith NA, et al. Nutrition Care Process and Model update: Toward realizing people-centered care and outcomes management. *J Acad Nutr Diet*. 2017;117(12):2003-2014.
4. The Joint Commission. Glossary. In: *Comprehensive Accreditation Manual for Hospitals*. Oak Brook, IL: Joint Commission Resources; 2017.
5. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. State Operations Manual. Appendix A—Survey protocol, regulations and interpretive guidelines for hospitals (rev. 151, 11-20-15); §482.12(a)(1) Medical staff, non-physician practitioners. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf. Accessed November 10, 2017.
6. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. 42 CFR Parts 413, 416, 440 et al. Medicare and Medicaid Programs; Regulatory provisions to promote program efficiency, transparency, and burden reduction; Part II; Final Rule (FR DOC #2014-10687; pp 27105-27157). http://www.gpo.gov/fdsys/pkg/FR-2014-05-12/pdf/2014-10687.pdf. Accessed November 10, 2017.
7. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. Transmittal 169—Advance Copy State Operations Manual. Appendix PP—Guidance to surveyors for long-term care facilities. Issued June 30, 2017 (updates current Appendix PP Rev. 168, with phase 2 revisions that become effective 11-28-17); §483.30 Physician Services, §483.60 Food and Nutrition Services. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf. Accessed November 10, 2017.
8. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. Medicare and Medicaid Programs; reform of requirements for long-term care facilities. 42 CFR Parts 405, 431, 447, 482, 483, 485, 488, and 489. Final rule (FR DOC#2016; pp 68688-68872)—Federal Register October 4, 2016;81(192):68688-68872; §483.30(f)(2) Physician services (pp 65-66), §483.60 Food and Nutrition Services (pp 89-94), §483.60 Food and Nutrition Services (pp 177-178). https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-

programs-reform-of-requirements-for-long-term-care-facilities. Accessed November 10, 2017.

9. Hodorowicz MA, White JV. Ethics in action. Elements of ethical billing for nutrition professionals. *J Acad Nutr Diet*. 2012;112(3):432-435.
10. Grandgenett R, Derelian D. Ethics in action. Ethics in business practice. *J Am Diet Assoc*. 2010;110(7):1103-1104.
11. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. State Operations Manual. Appendix A–Survey protocol, regulations and interpretive guidelines for hospitals (rev. 151, 11-20-15); §482. 28 Food and Dietetic Services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf. Accessed November 10, 2017.
12. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. State Operations Manual. Appendix W–Survey protocol, regulations and interpretive guidelines for critical access hospitals (CAHs) and swing-beds in CAHs (Rev. 165, 12-16-16); §485.635 (a)(3)(vii) Dietary Services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf. Accessed November 10, 2017.
13. Academy of Nutrition and Dietetics Quality Management Committee and Scope of Practice Subcommittee of the Quality Management Committee. Academy of Nutrition and Dietetics: Revised 2012 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitians. *J Acad Nutr Diet*. 2013;113(6 suppl 2):S29-S45.
14. Academy of Nutrition and Dietetics Quality Management Committee and Scope of Practice Subcommittee of the Quality Management Committee. Academy of Nutrition and Dietetics Revised 2012 Standards of Practice in Nutrition Care and Standards of Professional Performance for Dietetic Technicians, Registered. *J Acad Nutr Diet*. 2013;113(6 suppl 2):S56-S71.
15. US Department of Health and Human Services, Centers for Medicare and Medicaid Services. Medicare and Medicaid Programs; revisions to requirements for discharge planning for hospitals, critical access hospitals, and home health agencies. 42 CFR Parts 482, 484, 485. Proposed rule—Federal Register November 3, 2015. https://www.federalregister.gov/documents/2015/11/03/2015-27840/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals. Accessed November 10, 2017.
16. National Health Policy Forum. The basics. Hospital discharge planning in Medicare: Current requirements and proposed changes. https://www.nhpf.org/library/the-basics/Basics_HospitalDischargePlanning_02-09-16.pdf. Accessed November 10, 2017.
17. Academy of Nutrition and Dietetics. Practice tips: What is meant by "under the supervision of the RDN." http://www.eatrightstore.org/product/9E555AC7-ED41-445E-931C-C951BE0F14B3. Accessed November 10, 2017.
18. Academy of Nutrition and Dietetics Quality Management Committee. Academy of Nutrition and Dietetics: Revised 2017 Scope of Practice for the Nutrition and Dietetics Technician, Registered. *J Acad Nutr Diet*. 2018;118(2). In press.
19. Academy of Nutrition and Dietetics Quality Management Committee. Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Nutrition and Dietetics Technicians, Registered. *J Acad Nutr Diet*. 2018;118(2). In press.
20. Academy of Nutrition and Dietetics. Practice Tips: RDN-NDTR team—Steps to preserve. http://www.eatrightstore.org/product/C6E60A2F-BCED-4F3F-BC55-9A99C6BF4002. Accessed November 10, 2017.
21. Academy of Nutrition and Dietetics. Nutrition Terminology Reference Manual (eNCPT): Dietetics language for nutrition care. https://ncpt.webauthor.com. Accessed November 10, 2017.
22. Weddle DO, Himburg SP, Collins N, Lewis R. The professional development portfolio process: Setting goals for credentialing. *J Am Diet Assoc*. 2002;102(10):1439-1444.
23. Worsfold L, Grant BL, Barnhill C. The essential practice competencies for the Commission on Dietetic Registration's credentialed nutrition and dietetics practitioners. *J Acad Nutr Diet*. 2015;115(6):978-984.
24. Gates GR, Amaya L. Ethics opinion: Registered dietitian nutritionists and nutrition and dietetics technicians, registered are ethically obliged to maintain personal competencies in practice. *J Acad Nutr Diet*. 2015;115(5):811-815.
25. Academy of Nutrition and Dietetics. Definition of terms. http://www.eatrightpro.org/scope. Accessed November 10, 2017.

AUTHOR INFORMATION

The Academy Quality Management Committee 2016-2018: Denise Andersen, MS, RDN, LD, CLC; Shari Baird, MS, RD, CPHQ, LSSBB; Tracey Bates, MPH, RD, LDN, FAND; Denise L. Chapel, MPH, MS, RDN, FAND; Alana D. Cline, PhD, RDN; Shyamala N. Ganesh, MS, RD, LD; Margaret Garner, MS, RDN, LD, FAND, CIC; Barbara L Grant, MS, RDN, CSO, FAND; Kathryn K. Hamilton, MA, RDN, CSO, CDN, FAND; Krista Jablonski, MS, RDN, LDN; Sherri L. Jones, MS, MBA, RDN, LDN, FAND; Alexandra G. Kazaks, PhD, RDN, CDE; Susan H. Konek, MA, RDN, CSP, LD, FAND; Kelly K. Leonard, MS, RDN; Kimi G. McAdam, MS, RD; Beth N. Ogata, MS, RDN, CSP, CD; Egondu M. Onuoha, MS, RDN, CDE, IBCLC, CDN, GPC, FAND; Gretchen Y. Robinson, MS, RDN, LD, FADA, FAND; Darrin W. Schmidt, NDTR, FAND; Nancy G. Walters, MMSC, RDN, CSG, FAND, LDN; Pauline Williams, PhD, MPA, RDN, CD; Pamela Wu, DPA, RDN; Karen Hui, RDN, LDN; Carol Gilmore, MS, RDN, LD, FADA, FAND; Mujahed Khan, MBA, RDN, LDN; Dana Buelsing, MS; and Sharon M. McCauley, MS, MBA, RDN, LDN, FADA, FAND.

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Standards of Practice for Registered Dietitian Nutritionists

Standard 1: Nutrition Assessment

The registered dietitian nutritionist (RDN) uses accurate and relevant data and information to identify nutrition-related problems.

Rationale:

Nutrition screening is the preliminary step to identify individuals who require a nutrition assessment performed by an RDN. Nutrition assessment is a systematic process of obtaining and interpreting data in order to make decisions about the nature and cause of nutrition-related problems and provides the foundation for nutrition diagnosis. It is an ongoing, dynamic process that involves not only initial data collection, but also reassessment and analysis of patient/client or population/community needs. Nutrition assessment is conducted using validated tools based in evidence, the five domains of nutrition assessment, and comparative standards. Nutrition assessment may be performed via in-person, or facility/practitioner assessment application, or Health Insurance Portability and Accountability Act (HIPAA)-compliant video conferencing telehealth platform.

Indicators for Standard 1: Nutrition Assessment		
Each RDN:		
1.1	Patient/client/population history: Assesses current and past information related to personal, medical, family, and psychosocial/social history	
1.2	Anthropometric assessment: Assesses anthropometric indicators (eg, height, weight, body mass index [BMI], waist circumference, arm circumference), comparison to reference data (eg, percentile ranks/*z*-scores), and individual patterns and history	
1.3	Biochemical data, medical tests, and procedure assessment: Assesses laboratory profiles (eg, acid–base balance, renal function, endocrine function, inflammatory response, vitamin/mineral profile, lipid profile), and medical tests and procedures (eg, gastrointestinal study, metabolic rate)	
1.4	Nutrition-focused physical examination (NFPE) may include visual and physical examination: Obtains and assesses findings from NFPE (eg, indicators of vitamin/mineral deficiency/toxicity, edema, muscle wasting, subcutaneous fat loss, altered body composition, oral health, feeding ability [suck/swallow/breathe], appetite, and affect)	
1.5	Food and nutrition-related history assessment (ie, dietary assessment): Evaluates:	
	1.5A	Food and nutrient intake, including composition and adequacy, meal and snack patterns, and appropriateness related to food allergies and intolerances
	1.5B	Food and nutrient administration, including current and previous diets and diet prescriptions and food modifications, eating environment, and enteral and parenteral nutrition administration
	1.5C	Medication and dietary supplement use, including prescription and over-the-counter medications, and integrative and functional medicine products
	1.5D	Knowledge, beliefs, and attitudes (eg, understanding of nutrition-related concepts, emotions about food/nutrition/health, body image, preoccupation with food and/or weight, readiness to change nutrition- or health-related behaviors, and activities and actions influencing achievement of nutrition-related goals)
	1.5E	Food security defined as factors affecting access to a sufficient quantity of safe, healthful food and water, as well as food/nutrition-related supplies

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Figure 2. Standards of Practice for Registered Dietitian Nutritionists (RDNs). Note: The terms *patient, client, customer, individual, person, group,* or *population* are used interchangeably with the actual term used in a given situation depending on the setting and the population receiving care or services.

Indicators for Standard 1: Nutrition Assessment		
	1.5F	Physical activity, cognitive and physical ability to engage in developmentally appropriate nutrition-related tasks (eg, self-feeding and other activities of daily living), instrumental activities of daily living (eg, shopping, food preparation), and breastfeeding
	1.5G	Other factors affecting intake and nutrition and health status (eg, cultural, ethnic, religious, lifestyle influencers, psychosocial, and social determinants of health)
1.6	Comparative standards: Uses reference data and standards to estimate nutrient needs and recommended body weight, body mass index, and desired growth patterns	
	1.6A	Identifies the most appropriate reference data and/or standards (eg, international, national, state, institutional, and regulatory) based on practice setting and patient-/client-specific factors (eg, age and disease state)
1.7	Physical activity habits and restrictions: Assesses physical activity, history of physical activity, and physical activity training	
1.8	Collects data and reviews data collected and/or documented by the nutrition and dietetics technician, registered (NDTR), other health care practitioner(s), patient/client, or staff for factors that affect nutrition and health status	
1.9	Uses collected data to identify possible problem areas for determining nutrition diagnoses	
1.10	Documents and communicates:	
	1.10A	Date and time of assessment
	1.10B	Pertinent data (eg, medical, social, behavioral)
	1.10C	Comparison to appropriate standards
	1.10D	Patient/client/population perceptions, values, and motivation related to presenting problems
	1.10E	Changes in patient/client/population perceptions, values, and motivation related to presenting problems
	1.10F	Reason for discharge/discontinuation or referral, if appropriate

Examples of Outcomes for Standard 1: Nutrition Assessment

- Appropriate assessment tools and procedures are used in valid and reliable ways
- Appropriate and pertinent data are collected
- Effective interviewing methods are used
- Data are organized and categorized in a meaningful framework that relates to nutrition problems
- Use of assessment data leads to the determination that a nutrition diagnosis/problem does or does not exist
- Problems that require consultation with or referral to another provider are recognized
- Documentation and communication of assessment are complete, relevant, accurate, and timely

Standard 2: Nutrition Diagnosis

The registered dietitian nutritionist (RDN) identifies and labels specific nutrition problem(s)/diagnosis(es) that the RDN is responsible for treating.

Rationale:

Analysis of the assessment data leads to identification of nutrition problems and a nutrition diagnosis(es), if present. The nutrition diagnosis(es) is the basis for determining outcome goals, selecting appropriate interventions, and monitoring progress. Diagnosing nutrition problems is the responsibility of the RDN.

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Figure 2. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs). Note: The terms *patient, client, customer, individual, person, group,* or *population* are used interchangeably with the actual term used in a given situation depending on the setting and the population receiving care or services.

Indicators for Standard 2: Nutrition Diagnosis	
Each RDN:	
2.1	Diagnoses nutrition problems based on evaluation of assessment data and identifies supporting concepts (ie, etiology, signs, and symptoms)
2.2	Prioritizes the nutrition problem(s)/diagnosis(es) based on severity, safety, patient/client needs and preferences, ethical considerations, likelihood that nutrition intervention/plan of care will influence the problem, discharge/transitions of care needs, and patient/client/advocate[a] perception of importance
2.3	Communicates the nutrition diagnosis(es) to patients/clients/advocates, community, family members or other health care professionals when possible and appropriate
2.4	Documents the nutrition diagnosis(es) using standardized terminology and clear, concise written statement(s) (eg, using Problem [P], Etiology [E], and Signs and Symptoms [S] [PES statement(s)] or Assessment [A], Diagnosis [D], Intervention [I], Monitoring [M], and Evaluation [E] [ADIME statement(s)])
2.5	Re-evaluates and revises nutrition diagnosis(es) when additional assessment data become available

Examples of Outcomes for Standard 2: Nutrition Diagnosis

- Nutrition diagnostic statements that accurately describe the nutrition problem of the patient/client and/or community in a clear and concise way
- Documentation of nutrition diagnosis(es) is relevant, accurate, and timely
- Documentation of nutrition diagnosis(es) is revised as additional assessment data become available

Standard 3: Nutrition Intervention/Plan of Care

The registered dietitian nutritionist (RDN) identifies and implements appropriate, person-centered interventions designed to address nutrition-related problems, behaviors, risk factors, environmental conditions, or aspects of health status for an individual, target group, or the community at large.

Rationale:

Nutrition intervention consists of two interrelated components—planning and implementation.

- Planning involves prioritizing the nutrition diagnoses, conferring with the patient/client and others, reviewing practice guidelines, protocols and policies, setting goals, and defining the specific nutrition intervention strategy.
- Implementation is the action phase that includes carrying out and communicating the intervention/plan of care, continuing data collection, and revising the nutrition intervention/plan of care strategy, as warranted, based on change in condition and/or the patient/client/population response.

An RDN implements the interventions or assigns components of the nutrition intervention/plan of care to professional, technical, and support staff in accordance with knowledge/skills/judgment, applicable laws and regulations, and organization policies. The RDN collaborates with or refers to other health care professionals and resources. The nutrition intervention/plan of care is ultimately the responsibility of the RDN.

Indicators for Standard 3: Nutrition Intervention/Plan of Care	
Each RDN:	
Plans the Nutrition Intervention/Plan of Care:	
3.1	Addresses the nutrition diagnosis(es) by determining and prioritizing appropriate interventions for the plan of care
3.2	Bases intervention/plan of care on best available research/evidence and information, evidence-based guidelines, and best practices

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Figure 2. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs). Note: The terms *patient, client, customer, individual, person, group,* or *population* are used interchangeably with the actual term used in a given situation depending on the setting and the population receiving care or services.

Indicators for Standard 3: Nutrition Intervention/Plan of Care			
3.3	Refers to policies and procedures, protocols and program standards		
3.4	Collaborates with patient/client/advocate/population, caregivers, interprofessional[b] team, and other health care professionals		
3.5	Works with patient/client/advocate/population and caregivers to identify goals, preferences, discharge/transitions of care needs, plan of care and expected outcomes		
3.6	Develops the nutrition prescription and establishes measurable patient-/client-focused goals to be accomplished		
3.7	Defines time and frequency of care including intensity, duration, and follow-up		
3.8	Uses standardized terminology for describing interventions		
3.9	Identifies resources and referrals needed		
Implements the Nutrition Intervention/Plan of Care:			
3.10	Collaborates with colleagues, interprofessional team, and other health care professionals		
3.11	Communicates and coordinates the nutrition intervention/plan of care		
3.12	Initiates the nutrition intervention/plan of care		
	3.12A	Uses approved clinical privileges, physician/non-physician practitioner[c]—driven orders (ie, delegated orders), protocols, or other facility-specific processes for order writing or for provision of nutrition-related services consistent with applicable specialized training, competence, medical staff, and/or organizational policy	
		3.12A1	Implements, initiates, or modifies orders for therapeutic diet, nutrition-related pharmacotherapy management, or nutrition-related services (eg, medical foods/nutrition/dietary supplements, food texture modifications, enteral and parenteral nutrition, intravenous fluid infusions, laboratory tests, medications, and education and counseling)
		3.12A2	Manages nutrition support therapies (eg, formula selection, rate adjustments, addition of designated medications and vitamin/mineral supplements to parenteral nutrition solutions or supplemental water for enteral nutrition)
		3.12A3	Initiates and performs nutrition-related services (eg, bedside swallow screenings, inserting and monitoring nasoenteric feeding tubes, and indirect calorimetry measurements, or other permitted services)
3.13	Assigns activities to NDTR and other professional, technical, and support personnel in accordance with qualifications, organizational policies/protocols, and applicable laws and regulations		
	3.13A	Supervises professional, technical, and support personnel	
3.14	Continues data collection		
3.15	Documents:		
	3.15A	Date and time	
	3.15B	Specific and measurable treatment goals and expected outcomes	
	3.15C	Recommended interventions	
	3.15D	Patient/client/advocate/caregiver/community receptiveness	
	3.15E	Referrals made and resources used	
	3.15F	Patient/client/advocate/caregiver/community comprehension	

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Figure 2. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs). Note: The terms *patient, client, customer, individual, person, group,* or *population* are used interchangeably with the actual term used in a given situation depending on the setting and the population receiving care or services.

Indicators for Standard 3: Nutrition Intervention/Plan of Care		
	3.15G	Barriers to change
	3.15H	Other information relevant to providing care and monitoring progress over time
	3.15I	Plans for follow up and frequency of care
	3.15J	Rationale for discharge or referral if applicable

Examples of Outcomes for Standard 3: Nutrition Intervention/Plan of Care

- Goals and expected outcomes are appropriate and prioritized
- Patient/client/advocate/population, caregivers, and interprofessional teams collaborate and are involved in developing nutrition intervention/plan of care
- Appropriate individualized patient-/client-centered nutrition intervention/plan of care, including nutrition prescription, is developed
- Nutrition intervention/plan of care is delivered and actions are carried out as intended
- Discharge planning/transitions of care needs are identified and addressed
- Documentation of nutrition intervention/plan of care is:
  - Specific
  - Measurable
  - Attainable
  - Relevant
  - Timely
  - Comprehensive
  - Accurate
  - Dated and timed

Standard 4: Nutrition Monitoring and Evaluation

The registered dietitian nutritionist (RDN) monitors and evaluates indicators and outcomes data directly related to the nutrition diagnosis, goals, preferences, and intervention strategies to determine the progress made in achieving desired results of nutrition care and whether planned interventions should be continued or revised.

Rationale:

Nutrition monitoring and evaluation are essential components of an outcomes management system in order to assure quality, patient-/client-/population-centered care, and to promote uniformity within the profession in evaluating the efficacy of nutrition interventions. Through monitoring and evaluation, the RDN identifies important measures of change or patient/client/population outcomes relevant to the nutrition diagnosis and nutrition intervention/plan of care; describes how best to measure these outcomes; and intervenes when intervention/plan of care requires revision.

Indicators for Standard 4: Nutrition Monitoring and Evaluation		
Each RDN:		
4.1	Monitors progress:	
	4.1A	Assesses patient/client/advocate/population understanding and compliance with nutrition intervention/plan of care
	4.1B	Determines whether the nutrition intervention/plan of care is being implemented as prescribed

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Figure 2. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs). Note: The terms *patient, client, customer, individual, person, group,* or *population* are used interchangeably with the actual term used in a given situation depending on the setting and the population receiving care or services.

Indicators for Standard 4: Nutrition Monitoring and Evaluation		
4.2	Measures outcomes:	
	4.2A	Selects the standardized nutrition care measurable outcome indicator(s)
	4.2B	Identifies positive or negative outcomes, including impact on potential needs for discharge/transitions of care
4.3	Evaluates outcomes:	
	4.3A	Compares monitoring data with nutrition prescription and established goals or reference standard
	4.3B	Evaluates impact of the sum of all interventions on overall patient/client/population health outcomes and goals
	4.3C	Evaluates progress or reasons for lack of progress related to problems and interventions
	4.3D	Evaluates evidence that the nutrition intervention/plan of care is maintaining or influencing a desirable change in the patient/client/population behavior or status
	4.3E	Supports conclusions with evidence
4.4	Adjusts nutrition intervention/plan of care strategies, if needed, in collaboration with patient/client/population/ advocate/caregiver and interprofessional team	
	4.4A	Improves or adjusts intervention/plan of care strategies based upon outcomes data, trends, best practices, and comparative standards
4.5	Documents:	
	4.5A	Date and time
	4.5B	Indicators measured, results, and the method for obtaining measurement
	4.5C	Criteria to which the indicator is compared (eg, nutrition prescription/goal or a reference standard)
	4.5D	Factors facilitating or hampering progress
	4.5E	Other positive or negative outcomes
	4.5F	Adjustments to the nutrition intervention/plan of care, if indicated
	4.5G	Future plans for nutrition care, nutrition monitoring and evaluation, follow-up, referral, or discharge

Examples of Outcomes for Standard 4: Nutrition Monitoring and Evaluation

- The patient/client/community outcome(s) directly relate to the nutrition diagnosis and the goals established in the nutrition intervention/plan of care. 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, morbidity, and mortality)
  - Patient-/client-/population-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, morbidity, and mortality)

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Figure 2. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs). Note: The terms *patient, client, customer, individual, person, group,* or *population* are used interchangeably with the actual term used in a given situation depending on the setting and the population receiving care or services.

- Nutrition intervention/plan of care and documentation is revised, if indicated
- Documentation of nutrition monitoring and evaluation is:
  - Specific
  - Measurable
  - Attainable
  - Relevant
  - Timely
  - Comprehensive
  - Accurate
  - Dated and timed

[a]**Advocate:** An *advocate* is a person who provides support and/or represents the rights and interests at the request of the patient/client. The person may be a family member or an individual not related to the patient/client who is asked to support the patient/client with activities of daily living or is legally designated to act on behalf of the patient/client, particularly when the patient/client has lost decision-making capacity. (Adapted from definitions within The Joint Commission Glossary of Terms[4] and the Centers for Medicare and Medicaid Services, Hospital Conditions of Participation[5]).

[b]**Interprofessional:** The term *interprofessional* is used in this evaluation resource as a universal term. It includes a diverse group of team members (eg, physicians, nurses, dietitian nutritionists, pharmacists, psychologists, social workers, and occupational and physical therapists), depending on the needs of the patient/client. Interprofessional could also mean interdisciplinary or multidisciplinary.

[c]**Non-physician practitioner:** A *non-physician practitioner* may include a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, anesthesiologist's assistant, qualified dietitian, or nutrition professional. Disciplines considered for privileging by a facility's governing body and medical staff must be in accordance with state law.[5,6] The term *privileging* is not referenced in the Centers for Medicare and Medicaid Services long-term care (LTC) regulations. With publication of the Final Rule revising the Conditions of Participation for LTC facilities effective November 2016, post-acute care settings, such as skilled and long-term care facilities, may now allow a resident's attending physician the option of delegating order writing for therapeutic diets, nutrition supplements, or other nutrition-related services to the qualified dietitian or clinically qualified nutrition professional, if consistent with state law, and organization policies.[7,8]

Figure 2. *(continued)* Standards of Practice for Registered Dietitian Nutritionists (RDNs). Note: The terms *patient, client, customer, individual, person, group,* or *population* are used interchangeably with the actual term used in a given situation depending on the setting and the population receiving care or services.

Standards of Professional Performance for Registered Dietitian Nutritionists

Standard 1: Quality in Practice

The registered dietitian nutritionist (RDN) provides quality services using a systematic process with identified ethics, leadership, accountability, and dedicated resources.

Rationale:

Quality practice in nutrition and dietetics is built on a solid foundation of education and supervised practice, credentialing, evidence-based practice, demonstrated competence, and adherence to established professional standards. Quality practice requires systematic measurement of outcomes, regular performance evaluations, and continuous improvement.

Indicators for Standard 1: Quality in Practice		
Each RDN:		
1.1	Complies with applicable laws and regulations as related to his/her area(s) of practice	
1.2	Performs within individual and statutory scope of practice and applicable laws and regulations	
1.3	Adheres to sound business and ethical billing practices applicable to the role and setting	
1.4	Uses national quality and safety data (eg, National Academies of Sciences, Engineering, and Medicine: Health and Medicine Division, National Quality Forum, Institute for Healthcare Improvement) to improve the quality of services provided and to enhance customer-centered services	
1.5	Uses a systematic performance improvement model that is based on practice knowledge, evidence, research, and science for delivery of the highest quality services	
1.6	Participates in or designs an outcomes-based management system to evaluate safety, effectiveness, quality, person-centeredness, equity, timeliness, and efficiency of practice	
	1.6A	Involves colleagues and others, as applicable, in systematic outcomes management
	1.6B	Defines expected outcomes
	1.6C	Uses indicators that are specific, measurable, attainable, realistic, and timely (S.M.A.R.T.)
	1.6D	Measures quality of services in terms of structure, process, and outcomes
	1.6E	Incorporates electronic clinical quality measures to evaluate and improve care of patients/clients at risk for malnutrition or with malnutrition (www.eatrightpro.org/emeasures)
	1.6F	Documents outcomes and patient reported outcomes (eg, PROMIS[a])
	1.6G	Participates in, coordinates, or leads program participation in local, regional, or national registries and data warehouses used for tracking, benchmarking, and reporting service outcomes
1.7	Identifies and addresses potential and actual errors and hazards in provision of services or brings to attention of supervisors and team members as appropriate	
1.8	Compares actual performance to performance goals (ie, Gap Analysis, SWOT Analysis [strengths, weaknesses, opportunities, and threats], PDCA Cycle [plan, do, check, act], DMAIC [define, measure, analyze, improve, control])	
	1.8A	Reports and documents action plan to address identified gaps in care and/or service performance
1.9	Evaluates interventions and workflow process(es) and identifies service and delivery improvements	
1.10	Improves or enhances patient/client/population care and/or services working with others based on measured outcomes and established goals	

Examples of Outcomes for Standard 1: Quality in Practice

- Actions are within scope of practice and applicable laws and regulations
- National quality standards and best practices are evident in customer-centered services

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Figure 3. Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

- Performance improvement program specific to program(s)/service(s) is established and updated as needed; is evaluated for effectiveness in providing desired outcomes data and striving for excellence in collaboration with other team members
- Performance indicators are specific, measurable, attainable, realistic, and timely (S.M.A.R.T.)
- Aggregate outcomes results meet pre-established criteria
- Quality improvement results direct refinement and advancement of practice

Standard 2: Competence and Accountability
The registered dietitian nutritionist (RDN) demonstrates competence in and accepts accountability and responsibility for ensuring safe, quality practice and services.
Rationale:
Competence and accountability in practice includes continuous acquisition of knowledge, skills, experience, and judgment in the provision of safe, quality customer-centered service.

Indicators for Standard 2: Competence and Accountability		
Each RDN:		
2.1	Adheres to the code(s) of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics)	
2.2	Integrates the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) into practice, self-evaluation, and professional development	
	2.2A	Integrates applicable focus area(s) SOP SOPP into practice (www.eatrightpro.org/sop)
2.3	Demonstrates and documents competence in practice and delivery of customer-centered service(s)	
2.4	Assumes accountability and responsibility for actions and behaviors	
	2.4A	Identifies, acknowledges, and corrects errors
2.5	Conducts self-evaluation at regular intervals	
	2.5A	Identifies needs for professional development
2.6	Designs and implements plans for professional development	
	2.6A	Develops plan and documents professional development activities in career portfolio (eg, organizational policies and procedures, credentialing agency[ies])
2.7	Engages in evidence-based practice and uses best practices	
2.8	Participates in peer review of others as applicable to role and responsibilities	
2.9	Mentors and/or precepts others	
2.10	Pursues opportunities (education, training, credentials, certifications) to advance practice in accordance with laws and regulations, and requirements of practice setting	

Examples of Outcomes for Standard 2: Competence and Accountability
- Practice reflects:
  - Code(s) of ethics (eg, Academy/CDR, other national organizations, and/or employer code of ethics)
  - Scope of Practice, Standards of Practice, and Standards of Professional Performance
  - Evidence-based practice and best practices
  - Commission on Dietetic Registration Essential Practice Competencies and Performance Indicators

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Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

- Practice incorporates successful strategies for interactions with individuals/groups from diverse cultures and backgrounds
- Competence is demonstrated and documented
- Services provided are safe and customer-centered
- Self-evaluations are conducted regularly to reflect commitment to lifelong learning and professional development and engagement
- Professional development needs are identified and pursued
- Directed learning is demonstrated
- Relevant opportunities (education, training, credentials, certifications) are pursued to advance practice
- Commission on Dietetic Registration recertification requirements are met

Standard 3: Provision of Services
The registered dietitian nutritionist (RDN) provides safe, quality service based on customer expectations and needs, and the mission, vision, principles, and values of the organization/business.
Rationale:
Quality programs and services are designed, executed, and promoted based on the RDN's knowledge, skills, experience, judgment, and competence in addressing the needs and expectations of the organization/business and its customers.

Indicators for Standard 3: Provision of Services		
Each RDN:		
3.1	Contributes to or leads in development and maintenance of programs/services that address needs of the customer or target population(s)	
	3.1A	Aligns program/service development with the mission, vision, principles, values, and service expectations and outputs of the organization/business
	3.1B	Uses the needs, expectations, and desired outcomes of the customers/populations (eg, patients/clients, families, community, decision makers, administrators, client organization[s]) in program/service development
	3.1C	Makes decisions and recommendations that reflect stewardship of time, talent, finances, and environment
	3.1D	Proposes programs and services that are customer-centered, culturally appropriate, and minimize disparities
3.2	Promotes public access and referral to credentialed nutrition and dietetics practitioners for quality food and nutrition programs and services	
	3.2A	Contributes to or designs referral systems that promote access to qualified, credentialed nutrition and dietetics practitioners
	3.2B	Refers customers to appropriate providers when requested services or identified needs exceed the RDN's individual scope of practice
	3.2C	Monitors effectiveness of referral systems and modifies as needed to achieve desirable outcomes
3.3	Contributes to or designs customer-centered services	
	3.3A	Assesses needs, beliefs/values, goals, resources of the customer, and social determinants of health
	3.3B	Uses knowledge of the customer's/target population's health conditions, cultural beliefs, and business objectives/services to guide design and delivery of customer-centered services
	3.3C	Communicates principles of disease prevention and behavioral change appropriate to the customer or target population

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Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services			
	3.3D	Collaborates with the customers to set priorities, establish goals, and create customer-centered action plans to achieve desirable outcomes	
	3.3E	Involves customers in decision making	
3.4	Executes programs/services in an organized, collaborative, cost effective, and customer-centered manner		
	3.4A	Collaborates and coordinates with peers, colleagues, stakeholders, and within interprofessional[b] teams	
	3.4B	Uses and participates in, or leads in the selection, design, execution, and evaluation of customer programs and services (eg, nutrition screening system, medical and retail foodservice, electronic health records, interprofessional programs, community education, grant management)	
	3.4C	Uses and develops or contributes to selection, design and maintenance of policies, procedures (eg, discharge planning/transitions of care), protocols, standards of care, technology resources (eg, Health Insurance Portability and Accountability Act [HIPAA]-compliant telehealth platforms), and training materials that reflect evidence-based practice in accordance with applicable laws and regulations	
	3.4D	Uses and participates in or develops processes for order writing and other nutrition-related privileges, in collaboration with the medical staff[c] or medical director (eg, post-acute care settings, dialysis center, public health, community, free-standing clinic settings), consistent with state practice acts; federal and state regulations; organization policies; and medical staff rules, regulations, and bylaws	
		3.4D1	Uses and participates in or leads development of processes for privileges or other facility-specific processes related to (but not limited to) implementing physician/non-physician practitioner[d]–driven delegated orders or protocols, initiating or modifying orders for therapeutic diets, medical foods/nutrition supplements, dietary supplements, enteral and parenteral nutrition, laboratory tests, medications, and adjustments to fluid therapies or electrolyte replacements
		3.4D2	Uses and participates in or leads development of processes for privileging for provision of nutrition-related services, including (but not limited to) initiating and performing bedside swallow screenings, inserting and monitoring nasoenteric feeding tubes, providing home enteral nutrition or infusion management services (eg, ordering formula and supplies) and indirect calorimetry measurements
	3.4E	Complies with established billing regulations, organization policies, grant funder guidelines, if applicable to role and setting, and adheres to ethical and transparent financial management and billing practices	
	3.4F	Communicates with the interprofessional team and referring party consistent with the HIPAA rules for use and disclosure of customer's personal health information	
3.5	Uses professional, technical, and support personnel appropriately in the delivery of customer-centered care or services in accordance with laws, regulations, and organization policies and procedures		
	3.5A	Assigns activities, including direct care to patients/clients, consistent with the qualifications, experience, and competence of professional, technical, and support personnel	
	3.5B	Supervises professional, technical, and support personnel	
3.6	Designs and implements food delivery systems to meet the needs of customers		
	3.6A	Collaborates in or leads the design of food delivery systems to address health care needs and outcomes (including nutrition status), ecological sustainability, and to meet the culture and related needs and preferences of target populations (ie, health care patients/clients, employee groups, visitors to retail venues, schools, child and adult day-care centers, community feeding sites, farm to institution initiatives, local food banks)	
	3.6B	Participates in, consults/collaborates with, or leads the development of menus to address health, nutritional, and cultural needs of target population(s) consistent with federal, state or funding source regulations or guidelines	

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Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 3: Provision of Services		
	3.6C	Participates in, consults/collaborates with, or leads interprofessional process for determining medical foods/ nutritional supplements, dietary supplements, enteral and parenteral nutrition formularies, and delivery systems for target population(s)
3.7	Maintains records of services provided	
	3.7A	Documents according to organization policies, procedures, standards, and systems including electronic health records
	3.7B	Implements data management systems to support interoperable data collection, maintenance, and utilization
	3.7C	Uses data to document outcomes of services (ie, staff productivity, cost/benefit, budget compliance, outcomes, quality of services) and provide justification for maintenance or expansion of services
	3.7D	Uses data to demonstrate program/service achievements and compliance with accreditation standards, laws, and regulations
3.8	Advocates for provision of quality food and nutrition services as part of public policy	
	3.8A	Communicates with policy makers regarding the benefit/cost of quality food and nutrition services
	3.8B	Advocates in support of food and nutrition programs and services for populations with special needs and chronic conditions
	3.8C	Advocates for protection of the public through multiple avenues of engagement (eg, legislative action, establishing effective relationships with elected leaders and regulatory officials, participation in various Academy committees, workgroups and task forces, Dietetic Practice Groups, Member Interest Groups, and State Affiliates)

Examples of Outcomes for Standard 3: Provision of Services

- Program/service design and systems reflect organization/business mission, vision, principles, values, and customer needs and expectations
- Customers participate in establishing program/service goals and customer-focused action plans and/or nutrition interventions (eg, in-person or via telehealth)
- Customer-centered needs and preferences are met
- Customers are satisfied with services and products
- Customers have access to food assistance
- Customers have access to food and nutrition services
- Foodservice system incorporates sustainability practices addressing energy and water use and waste management
- Menus reflect the cultural, health and/or nutritional needs of target population(s) and consideration of ecological sustainability
- Evaluations reflect expected outcomes and established goals
- Effective screening and referral services are established or implemented as designed
- Professional, technical, and support personnel are supervised when providing nutrition care to customers
- Ethical and transparent financial management and billing practices are used per role and setting

Standard 4: Application of Research

The registered dietitian nutritionist (RDN) applies, participates in, and/or generates research to enhance practice. Evidence-based practice incorporates the best available research/evidence and information in the delivery of nutrition and dietetics services.

Rationale:

Application, participation, and generation of research promote improved safety and quality of nutrition and dietetics practice and services.

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Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.

Indicators for Standard 4: Application of Research		
Each RDN:		
4.1	Reviews best available research/evidence and information for application to practice	
	4.1A	Understands basic research design and methodology
4.2	Uses best available research/evidence and information as the foundation for evidence-based practice	
4.3	Integrates best available research/evidence and information with best practices, clinical and managerial expertise, and customer values	
4.4	Contributes to the development of new knowledge and research in nutrition and dietetics	
4.5	Promotes application of research in practice through alliances or collaboration with food and nutrition and other professionals and organizations	

Examples of Outcomes for Standard 4: Application of Research

- Evidence-based practice, best practices, clinical and managerial expertise, and customer values are integrated in the delivery of nutrition and dietetics services
- Customers receive appropriate services based on the effective application of best available research/evidence and information
- Best available research/evidence and information is used as the foundation of evidence-based practice

Standard 5: Communication and Application of Knowledge

The registered dietitian nutritionist (RDN) effectively applies knowledge and expertise in communications.

Rationale:

The RDN works with others to achieve common goals by effectively sharing and applying unique knowledge, skills, and expertise in food, nutrition, dietetics, and management services.

Indicators for Standard 5: Communication and Application of Knowledge		
Each RDN:		
5.1	Communicates and applies current knowledge and information based on evidence	
	5.1A	Demonstrates critical thinking and problem-solving skills when communicating with others
5.2	Selects appropriate information and the most effective communication method or format that considers customer-centered care and the needs of the individual/group/population	
	5.2A	Uses communication methods (ie, oral, print, one-on-one, group, visual, electronic, and social media) targeted to various audiences
	5.2B	Uses information technology to communicate, disseminate, manage knowledge, and support decision making
5.3	Integrates knowledge of food and nutrition with knowledge of health, culture, social sciences, communication, informatics, sustainability, and management	
5.4	Shares current, evidence-based knowledge, and information with various audiences	
	5.4A	Guides customers, families, students, and interns in the application of knowledge and skills
	5.4B	Assists individuals and groups to identify and secure appropriate and available educational and other resources and services

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Indicators for Standard 5: Communication and Application of Knowledge		
	5.4C	Uses professional writing and verbal skills in all types of communications
	5.4D	Reflects knowledge of population characteristics in communication methods
5.5	Establishes credibility and contributes as a food and nutrition resource within the interprofessional health care and management team, organization, and community	
5.6	Communicates performance improvement and research results through publications and presentations	
5.7	Seeks opportunities to participate in and assume leadership roles with local, state, and national professional and community-based organizations (eg, government-appointed advisory boards, community coalitions, schools, foundations or nonprofit organizations serving the food insecure) providing food and nutrition expertise	

Examples of Outcomes for Standard 5: Communication and Application of Knowledge

- Expertise in food, nutrition, dietetics, and management is demonstrated and shared
- Interoperable information technology is used to support practice
- Effective and efficient communications occur through appropriate and professional use of e-mail, texting, and social media tools
- Individuals, groups, and stakeholders:
  - Receive current and appropriate information and customer-centered service
  - Demonstrate understanding of information and behavioral strategies received
  - Know how to obtain additional guidance from the RDN or other RDN-recommended resources
- Leadership is demonstrated through active professional and community involvement

Standard 6: Utilization and Management of Resources

The registered dietitian nutritionist (RDN) uses resources effectively and efficiently.

Rationale:

The RDN demonstrates leadership through strategic management of time, finances, facilities, supplies, technology, natural and human resources.

Indicators for Standard 6: Utilization and Management of Resources		
Each RDN:		
6.1	Uses a systematic approach to manage resources and improve outcomes	
6.2	Evaluates management of resources with the use of standardized performance measures and benchmarking as applicable	
	6.2A	Uses the Standards of Excellence Metric Tool to self-assess quality in leadership, organization, practice, and outcomes for an organization (www.eatrightpro.org/excellencetool)
6.3	Evaluates safety, effectiveness, efficiency, productivity, sustainability practices, and value while planning and delivering services and products	
6.4	Participates in quality assurance and performance improvement and documents outcomes and best practices relative to resource management	
6.5	Measures and tracks trends regarding internal and external customer outcomes (eg, satisfaction, key performance indicators)	

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Examples of Outcomes for Standard 6: Utilization and Management of Resources

- Resources are effectively and efficiently managed
- Documentation of resource use is consistent with operational and sustainability goals
- Data are used to promote, improve, and validate services, organization practices, and public policy
- Desired outcomes are achieved, documented, and disseminated
- Identifies and tracks key performance indicators in alignment with organizational mission, vision, principles, and values

[a]**PROMIS:** The Patient-Reported Outcomes Measurement Information System (*PROMIS*) (https://commonfund.nih.gov/promis/index) is a reliable, precise measure of patient-reported health status for physical, mental, and social well-being. *PROMIS* is a web-based resource and is publicly available.

[b]**Interprofessional:** The term *interprofessional* is used in this evaluation resource as a universal term. It includes a diverse group of team members (eg, physicians, nurses, dietitian nutritionists, pharmacists, psychologists, social workers, and occupational and physical therapists), depending on the needs of the customer. Interprofessional could also mean interdisciplinary or multidisciplinary.

[c]**Medical staff:** *Medical staff* is composed of doctors of medicine or osteopathy and can, in accordance with state law, including scope of practice laws, include other categories of physicians, and non-physician practitioners who are determined to be eligible for appointment by the governing body.[5]

[d]**Non-physician practitioner:** A *non-physician practitioner* may include a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, anesthesiologist's assistant, qualified dietitian, or nutrition professional. Disciplines considered for privileging by a facility's governing body and medical staff must be in accordance with state law.[5,6] The term *privileging* is not referenced in the Centers for Medicare and Medicaid Services long-term care (LTC) regulations. With publication of the Final Rule revising the Conditions of Participation for LTC facilities effective November 2016, post-acute care settings, such as skilled and long-term care facilities, may now allow a resident's attending physician the option of delegating order writing for therapeutic diets, nutrition supplements or other nutrition-related services to the qualified dietitian or clinically qualified nutrition professional, if consistent with state law, and organization policies.[7,8]

Figure 3. *(continued)* Standards of Professional Performance for Registered Dietitian Nutritionists (RDNs). Note: The term *customer* is used in this evaluation resource as a universal term. Customer could also mean client/patient/customer, family, participant, consumer, or any individual, group, or organization to which the RDN provides service.