INTEGRATED COMPETENCIES FOR DIETETIC EDUCATION AND PRACTICE (ICDEP)

Content of this document is unchanged and remains applicable to dietetic entry to practice in Canada.

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I FOREWORD

The Partnership for Dietetic Education and Practice (PDEP) is an unincorporated, collaborative inter-organizational network formed to create opportunities where the Partners' goals and achievements intersect. It undertakes projects in areas of common interest to benefit the safety and quality of dietetic services and the advancement of the dietetic profession in Canada.

The partners represent three sectors: Dietitians of Canada (DC) representing the profession;
The Alliance of Canadian Dietetic Regulatory Bodies (the Alliance) representing the 10 provincial dietetic regulatory bodies; and the dietetic academic and practical education programs in Canada.

PDEP's core purpose is to bring the dietetics profession, education and regulatory sectors together to work on priority issues to advance education and practice where their mandates intersect.

PDEP's vision is synergy that enables excellence in dietetic education and practice.

In carrying out its Core Purpose in pursuit of its Vision, PDEP:

a. Creates a Common Vision for the education and the practice of dietitians to inform future joint initiatives;
b. Develops, monitors and maintains the currency of the Integrated Competencies for Dietetic Education and Practice;
c. Develops, monitors and implements the Accreditation Standards of dietetic education (academic and practical training programs) through collaborative structures and processes; and
d. Maintains effective and efficient Partnership operations.

For further information about PDEP's activities visit www.pdep.ca.

II ACKNOWLEDGEMENTS

The PDEP Steering Committee would like to extend their gratitude to the members of the **ICDEP Working Group** for undertaking this extensive and important project over the past three years.

Volunteers

- **Doris E. Gillis**, PhD, PDt, Senior Research Professor, Department of Human Nutrition, St. Francis Xavier University (Nova Scotia)
- **Bryna Shatenstein**, PhD, PDt, Retired Full Professor, Département de nutrition, Université de Montréal, and Researcher, Centre de recherche, Institut universitaire de gériatrie de Montréal (Québec)
- **Jaki Thornhill**, MHA, RD, Professional Practice Leader, Providence Health Care (British Columbia)
- **Helen Toews**, MSc, RD, Dietetic Education Coordinator Hamilton Health Sciences in collaboration with the School of Food and Nutrition, Brescia University College (Ontario)

Expert Consultant

- **David Cane**, PhD, Catalysis Consulting www.catalysisconsulting.net

Thank you to others who contributed their time and expertise to the revision of ICDEP, and in particular:

- Accreditation Council
- Alliance of Canadian Dietetic Regulatory Bodies
- CDRE Project Manager and Examination Development Committee
- Dietitians from across Canada who participated in the Practice Competencies (PC) validation survey and other consultations
- Dietetic Educators from across Canada who participated in the Performance Indicators (PI) survey
- Dietitians working in Indigenous communities who provided input and feedback
- French Language Terminology Verification Working Group
- ICDEP Implementation Working Group

And a final thank you to the hard working members of the **PDEP Steering Committee**:

- **Nicole Arsenault Bishop**, Registrar and Executive Director, New Brunswick Association of Dietitians
- **Joanie Bouchard**, Registrar and Executive Director, College of Dietitians of British Columbia
- **Jodi Crawford**, Dietitian, AgeCare Communities of Care and Wellness, Alberta
- **Corinne Eisenbraun**, Senior Director, Education Policy and Programs, Dietitians of Canada, Manitoba
- **Connie Foote**, Instructor and Dietetic Practicum Coordinator, Acadia University
- **Isabelle Giroux**, Full Professor, School of Nutrition Sciences, Academic Vice-Dean, Faculty of Health Science, University of Ottawa
- **Carolyn Knox**, Registrar, College of Dietitians of Prince Edward Island
- **Katherine Vandenbussche,** Dietitian, Michael Garron Hospital, Ontario
- **Cynthia Whalen**, Registrar and Executive Coordinator, Newfoundland and Labrador College of Dietitians
- **Melisse Willems**, Registrar and Executive Director, College of Dietitians of Ontario
- **Gordon Zello**, Professor of Nutrition, University of Saskatchewan

CONTENTS

1 INTRODUCTION

The Integrated Competencies for Dietetic Education and Practice (ICDEP) serve two main purposes. First, they define the minimum set of practice abilities that dietitians are expected to possess at the point of initial registration, enabling their entry to practice. This set of practice abilities is referred to as the *Practice Competencies* (PCs).

Second, they delineate the manner in which possession of the PCs is assessed prior to registration through a candidate's[1] demonstration of *Performance Indicators* (PIs). The assessment of PIs takes place in three distinct settings:

1. the academic component of education programs
2. the practicum component of education programs
3. the Canadian Dietetic Registration Examination (CDRE)[2]

The primary users of ICDEP are:

- Education programs, to guide curriculum and assessment of candidate learning outcomes
- The CDRE Examination Development Committee, item writers and Project Manager, in creating specifications for the examination
- The Partnership for Dietetic Education and Practice (PDEP) Accreditation Council, in evaluating compliance with standards for accrediting dietetic education programs.

The PCs within ICDEP may also be useful to the public, employers and other health professionals, to enable a common understanding of entry-level dietetic practice.

The foundation of ICDEP is the *Domains of Competence.* The PCs are embedded throughout the following seven interrelated Domains:

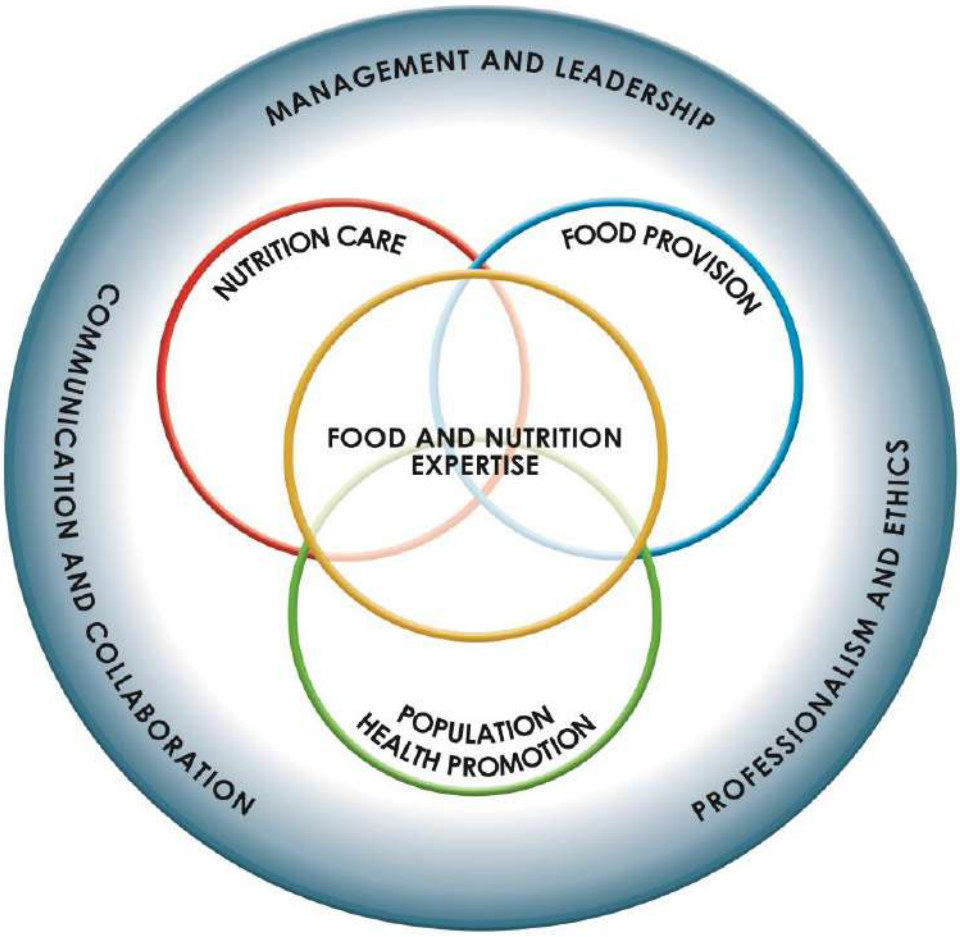
1. Food and Nutrition Expertise
2. Professionalism and Ethics
3. Communication and Collaboration
4. Management and Leadership
5. Nutrition Care
6. Population Health Promotion
7. Food Provision

The foundation of ICDEP is the Domains of Competence. The Practice Competencies are embedded throughout seven interrelated Domains.

[1] In ICDEP the term "candidate" is used to refer to a student in an academic program, an intern in a practicum program or an individual writing the CDRE, according to context.
[2] The CDRE is a requirement for registration in all provinces except Quebec.

The inter-relationship of the Domains of Competence is illustrated through their intersecting coloured bands in Figure 1. The *Food and Nutrition Expertise* Domain is central to all activities carried throughout the three dietetic practice Domains of *Nutrition Care*, *Population Health Promotion* and *Food Provision*. Framing and informing these practice domains are the broader Domains of *Professionalism and Ethics*, *Communication and Collaboration*, and *Management and Leadership*.

Figure 1. Domains of Competence at Entry-to-Practice, and their Inter-Relationship



Each Domain is described by a context statement, and is defined by the PCs listed within it. See the table of PCs that follows on page 11. By appropriately demonstrating abilities in all seven Domains prior to entry-to-practice, candidates are prepared for practice in Canada.

2 REGISTERED DIETITIANS IN CANADA

Dietitians are health professionals who use expertise in food and nutrition to enhance the lives and improve the health of Canadians. Practicing in a wide range of settings, we use our unique knowledge and skills to meet the varied concerns and interests of the diverse population of Canada.

As dietitians, we tailor food information and nutritional advice to the needs and capacities of individuals, groups and communities. In collaboration with our clients, we strive to enhance their understanding and enjoyment of food within the varied contexts of their everyday lives. As practitioners and educators, we translate the science of nutrition into terms our clients can understand, and we support them in developing food-related skills to achieve their dietary goals.

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Dietitians in Canada work in ever-changing contexts and settings. For example, we provide individualized nutrition care, promote health in an increasingly diverse population, and manage and consult in the provision of safe and healthy food. In collaboration with health and other professionals, we engage in research and share new knowledge to advance health through food and nutrition, such as by informing public policy, driving innovation in the food system, and using management and leadership skills to enhance community capacity building. The following are examples of activities performed by dietitians within various practice settings.

- Assessing the nutritional health of individuals, groups and populations.
- Developing, implementing and evaluating nutrition goals for population health, management of disease, and disease prevention.
- Developing and advising on communications and policies related to food and nutrition.
- Developing nutrition-related tools and communication strategies.
- Managing, leading or consulting on food provision and nutrition programs.
- Teaching and counseling patients, clients, families and relevant others.
- Conducting and contributing to food and nutrition related research.

Food is an essential and central part of life within all cultural groups in Canada, and dietetic practice reflects this rich diversity and complexity. Understanding and appreciating these many facets is central to our practice so that we, as dietitians, can assist all Canadians in accessing culturally safe and appropriate food and nutrition advice, care and support.

EXAMPLES OF COMMON PRACTICE SETTINGS FOR DIETITIANS

***Acute and long term care*:** providing nutrition care to patients and residents; counseling patients, residents and families; providing nutrition-related education to nurses, doctors and other members of healthcare teams

Business and industry: contributing food and nutrition expertise in roles related to food provision, manufacturing, advertising, marketing, research and product development

***Community agencies*:** identifying population nutrition issues and developing strategies to address them

Community health centres and clinics: counseling individuals and groups to prevent disease and promote health

Government: developing and implementing food and nutrition policies

Home health agencies: providing guidance and education on food access and preparation to individuals and families with special needs

Institutional food provision: managing food service systems in settings such as hospitals, long term care, daycare, schools, recreational settings, and correctional facilities

Post-secondary education: teaching and conducting academic research

Private practice: providing consultation services to individual clients and their families, corporate wellness programs, supermarkets, sports teams, and restaurants

3 REGULATION OF DIETETIC PRACTICE

Dietitians are regulated health professionals in Canada, and are accountable for maintaining high standards of education, practice and ethics. Ten independent provincial regulators collaborate under the auspices of the *Alliance of Canadian Dietetic Regulatory Bodies*.

Applicants for registration in most provinces must successfully complete the CDRE, which is administered by the Alliance.

4 DIETETIC EDUCATION

Prior to registration with a provincial regulatory body, dietitians are required to complete comprehensive education. This generally entails obtaining, as a minimum, an approved Bachelor's degree in food and nutrition from a Canadian university, and completing an approved program of practicum training. Various models of dietetic education exist across the country. The program components of every model are accredited by the PDEP Accreditation Council.

5 PURPOSES AND STRUCTURE OF ICDEP

ICDEP provides outcome-based standards for entry-to-practice dietetic education and entry-level dietetic practice. Outcome-based standards focus on abilities possessed as a result of learning, whether learning takes place in a formalized education program, or through work or life experience. The effectiveness of learning varies with both the methodology employed and the characteristics of the learner. When training for professional practice, the outcome-based approach to standards emphasizes that the most important result in the public interest lies in learners' ability to proficiently perform on-the-job tasks.

The ability to perform a task to a specified standard, and in a way that is observable to others, is typically called *a competency.* Dietetic practice, then, results from the application of relevant PCs by registered dietitians. ICDEP identifies a total of 50 PCs, consistent with the needs of entry-level dietetic practice. While each PC is written as a distinct statement of ability, in practice situations PCs are not applied independently. In reality each PC informs and qualifies the others, and the dietitian applies them in combination, according to the situation at hand, utilizing professional judgment.

Ideally, assessment of a candidate's possession of the PCs should take place in an actual practice situation. In reality however, education programs face varying constraints and opportunities, affecting the range of practice settings and resources available for training and assessment purposes. Thus, there may be a gap between the observed performance of candidates in assessment compared to desired performance in practice as regulated health professionals[3]. It is in the interest of all stakeholders in dietetic education and practice to minimize this gap by seeking and utilizing emerging opportunities for practice-based learning. It is to this end that ICDEP has been developed and structured as it is.

Drawn from the PCs, which apply in the dietetic workplace, are Performance Indicators (PIs) which describe candidate behaviours that are required within the constraints of pre-registration education and assessment. ICDEP includes 209 PIs derived from the 50 PCs.

While each PI is written in competency format (i.e., as an outcome-based ability that is observable to others) the PIs describe abilities that are intended to be demonstrated either within education programs or within the CDRE. The PIs, then, might be considered as competencies to be demonstrated *pre-practice*, while the PCs are competencies to be demonstrated *in practice*. Through demonstration of the PIs pre-practice, it is assumed that a candidate has the abilities to perform the PCs in practice. It is for this reason that ICDEP is referred to as *Integrated Competencies for Dietetic Education and Practice.*

PCs vs PIs – WHAT'S THE DIFFERENCE?

It's important to recognize that the exclusive purpose of PIs is to express the learning outcome expectations for pre-registration education and assessment of candidates. The PIs do not express the performance expectations of a registered dietitian in professional practice (even at entry-level); practice expectations are expressed by the PCs.

[3] It should be noted that this challenge is not limited to dietetic education and assessment; it in fact exists to a greater or lesser extent in all health education due to inherent constraints.

6 APPLICATIONS OF ICDEP

APPLICATION IN EDUCATION PROGRAMS

With respect to education programs, the PIs do not describe program curriculum as such, but rather reflect measurable learning outcomes that should result from the design and implementation of curriculum. Thus, programs use the PIs to develop and inform curriculum.

APPLICATION IN THE CANADIAN DIETETIC REGISTRATION EXAMINATION

With respect to the CDRE, the PIs are not test items, but collectively constitute a blueprint or list of specifications from which test items can be developed.

APPLICATION IN EDUCATION PROGRAM ACCREDITATION

The PDEP Steering Committee sets accreditation standards that incorporate the requirements of ICDEP. The Accreditation Council (AC) administers evaluation processes to programs, and awards accreditation in confirmation that the standards are met.

ASSESSMENT OF CANDIDATE PERFORMANCE RELATIVE TO PERFORMANCE INDICATORS

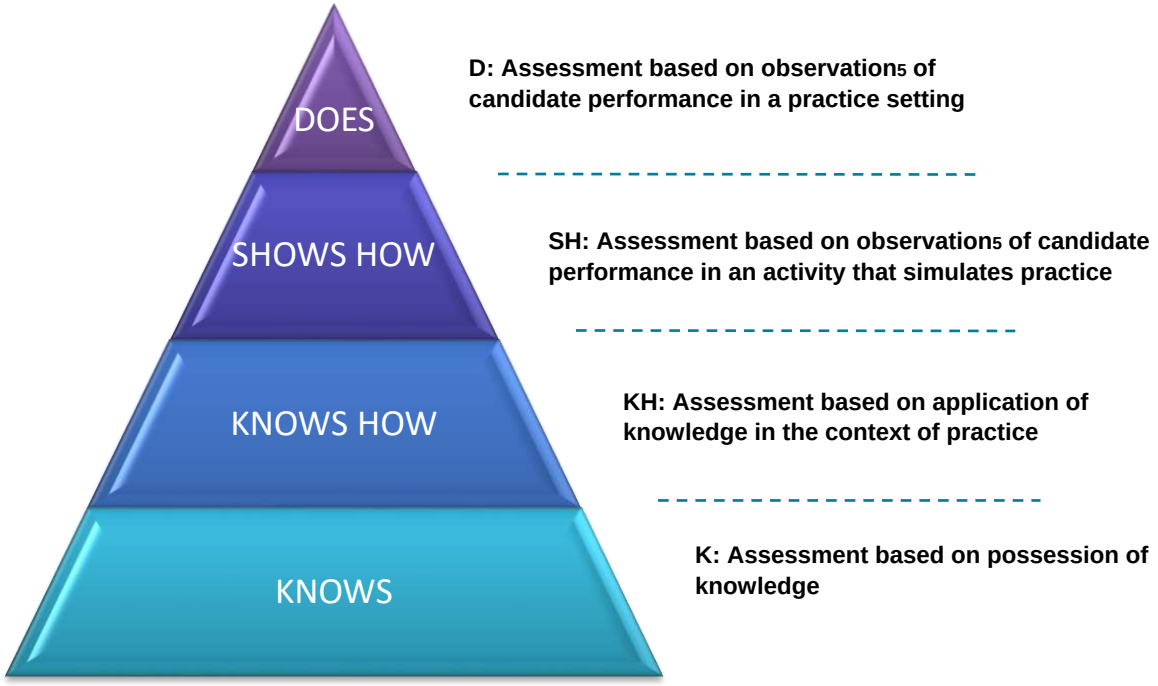
In pre-registration assessment, the candidate is expected, as a minimum, to exhibit behaviour consistent with the following *Statement of Entry-Level Proficiency*:

> *Entry-level dietitians apply approaches consistent with standards and best practices in the profession. They recognize situations beyond their capacity and take appropriate steps to ensure such situations are addressed safely and ethically.*

The standard expressed by the Integrated Competencies is a minimum requirement, designed to ensure safe, effective and ethical entry-level practice. Education programs are encouraged to exceed the content required by ICDEP. Dietitians, even at entry-to-practice, are encouraged to higher-level achievement. Once dietitians achieve registration and enter the workplace, their abilities will evolve, consistent with their practice experience and continuing education.

The observable behaviours that are described as PIs are meant to be interpreted broadly and in the context of the resources and operational norms of the academic and practice settings within which education programs are located. Dietetic practice is nuanced and dynamic, and changes over time as Canadian society, culture and the profession evolve. Local contexts of dietetic education and dietetic practice may necessarily lead to diverse approaches to PI interpretation, application, and assessment.

A modified version of *Miller's Pyramid*[4] is used in ICDEP to specify the nature of assessment required within each assessment setting, as shown below.



The pyramid depicts increasing complexity of assessment, and increasing clinical relevance, moving upwards from a broad base of knowledge.

At the base level, *Knows* (K) assessment is cognitive and indicates possession of foundational knowledge relevant to dietetic practice, or – at its simplest level – basic awareness. Written or oral assessment of performance at this level might involve using assignments, short-answer or multiple-choice examinations. The verb combinations *Demonstrate awareness* (i.e., recall), or *Demonstrate knowledge* (i.e., demonstrate broad knowledge; comprehend) are used to indicate *Knows* level assessment.

[4] For further information on Miller's Pyramid see Glossary.
[5] Observation may be direct (undertaken by the assessor) or indirect (anecdotal, based on the assessor's discussion with others).

Knows How (KH) assessment demands more complex cognitive ability involving the direct application of knowledge in the context of dietetic practice. Written or oral assessment of performance at this level might involve using scenario-based questions in multiple-choice testing, short-answer questions, or case studies. The verb combination *Demonstrate understanding* (i.e., analyze, interpret, apply) is used to indicate *Knows How* assessment.

Moving upwards to the third level of the pyramid, *Shows How* (SH) assessment takes place in an artificially-constructed setting, designed to simulate an aspect of practice but not involving the actual practice environment. This might involve direct or indirect observation of performance in situations such as Objective Structured Clinical Evaluation (OSCE), skill station, laboratory, role playing, demonstration of skills with a standardized patient, participating effectively in teamwork with fellow candidates, problem based learning, etc. PI language at the *Shows How* level is framed around situation-specific action verbs that require cognitive, affective and psychomotor activity.

At the top of the pyramid, and maximizing clinical relevance, lies *Does* (D) assessment, which focuses on observation of a candidate's cognitive, affective, and psychomotor behaviour in a setting that involves actual dietetic practice. This might involve direct or indirect observation of performance in situations such as chart reviews, behaviour-based interviews, development of resources or reports, oral presentations, reflective practice exercises, chart-stimulated recall, capstone project, direct interactions with clients / patients, stakeholders, or team members.

Similar to *Shows How*, PI language for *Does* is framed around situation-specific action verbs. The stated assessment requirement is a minimum standard. The Miller level cited for a PI must be feasible for all candidates in a program. Thus while *Does* assessment might be desirable in a practicum setting, it may not be feasible to expose all candidates to such an assessment opportunity for practical or regulatory reasons. In such instances, ICDEP cites *Shows How* as the minimum requirement.

CONTRIBUTE TO vs PARTICIPATE IN

In instances where the performance of the candidate is not expected to be autonomous in the practice setting the verbs *participate in* and *contribute to* rather than 'perform' have been used. These terms are defined as follows:

- Contribute to = play a constructive role in
- Participate in = take part in

Thus *contribute to* is a higher-level expectation than *participate in*.

TEACHING ILLUSTRATION 1

Here is an example of how Miller's Pyramid might be applied to PC 2.06 *Ensure appropriate and secure documentation*, and specifically to PI 2.06a *Document relevant information accurately and completely, in a timely manner*.

The PI describes the observable behaviour which is to be the basis for assessment. This behaviour can be assessed at any of the 4 Miller levels:

Knows:

- *Knows* assessment would indicate that the candidate knows about the characteristics of documentation normally required, devoid of any specific context or application. This assessment could take place in a written assignment or test, an oral test, or a multiple choice question.

Knows How:

- *Knows How* assessment would indicate that in addition to *Knows*, the candidate is able to identify the characteristics of documentation that would apply in a specific context of practice or practice scenario. Similar to *Knows* assessment, *Knows How* assessment could take place in a written assignment or test, an oral test, or a multiple choice question.

Shows How:

- *Shows How* assessment would indicate that the candidate can actually perform the required task of documenting appropriately, based on observation of her/his performance in an artificially structured simulation of practice such as a food/communication lab, a simulation with a standardized patient, a computer-based simulation, or a case study.

Does:

- *Does* assessment would indicate that the candidate can actually perform the required task of documenting appropriately in a practice setting, based on observation of her/his performance in the dietetic workplace. Such observation may, for example, involve a preceptor reviewing and assessing the candidate's chart notes following a patient interaction for performance consistent with entry-level proficiency.

It is only at the *Does* level that the candidate performs in a setting that closely mirrors what real-life practice as a Dietitian may be like; thus *Does* assessment is sometimes considered to be the 'gold standard' relative to clinical competence and it lies at the top of the pyramid. That said, dependent on the nature of the PI and the practicum situations available, *Does* assessment may not be reliably observable for all candidates. Additionally, it might be considered that *Knows How* assessment can elicit more comprehensive information about anticipated candidate performance.

TEACHING ILLUSTRATION 2

Here is an example of how Miller's Pyramid might be applied to PC 4.08 *Foster development of food skills in others*, and specifically 4.08i *Engage with client in building food skills*. This example also demonstrates the interconnectedness between the PCs.

The PI describes the observable behaviour which is to be the basis for assessment. This behaviour can be assessed at any of the 4 Miller levels:

Knows:

- *Knows* assessment would indicate that the candidate knows the definition and characteristics of food skills, devoid of any specific context or application. This assessment could take place in a written assignment or test, an oral test, or a multiple choice question.

Knows How:

- *Knows How* assessment would indicate that in addition to *Knows*, the candidate is able to apply the concept of food skills to a specific context of practice or practice scenario, for example, identifying the impact of food skills on a community or client's nutritional health. Similar to Knows assessment, *Knows How* assessment could take place in a written case assignment or test, an oral test, or a multiple choice question.

Shows How:

- *Shows How* assessment would indicate that the candidate can engage with client in building food skills, based on direct or indirect observation of her/his performance in an artificially structured simulation of practice. For example, the candidate incorporates activities to build food skills when planning a community intervention for a class assignment, or the candidate is able to incorporate building food skills as part of a simulated interaction with a standardized patient.

Does:

- *Does* assessment would indicate that the candidate can engage with the client in building food skills, based on direct or indirect observation of her/his performance in a practice setting. For example, stakeholder evaluation of the implemented community intervention as part of a class assignment, or a preceptor observing a candidate-client counselling interaction for performance consistent with entry-level proficiency.

This illustration demonstrates that practice activities are rarely the application of a single PC. In the example of 4.08i, performance consistent with entry-level practice for this PI would also involve the application of PCs/PIs from the Professionalism and Ethics, and the Communication and Collaboration Domains, and depending on the scenario, could also involve PCs/PIs from the Nutrition Care or the Population Health Promotion Domains.

7 PRACTICE COMPETENCIES

The table below presents the PCs – the workplace abilities expected of the dietitian at entry-to-practice. The following table (starting on page 14) provides the PIs drawn from each PC, which describe the performance that will be assessed prior to registration.

Note: Underlined terms in the following table are hyperlinked to definitions and references in the Glossary.

1. FOOD AND NUTRITION EXPERTISE

Dietitians integrate their food and nutrition expertise to support the health of individuals, communities and populations

1.01 Apply understanding of food composition and food science
1.02 Apply understanding of food environments
1.03 Apply understanding of human nutrition and metabolism
1.04 Apply understanding of dietary requirements and guidelines
1.05 Apply understanding of dietary practices
1.06 Integrate nutrition care principles and practices
1.07 Integrate population health promotion principles and practices
1.08 Integrate quantity food provision principles and practices

2. PROFESSIONALISM AND ETHICS

Dietitians use professional, ethical and client-centred approaches, to practice with integrity and accountability

2.01 Practice within the context of Canadian diversity
2.02 Act ethically and with integrity
2.03 Practice in a manner that promotes cultural safety
2.04 Employ a client-centred approach
2.05 Practice according to legislative, regulatory and organizational requirements
2.06 Ensure appropriate and secure documentation
2.07 Use risk management approaches
2.08 Manage time and workload
2.09 Employ an evidence-informed approach to practice
2.10 Engage in reflective practice
2.11 Practice within limits of current personal level of professional knowledge and skills
2.12 Maintain comprehensive and current knowledge relevant to practice
2.13 Use information management technologies to support practice

3. COMMUNICATION AND COLLABORATION

Dietitians communicate effectively and collaborate with others to achieve practice goals

3.01 Use appropriate communication approaches

3.02 Use effective written communication skills

3.03 Use effective oral communication skills

3.04 Use effective electronic communication skills

3.05 Use effective interpersonal skills

3.06 Engage in teamwork

3.07 Participate in collaborative practice

4. MANAGEMENT AND LEADERSHIP

Dietitians use management skills and provide leadership to advance health, through food and nutrition

4.01 Manage programs and projects

4.02 Assess and enhance approaches to practice

4.03 Participate in practice-based research activities

4.04 Undertake knowledge translation

4.05 Advocate for ongoing improvement of nutritional health and care

4.06 Foster learning in others

4.07 Foster development of food literacy in others

4.08 Foster development of food skills in others

5. NUTRITION CARE

Dietitians use the Nutrition Care Process to provide individualized care

5.01 Conduct nutrition assessment

5.02 Determine nutrition diagnosis

5.03 Plan nutrition intervention(s)

5.04 Implement nutrition intervention(s)

5.05 Monitor nutrition intervention(s) and evaluate achievement of nutrition goals

6. POPULATION HEALTH PROMOTION

Dietitians assess food and nutrition needs with communities / populations, and collaborate in planning to promote health

6.01 Assess food- and nutrition-related situation of communities and populations

6.02 Determine food- and nutrition-related issues of communities and populations

6.03 Develop food- and nutrition-related community / population health plan

6.04 Implement food- and nutrition-related community / population health plan

6.05 Monitor and evaluate food- and nutrition-related community / population health plan

7. FOOD PROVISION

Dietitians manage and consult on quantity food provision to support health

7.01 Determine food provision requirements of a group / organization

7.02 Plan food provision

7.03 Manage food provision

7.04 Monitor and evaluate food provision

8 PRACTICE COMPETENCIES WITH PERFORMANCE INDICATORS

Note: Underlined terms in the following table are hyperlinked to definitions and references in the Glossary.

1. FOOD AND NUTRITION EXPERTISE

Dietitians integrate their food and nutrition expertise to support the health of individuals, communities and populations

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
1.01	**Apply understanding of food composition and food science**	a. Demonstrate understanding of physical and chemical properties of food	KH		KH
		b. Demonstrate understanding of food preparation, processing and preservation	KH		KH
		c. Demonstrate understanding of the role of ingredients and their interaction in food preparation	KH		KH
		d. Demonstrate understanding of the sensory evaluation of food	KH		KH
		e. Demonstrate understanding of microbes in food	KH		KH
		f. Identify sources of micronutrients and macronutrients in food	K		K
		g. Identify sources of non-nutrient functional components in food	K		K
1.02	**Apply understanding of food environments**	a. Demonstrate knowledge of government policy in regulating food products in Canada	K		K
		b. Demonstrate understanding of factors affecting food systems in Canada	KH		KH
		c. Demonstrate awareness of Indigenous values and ways of knowing related to food environments	K		K
		d. Demonstrate understanding of factors affecting food security of Canadians	KH		KH
		e. Demonstrate understanding of factors affecting food safety	KH		KH
		f. Demonstrate understanding of sustainable food systems	KH		KH
1.03	**Apply understanding of human nutrition and metabolism**	a. Demonstrate understanding of the role of nutrients and other food components	KH		KH
		b. Demonstrate understanding of the processes of ingestion, digestion, absorption and excretion	KH		KH
		c. Demonstrate understanding of metabolism	KH		KH

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
1.04	**Apply understanding of dietary requirements and guidelines**	a. Demonstrate understanding of dietary requirements across the lifespan, in health and disease	KH		KH
		b. Demonstrate understanding of factors affecting energy balance in determining dietary requirements	KH		KH
		c. Demonstrate understanding of current nutrition recommendations and dietary guidelines	KH		KH
		d. Demonstrate understanding of how deficiencies and toxicities of nutrients affect health	KH		KH
		e. Demonstrate understanding of the role of dietary supplements	KH		KH
1.05	**Apply understanding of dietary practices**	a. Demonstrate understanding of behavioural theories relevant to food choice and eating	KH		KH
		b. Demonstrate understanding of social aspects of food choice and eating	KH		KH
		c. Demonstrate understanding of psychological aspects of food choice and eating	KH		KH
		d. Demonstrate understanding of the impact of financial resources on food choice and eating	KH		KH
		e. Demonstrate awareness of the role of Indigenous traditional / country foods in dietary practices	K		K
		f. Demonstrate awareness of the role of religion and culture in dietary practices	K		K
		g. Demonstrate knowledge of trends in food consumption	K		K
1.06	**Integrate nutrition care principles and practices**	a. Demonstrate knowledge of human physiological systems in health and disease	K		K
		b. Demonstrate knowledge of the etiology and pathophysiology of nutrition-related diseases	K		K
		c. Demonstrate understanding of nutrition-related disease management strategies	KH		KH
		d. Demonstrate understanding of the Nutrition Care Process	KH		KH
1.07	**Integrate population health promotion principles and practices**	a. Demonstrate understanding of determinants of health, health equity, and social justice	KH		KH
		b. Demonstrate knowledge of frameworks for population and public health	K		K
		c. Demonstrate understanding of capacity development strategies related to community food and nutrition issues	KH		KH
		d. Demonstrate understanding of health promotion concepts and approaches	KH		KH
1.08	**Integrate quantity food provision principles and practices**	a. Demonstrate understanding of food provision strategies that foster health in individuals, communities and population	KH		KH
		b. Demonstrate understanding of strategies that support sustainable food provision	KH		KH
		c. Demonstrate knowledge of approaches to food marketing	K		K
		d. Demonstrate knowledge of food provision in emergency planning	K		K

2. PROFESSIONALISM AND ETHICS

Dietitians use professional, ethical and client-centred approaches, to practice with integrity and accountability

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
2.01	**Practice within the context of Canadian diversity**	a. Demonstrate knowledge of the diversity in Canadian society	K		K
		b. Demonstrate knowledge of health systems in Canada	K		K
		c. Demonstrate understanding of the impact of diverse attitudes and values on health	KH		KH
		d. Identify structures that impact health equity and social justice	KH	D	KH
2.02	**Act ethically and with integrity**	a. Treat others with respect	SH	D	KH
		b. Act in a manner that engenders trust	SH	D	KH
		c. Act in accordance with ethical principles	SH	D	KH
		d. Accept accountability for decisions and actions	SH	D	KH
		e. Act in a manner that upholds the reputation of the profession	SH	D	KH
		f. Maintain professional boundaries	KH	D	KH
2.03	**Practice in a manner that promotes cultural safety**	a. Act with sensitivity and humility with regard to diverse cultural groups	KH	D	KH
		b. Demonstrate awareness of Indigenous values and ways of knowing related to health and wellness	K		K
		c. Demonstrate awareness of the ongoing impact of colonization / residential schools / intergenerational trauma / systemic racism on Indigenous peoples in Canada	K		K
		d. Demonstrate awareness of the role of self-determination in supporting capacity development	K		K
		e. Act with awareness of how one's own biases, beliefs, behaviours, power and privilege may affect others	KH	D	KH
2.04	**Employ a client-centred approach**	a. Demonstrate knowledge of principles of a client-centred approach	K		K
		b. Ensure informed consent	KH	D	KH
		c. Identify client perspectives, needs and assets	KH	D	KH
		d. Engage client in collaborative decision making	KH	D	KH
		e. Maintain client confidentiality and privacy	KH	D	KH

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
2.05	**Practice according to legislative, regulatory and organizational requirements**	a. Demonstrate knowledge of federal requirements relevant to dietetic practice	K		K
		b. Demonstrate knowledge of provincial / territorial requirements relevant to dietetic practice	K		K
		c. Demonstrate knowledge of regulatory scope of practice, bylaws, standards of practice and codes of ethics	K		K
		d. Adhere to regulatory requirements		D	KH
		e. Comply with organizational policies and directives		D	KH
2.06	**Ensure appropriate and secure documentation**	a. Document relevant information accurately and completely, in a timely manner	KH	D	KH
		b. Maintain security and confidentiality of records	KH	D	KH
2.07	**Use risk management approaches**	a. Identify risks and hazards in the practice setting	K	D	KH
		b. Contribute to an organizational culture of safety	KH	D	KH
2.08	**Manage time and workload**	a. Prioritize activities	SH	D	KH
		b. Meet deadlines	SH	D	
2.09	**Employ an evidence-informed approach to practice**	a. Demonstrate knowledge of factors that inform decision making	K		K
		b. Demonstrate knowledge of the process of evidence-informed decision making	K		K
		c. Make evidence-informed decisions	KH	D	KH
2.10	**Engage in reflective practice**	a. Demonstrate knowledge of principles of reflective practice	K		K
		b. Critically assess approaches to practice		D	KH
		c. Develop goals and seek resources to improve practice		D	KH
2.11	**Practice within limits of current personal level of professional knowledge and skills**	a. Articulate individual level of professional knowledge and skills	KH	D	KH
		b. Identify situations which are beyond personal capacity		D	KH
		c. Address situations beyond personal capacity		D	KH
2.12	**Maintain comprehensive and current knowledge relevant to practice**	a. Use relevant terminology	SH	D	KH
		b. Identify relevant sources of information	KH	D	KH
		c. Critically appraise information relevant to practice	KH	D	KH
		d. Identify emerging information relevant to practice	K	D	KH
2.13	**Use information management technologies to support practice**	a. Demonstrate knowledge of information technologies relevant to practice	K		K
		b. Use information management systems	SH	D	

3. COMMUNICATION AND COLLABORATION

Dietitians communicate effectively and collaborate with others to achieve practice goals

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
3.01	**Use appropriate communication approaches**	a. Identify opportunities for and barriers to communication relevant to context	KH	D	KH
		b. Use communication approaches appropriate to context	SH	D	KH
		c. Use language tailored to audience	SH	D	KH
3.02	**Use effective written communication skills**	a. Write in a manner responsive to audience	SH	D	
		b. Write clearly and in an organized fashion	SH	D	
3.03	**Use effective oral communication skills**	a. Speak in a manner responsive to audience	SH	D	
		b. Speak clearly and in an organized fashion	SH	D	
3.04	**Use effective electronic communication skills**	a. Demonstrate knowledge of electronic communication applications	K		K
		b. Use electronic communication relevant to context	SH	D	
3.05	**Use effective interpersonal skills**	a. Employ principles of active listening	SH	D	KH
		b. Use and interpret non-verbal communication	SH	D	KH
		c. Act with empathy	SH	D	KH
		d. Establish rapport	SH	D	KH
		e. Employ principles of negotiation and conflict management	SH	D	KH
		f. Seek and respond to feedback	SH	D	KH
		g. Provide constructive feedback to others	SH	D	KH
3.06	**Engage in teamwork**	a. Demonstrate knowledge of principles of teamwork and collaboration	K		K
		b. Contribute effectively to teamwork	SH	D	
3.07	**Participate in collaborative practice**	a. Identify scenarios where dietetics knowledge is a key element in collaborative practice	K		K
		b. Identify scenarios where the expertise of others is a key element in dietetic practice	K		K
		c. Participate in discussions with team members	SH	D	KH
		d. Contribute dietetics knowledge in collaborative practice	KH	D	KH
		e. Draw upon the expertise of others	KH	D	KH
		f. Contribute to collaborative decision making	SH	D	KH

4. MANAGEMENT AND LEADERSHIP

Dietitians use management skills and provide leadership to advance health, through food and nutrition

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
4.01	**Manage programs and projects**	a. Demonstrate understanding of management principles	KH		KH
		b. Contribute to strategic and operational planning	KH	D	KH
		c. Contribute to human resource management	KH	D	KH
		d. Contribute to financial management	KH	D	KH
		e. Contribute to physical resource management	KH	D	KH
4.02	**Assess and enhance approaches to practice**	a. Assess a practice situation	SH	D	KH
		b. Interpret and consolidate evidence to establish a course of action	SH	D	KH
		c. Plan the implementation of change	SH	D	KH
		d. Plan the evaluation of change	SH	D	KH
4.03	**Participate in practice-based research activities**	a. Frame question(s)	SH	D	KH
		b. Critically appraise literature	SH	D	KH
		c. Identify relevant methodology	SH	D	KH
		d. Interpret findings	SH	D	KH
		e. Communicate findings	SH	D	KH
4.04	**Undertake knowledge translation**	a. Identify food and nutrition knowledge relevant to others	K	D	KH
		b. Reframe knowledge into a format accessible to others	SH	D	KH
4.05	**Advocate for ongoing improvement of nutritional health and care**	a. Identify opportunities for advocacy	K	D	KH
		b. Identify strategies for effective advocacy	KH	D	KH
		c. Engage in advocacy		D	

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
4.06	**Foster learning in others**	a. Demonstrate understanding of theories of teaching and learning	KH		KH
		b. Identify opportunities for learning	KH	D	KH
		c. Assess learning needs and assets	KH	D	KH
		d. Develop learning outcomes	KH	D	KH
		e. Implement educational strategies	KH	D	KH
		f. Evaluate achievement of learning outcomes	KH	D	KH
4.07	**Foster development of food literacy in others**	a. Demonstrate knowledge of the concept of food literacy	K		K
		b. Identify strategies to assist the development of food literacy	KH	D	KH
		c. Engage in activities to build food literacy	SH	D	
4.08	**Foster development of food skills in others**	a. Demonstrate understanding of factors that impact client ability to safely plan, access, select, store and prepare food that meets their needs	KH		KH
		b. Demonstrate awareness of the availability and preparation of Indigenous traditional / country foods	K		K
		c. Demonstrate awareness of the availability and preparation of foods specific to cultural groups	K		K
		d. Respond to the cultural foodways of client	KH	D	KH
		e. Identify strategies to assist in the development of food skills	KH	D	KH
		f. Critically appraise food messaging and marketing	SH	D	KH
		g. Interpret food label	SH	D	KH
		h. Demonstrate food preparation techniques	SH	D	
		i. Engage with client in building food skills	KH	D	KH

5. NUTRITION CARE

Dietitians use the Nutrition Care Process to provide individualized care

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
5.01	**Conduct nutrition assessment**	a. Use appropriate nutrition risk screening strategies	KH	D	KH
		b. Identify relevant information	KH	D	KH
		c. Assess and interpret food- and nutrition-related history	KH	D	KH
		d. Obtain and interpret medical history	KH	D	KH
		e. Obtain and interpret demographic, psycho-social and health behaviour history	KH	D	KH
		f. Assess and interpret anthropometric parameters	KH	D	KH
		g. Assess and interpret nutrition-focused physical findings	KH	D	KH
		h. Obtain and interpret biochemical data	KH	D	KH
		i. Obtain and interpret results from medical tests and procedures	KH	D	KH
		j. Obtain and interpret medication data	KH	D	KH
		k. Assess and interpret chewing, swallowing and eating abilities	KH	SH	KH
5.02	**Determine nutrition diagnosis**	a. Integrate assessment findings to identify nutrition problem(s)	KH	D	KH
		b. Prioritize nutrition problems	KH	D	KH
5.03	**Plan nutrition intervention(s)**	a. Determine nutrition goals	KH	D	KH
		b. Determine nutrition requirements	KH	D	KH
		c. Determine dietary modifications	KH	D	KH
		d. Determine therapeutic supplementation	KH	D	KH
		e. Determine supportive physical and social / environmental accommodations	KH	D	KH
		f. Determine enteral nutrition regimens	KH	SH	KH
		g. Determine parenteral nutrition regimens	KH	SH	KH
		h. Determine client learning needs and assets	KH	D	KH
		i. Determine required resources and support services	KH	D	KH
5.04	**Implement nutrition intervention(s)**	a. Coordinate implementation of nutrition intervention(s)	KH	D	KH
		b. Provide nutrition education	SH	D	KH
		c. Provide nutrition counselling	SH	D	KH

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
5.05	**Monitor nutrition intervention(s) and evaluate achievement of nutrition goals**	a. Determine strategies to monitor effectiveness of nutrition intervention(s)	KH	D	KH
		b. Evaluate progress in achieving nutrition goals	KH	D	KH
		c. Adjust nutrition intervention(s) when appropriate	KH	D	KH

6. POPULATION HEALTH PROMOTION

Dietitians assess food and nutrition needs with communities / populations, and collaborate in planning to promote health

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
6.01	**Assess food- and nutrition-related situation of communities and populations**	a. Identify types and sources of information required to assess food and nutrition-related situation of communities and populations	KH	D	KH
		b. Identify stakeholders	KH	D	KH
		c. Access relevant assessment information	KH	D	KH
		d. Interpret food and nutrition surveillance data	KH	D	KH
		e. Interpret health status data	KH	D	KH
		f. Interpret information related to the determinants of health and health equity	KH	D	KH
		g. Interpret information related to food systems and dietary practices	KH	D	KH
6.02	**Determine food- and nutrition-related issues of communities and populations**	a. Integrate assessment findings to identify food- and nutrition-related assets, resources and needs	KH	D	KH
		b. Prioritize issues requiring action	KH	D	KH
6.03	**Develop food- and nutrition-related community / population health plan**	a. Contribute to development of goals and objectives	KH	D	KH
		b. Identify strategies to meet goals and objectives	KH	D	KH
		c. Identify required resources and supports	KH	D	KH
		d. Contribute to identification of evaluation strategies	KH	D	KH
6.04	**Implement food- and nutrition-related community / population health plan**	a. Participate in implementation activities	KH	D	KH
6.05	**Monitor and evaluate food- and nutrition-related community / population health plan**	a. Contribute to monitoring implementation activities	KH	D	KH
		b. Contribute to evaluation activities	KH	D	KH
		c. Propose adjustments to increase effectiveness or meet modified goals and objectives	KH	D	KH

7. FOOD PROVISION

Dietitians manage and consult on quantity food provision to support health

PRACTICE COMPETENCIES (workplace abilities expected of the dietitian at entry-to-practice)		PERFORMANCE INDICATORS (performance that will be assessed prior to registration)	PI ASSESSMENT REQUIRED (K = Knows; KH – Knows How; SH – Shows How; D = Does (based on Miller's Pyramid))		
			Academic	Practicum	CDRE
7.01	**Determine food provision requirements of a group / organization**	a. Identify types and sources of information required to assess food provision needs	KH	D	KH
		b. Access relevant information	KH	D	KH
		c. Interpret situational factors that impact food provision	KH	D	KH
		d. Assess food provision requirements	KH	D	KH
		e. Integrate findings to determine food provision priorities	KH	D	KH
7.02	**Plan food provision**	a. Participate in development of goals and objectives	KH	D	KH
		b. Identify strategies to meet goals and objectives	KH	D	KH
		c. Identify required resources and supports	KH	D	KH
		d. Participate in identification of evaluation strategies	KH	D	KH
7.03	**Manage food provision**	a. Identify facility layout and equipment requirements for food production	SH	D	KH
		b. Participate in purchasing, receiving, storage, inventory control and disposal of food	SH	D	KH
		c. Develop and standardize recipes	SH	D	KH
		d. Participate in menu planning	SH	D	KH
		e. Participate in management of food production and distribution procedures	SH	D	KH
		f. Participate in maintaining safety, and quality control	KH	D	KH
7.04	**Monitor and evaluate food provision**	a. Participate in monitoring food provision activities	KH	D	KH
		b. Contribute to evaluation of food provision activities	KH	D	KH
		c. Propose adjustments to food provision to increase effectiveness or meet modified goals and objectives	KH	D	KH

9 GLOSSARY

The terms defined in the Glossary are provided with the sole intent to clarify the use of these terms as they were understood and as they influenced the context of ICDEP. The terms included may be nuanced and dynamic, and may change as Canadian culture evolves and professional exploration continues. Furthermore, local contexts and interpretations may lead to diverse understandings of these terms. References are provided following some entries; they refer to the numerical listing in the References section that follows the Glossary.

TERM	DEFINITION, NOTES & REFERENCES
Assets	Assets are individual, group and community characteristics and resources that contribute to health and well-being, and support resilience. An asset-based approach promotes capacity and connectedness by making visible and valuing the skills, knowledge, connections and potential in an individual, group or community.(1)
Capacity development	Capacity, most simply defined, is the ability to carry out stated objectives. "Capacity development" and "capacity building" are terms often used interchangeably, essentially referring to the process by which individuals, groups, organizations and societies increase their ability to perform, solve problems, define objectives, understand and deal with development needs to achieve objectives in a sustainable manner.(2)
Client	A client may be an individual, family, group, community, population, organization, business, or government.
Collaborative practice	Collaborative practice is two or more individuals working cooperatively to achieve a common goal. Dietitians work in partnership with nutrition, dietetic, interprofessional and/or intersectoral colleagues, clients and other stakeholders.
Cultural safety	Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.(3)
Determinants of health	Determinants of health refers to the range of personal, social, economic and environmental factors which determine the health status of individuals or populations.(4)
Diversity	Diversity refers to the variety of unique dimensions, qualities and characteristics that an individual possesses, such as race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. Dietitians work to create a culture that strives for equity and embraces, respects, accepts and values difference.(5)
Evidence-informed approach	Evidence-informed practice brings together the best available research evidence and the dietitian's experiential knowledge, along with the client's preferences, context, and available resources in the decision-making process.
Food- and nutrition-related community / population health plan	Food- and nutrition-related community / population health plan may include any or all of the following: monitoring and evaluation of nutritional health and its physical, political, economic and sociocultural determinants; food systems and public policies influencing diet; promotion of healthy eating, and prevention of nutrition-related diseases.

TERM	DEFINITION, NOTES & REFERENCES
Food environments	Food environments refer to the aspects of the social and physical environment that affect the types of food available, the accessibility of food, and the nutrition information that people are exposed to, including food marketing.(6)
Food literacy	Food literacy is the ability of an individual to understand food in a way that they develop a positive relationship with it, including food skills and practices across the lifespan, in order to navigate, engage, and participate within a complex food system. It includes the ability to make decisions to support the achievement of personal health and a sustainable food system considering environmental, social, economic, cultural, and political components.(7)
Food provision	Food provision refers to the activities involved in feeding groups of people in contexts such as: institutional (healthcare, educational, carceral, daycare, long term care); community-based (food distribution, gardens, kitchens); recreational (sports activities, entertainment sites, camps); business and commercial (hospitality, restaurants, catering, food and beverage industry including therapeutic products).
Food security	Food security exists when all people, at all times, have physical and economical access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life.(8) Household food insecurity is the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so. Household food insecurity is often linked with the household's financial ability to access adequate food.(9,10)
Food skills	Food skills include the information, abilities and practices to acquire foods and prepare meals and snacks that are safe, nutritious and culturally acceptable.(11)
Food systems	Food systems are complex, non-linear, systems that embrace all the elements (environment, people inputs, processes, infrastructure, institutions, markets and trade) and activities that relate to the production, processing, distribution and marketing, preparation and consumption of food and the outputs of these activities, including socio-economic and environmental outcomes.(12,13)
Foodways	Foodways are the cultural, social and economic practices relating to the production and consumption of food. Foodways often refers to the intersection of food and culture, traditions and history.(14)
Health	Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.(15)
Health equity	Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. Health equity implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.(16,17)
Health systems	Health systems consist of all organizations, people and actions whose primary intent is to promote, restore or maintain health.(18)

TERM	DEFINITION, NOTES & REFERENCES
Indigenous traditional / country foods	Traditional foods (also known as country foods) are foods that are locally available from natural resources and have cultural significance for Indigenous peoples in Canada. Traditional food is the preferred term for First Nations and Métis peoples, and country food is the preferred term for Inuit.(6)
Knowledge translation	Knowledge translation is a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products, and strengthen the health care system. This means getting the right information to the right people in the right format at the right time so as to influence decision-making.(19,20)
Leadership	Leadership is a process of influencing and inspiring others toward a common goal, whether formally (through a set role) or informally.(21)
Miller's Pyramid	In 1990 Miller provided a structured approach to the assessment of competence in the clinical sciences.(22) His work has been broadly applied by health educators, and used as a tool to review assessment practices in dietetics trainees.(23) The US Accreditation Council for Education in Nutrition and Dietetics bases its *Future Education Model Accreditation Standards* on the Miller framework.(24)
Nutrition Care Process	The Nutrition Care Process is a systematic approach to providing high quality nutrition care. It includes four inter-related steps: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention, Nutrition Monitoring and Evaluation.(25)
Practice-based research	Practice-based research is grounded in, informed by, and intended to improve practice.(26)
Reflective practice	Reflective practice is the ability to reflect on one's actions so as to engage in a process of continuous learning.(27)
Risk management	Risk management involves identifying, analyzing and evaluating potential problems, shortfalls, crises or even missed opportunities followed by the development of strategies or methods to mitigate, control or eliminate the risks.(28)
Self-determination	Self-determination is the right to freely determine political status and freely pursue economic, social and cultural development.(29)
Social justice	Social justice is the fair and reasonable distribution of wealth, opportunities, and privileges within a society.(30)
Sustainable	Sustainable refers to the capacity of being maintained over the long term and meeting the needs of the present without jeopardizing the ability to meet the needs of future generations.(31)

10 LIST OF GLOSSARY REFERENCES

1 National Collaborating Centre for Determinants of Health. Glossary. Cited 2020 May 29. Available from: http://nccdh.ca/resources/glossary

2 Shrimpton R, Hughes R, Recine E, Mason JB. (2014). Nutrition capacity development: a practice framework. Public Health Nutr. 2015;17(3):682-688. Cited 2020 May 29. Available from: https://doi.org/10.1017/S1368980013001213

3 First Nations Health Authority. Cultural humility. Cited 2020 May 29. Available from: www.fnha.ca/wellness/cultural-humility

4 Health Promotion Canada. Glossary. Cited 2020 May 29. Available from: https://www.healthpromotioncanada.ca/wp-content/uploads/2016/07/2015-HPComp-Glossary-new-logo.pdf

5 Canadian Centre for Diversity and Inclusion. Diversity defined. Cited 2020 May 29. Available from: https://ccdi.ca/our-story/diversity-defined/

6 Government of Canada. Canada's food guide: Canada's dietary guidelines. Cited 2020 May 29. Available from: https://food-guide.canada.ca/en/guidelines/glossary/

7 Cullen T, Hatch J, Martin W, Higgins JW, Sheppard R. Food literacy: definition and framework for action. Can J Diet Pract Res. 2015;76:1–6.

8 Food and Agriculture Organization of the United Nations. Policy brief: food security. 1996. Cited 2020 May 29. Available from: http://www.fao.org/fileadmin/templates/faoitaly/documents/pdf/pdf_Food_Security_Cocept_Note.pdf

9 Government of Canada. Household food security in Canada. Cited 2020 May 29. Available from: https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/household-food-insecurity-canada-overview.html

10 Power E. (2005). Individual and household food insecurity in Canada: position of Dietitians of Canada". Can J Diet Pract Res. 2005;66(1):43–46.

11 Government of Canada. Canada's food guide: section 3 importance of food skills. Cited 2020 May 29. Available from: https://food-guide.canada.ca/en/guidelines/section-3-importance-of-food-skills/

12 Dietitians of Canada. The role of dietitians in sustainable food systems and sustainable diets. 2020 Jan. Cited 2020 May 29. Available from: https://www.dietitians.ca/Advocacy/Toolkits-and-Resources?n=The%20Role%20of%20Dietitians%20in%20Sustainable%20Food%20Systems%20and%20Sustainable%20Diets%20(role%20paper)&Page=1

13 Food and Agriculture Organization of the United Nations. Nutrition and food systems: A report by the high level panel of experts on food security and nutrition of the committee on world food security and nutrition. 2017 Sep. Cited 2020 May 29. Available from: http://www.fao.org/3/a-i7846e.pdf

14 Michigan State University. Foodways: When food meets culture and history. 2012 Dec. Cited 2020 May 29. Available from: https://www.canr.msu.edu/news/foodways_when_food_meets_culture_and_history

15 World Health Organization. Health promotion glossary: Health. 1998. Cited 2020 May 29. Available from: https://www.who.int/healthpromotion/about/HPG/en/

16 World Health Organization. Health promotion glossary: Equity in health. 1998. Cited 2020 May 29. Available from: https://www.who.int/healthpromotion/about/HPG/en/

17 World Health Organization. Health equity through intersectoral action: an analysis of 18 country case studies. 2008. Cited 2020 May 29. Available from: https://www.who.int/social_determinants/EN_intersectoral_action_final_report.pdf

18 World Health Organization. Strengthening health systems to improve health outcomes. 2007. Cited 2020 May 29. Available from: http://www.who.int/healthsystems/strategy/everybodys_business.pdf

19 Canadian Institutes of Health Research. Knowledge translation. 2016 Jul 28. Cited 2020 May 29. Available from: http://www.cihr-irsc.gc.ca/e/29418.html

20 Levesque P. Knowledge mobilization. In: Coghlan D, Brydon-Miller M, eds. The sage encyclopedia of action research. Thousand Oaks: SAGE Publications; 2014: 82-84.

21 Canadian Council of Registered Nurse Regulators. Competencies in the context of entry-level registered nurse practice. 2012. Cited 2020 May 29. Available from: https://www.ccrnr.ca/assets/jcp_rn_competencies_2012_edition.pdf

22 Miller GE. The assessment of clinical skills/competence/performance. Acad Med. 1990;65:S63-67

23 Jamieson J, et al. Assessment practices for dietetics trainees: a systematic review. J Acad Nutr Diet. 2019;119(2):272-292.

24 Accreditation Council for Education in Nutrition and Dietetics: ACEND standards update. 2018 Feb. Cited 2020 May 29. Available from https://www.eatrightpro.org/-/media/eatrightpro-files/acend/standardsupdatefebruary2018.pdf?la=en&hash=F1B92E526A20087889681CD29E3626E790F25BA8

25 Academy of Nutrition and Dietetics. Definition of terms list. 2020 May. Cited 2020 May 29. Available from: https://www.eatrightpro.org/-/media/eatrightpro-files/practice/scope-standards-of-practice/academy-definition-of-terms-list.pdf?la=en&hash=1B1A1D4E3D16A054E6EE253A84FA2CADE952D77F

26 Westfall J, Mold J, Fagnan L. Practice-based research: “blue highways” on the NIH roadmap. JAMA. 2007;297(4):403-406.

27 Schon D. The reflective practitioner: how professionals think in action. New York: Basic Books;1983.

28 Commission on Dietetic Regulation. Essential practice competencies: Glossary. Cited 2020 May 29. Available from: https://admin.cdrnet.org/vault/2459/web/files/FINAL-CDR_Competency.pdf

29 United Nations. Declaration on the rights of indigenous peoples. Cited 2020 May 29. Available from: https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

30 New Zealand Dietitians Board. Professional competencies & standards for dietitians. 2017. Cited 2020 May 29. Available from: https://www.dietitiansboard.org.nz/practitioners/professional-standards-competencies/

31 Tagtow A, et al. Academy of Nutrition and Dietetics: standards of professional performance for registered dietitian nutritionists (competent, proficient, and expert) in sustainable, resilient, and healthy food and water systems. J Acad Nutr Diet. 2014;114(3):475-488. Cited 2020 May 29. Available from: doi.org/10.1016/j.jand.2013.11.011

APPENDIX

HISTORY OF ICDEP

Work to develop the Integrated Competencies began in 2009, as one of the first initiatives of the (then) recently-formed PDEP. Creating ICDEP was the first attempt to develop a single, practice-derived Canadian standard spanning entry-level education, the accreditation of education programs, and the content of the CDRE. The work was partially funded by a grant from (then) Human Resources and Skills Development Canada, awarded with the objective of enhancing labour mobility among Canadian dietitians.

Two phases of activity took place. In Phase 1, proposed practice competencies were drafted by a six-person working group representing practicing dietitians, dietetic educators and regulators; the group was supported by a project manager and a consultant in outcome-based learning. PC drafting was based on review of relevant Canadian and international source documents, and the group's own expertise. The competencies were validated primarily through consultation with practicing dietitians from across Canada. In Phase 2 the working group drafted performance indicators, as well as foundational knowledge specifications. Validation was achieved through consultation with the CDRE Management Committee and education programs. At the culmination of Phase 2, in March 2012, ICDEP v1.0 was published.

Stakeholders requested a further opportunity to review and provide input into the new standard that ICDEP provided; PDEP agreed to more consultations during 2012. The foundational knowledge specifications were revised as a result of a workshop involving academic educators. A gap analysis survey was undertaken to assess the level to which the proposed indicators and knowledge requirements were currently being met by programs and, where they were not, the feasibility of programs making corresponding adjustments. A further review of indicators for CDRE assessment took place. ICDEP v2.0 was developed in response to the input received during 2012, and was published in April 2013.

DEVELOPMENT OF ICDEP V3.0

In the fall of 2016 the scene was set for an update of ICDEP v2.0 with a preliminary stakeholder consultation. This involved distance-based focus group discussions with representatives of the following stakeholder groups:

- Accreditation Council
- Alliance of Regulators
- CDRE Committee
- Education Programs
- Accreditation Surveyors
- Francophone Educators

A high-level summary of the results of the preliminary consultation read as follows:

  - Overall, respondents indicated that the impact of ICDEP [v2.0] on their work was significant, and positive. In terms of the design of ICDEP, this was seen as good, but with some room for improvement. Opinion on the Practice Competencies (PCs), the Performance Indicators (PIs), and the Foundational Knowledge Specifications (FK), was more mixed; the average response rating for each of these components was between 3 and 4 on a scale of 1 (poor) through 5 (excellent).

The most significant and most commonly-mentioned points of feedback regarding ICDEP v2.0 were:

- ICDEP remains a relatively recently-introduced document. Many stakeholders are continuing to actively work on applying it within their sphere of interest (e.g., in curriculum review and adjustment; in developing registration requirements for internationally-educated dietitians). It would be counterproductive for the update to see ICDEP undergo a wholesale change of approach. The update project should be just that – updating, clarifying and refining.
- The French translation of ICDEP is problematic. In some instances, it is inaccurate; in others the French terminology used does not match terminology of the French CDRE. In the update project, more emphasis should be placed on translation validation.
- The relatively high-level content of ICDEP is both a strength and a weakness. On the positive side, it leaves plenty of room for requirements to be met flexibly, according to the context of use. Less positively, many users struggle with the interpretation of certain terminology, and as a result there may be considerable inconsistency in the standard achieved. A glossary and interpretation guide for ICDEP should be considered, ideally as an annex rather than within the ICDEP document itself. The guide could be a living product, perhaps online, and managed through a "community of interest" approach.
- In terms of its organizational structure, ICDEP should follow the progression of candidate learning: FK to PIs to PCs. This approach would also allow the PCs to more clearly stand alone as the expected workplace outcome.
- The definition of Entry-Level Proficiency should be reviewed in order to (a) create a clearer distinction between entry-level practice and mature practice and (b) allow for some variation in entry-level expectations across PCs.
- The FK specifications need to be better integrated into the PCs and PIs; currently FK appears somewhat disjointed. FK should continue to be addressed broadly, since education programs approach it in very different ways. FK content needs review both for comprehensiveness and for complexity.
- In the update project, PI validation needs increased attention both from educators and from CDRE personnel. The commonly-used term "demonstrate knowledge of…" is too nebulous and needs clearer specification as to the level of cognitive complexity expected.
- In the update project, PC validation for currency should be addressed with employers, with a view to both future workplace needs and to expanding fields of practice (e.g., agriculture, marketing, private practice). Regulators are concerned that dysphagia care and parenteral nutrition expectations are inadequately addressed.

The development of ICDEP v3.0 was led by a working group composed of a consultant in outcome-based learning and four experienced dietetic educators from different sectors and regions in Canada. The working group reported to the PDEP Steering Committee.

The update process leading to ICDEP v3.0 took place over the period July 2017 – June 2020 and involved:

Summary of meeting activity

- 13 in-person working group meetings (with duration of 2-3 days each)
- Approximately 40 online working group meetings (with duration in the region of 90-minutes each)
- 6 working group / PDEP Steering Committee consultation sessions (both in-person and online)
- 3 working group / Alliance of Regulators consultation sessions (both in-person and online)
- 2 day-long in-person presentation / consultation sessions with the PDEP membership

- Extensive collaborative discussions with a professional translator and with the PDEP French language terminology verification working group

Foci of attention for the working group, in approximate chronological order

- Review of relevant Canadian and international source documents, throughout the process
- Development of updated, domain-based structural framework for PCs & PIs
- Updating of PCs
- Canada-wide, online, bilingual PC validation survey with registered dietitians
- Conversion of foundational knowledge statements to outcome-based PIs
- Updating of existing PIs
- Determination of PI assessment expectations using an adapted Miller's Pyramid model
- Incorporation of input and feedback from dietitians working in Indigenous communities
- Canada-wide, online, bilingual PI feedback survey with dietetic educators
- Liaison with Alliance of Canadian Dietetic Regulatory Bodies
- Liaison with Accreditation Council
- Liaison with CDRE personnel
- Development of content to assist user-interpretation of ICDEP
- Translation into French, and translation verification, for all materials

ICDEP V3.0 VS ICDEP V2.0 – WHAT'S CHANGED?

The significant points of refinement and clarification that distinguish ICDEP v3.0 from v2.0 are as follows:

- A restructuring and increase in the Domains of Competence (formerly called 'areas of practice') which form the structural framework for the PCs and PIs. Domains are increased from 5 in number containing 30 PCs (v2.0), to 7 in number containing 50 PCs (v3.0). This provides a more balanced picture of the abilities and expertise that dietitians bring to the workplace, creating a more meaningful stand-alone listing of PCs.
- Addition of a *Food and Nutrition Expertise* domain providing an outcome-based summary of the Foundational Knowledge Specifications listed in ICDEP v2.0.
- A shift in the deliverable requirements for dietetic education programs to 100% measurable candidate learning outcomes (PIs) and away from a partial listing of curriculum topics ('foundational knowledge' in v2.0).
- Removal of redundant and repetitive PIs in v2.0.
- A decrease in the total number of deliverables expected within education programs from 441 items (PIs & FK specifications in v2.0) to 210 items (PIs in v3.0).
- Addition of new content through 7 new PCs, to ensure currency:
    - 2.01 Practice within the context of Canadian diversity
    - 2.03 Practice in a manner that promotes cultural safety
    - 2.07 Use risk management approaches
    - 3.04 Use effective electronic communication skills
    - 4.04 Undertake knowledge translation
    - 4.07 Foster development of food literacy in others
    - 4.08 Foster development of food skills in others

- Clarification of the nature of PI assessment expected (through specifying 'Knows/Knows How/Shows How/Does assessment using an adapted Miller's Pyramid model) rather than simply noting the program components in which assessment is required.
- Addition of more thorough interpretive material including a Glossary of terminology with definitions and references.
- New French translation and thorough verification of French terminology throughout.